Electronically Delivered

July 30, 2024

Licensee
Heart of a Star Homecare
6430 Toledo Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36654015

Dear Licensee:

On July 10, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the April 11, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter with your organization's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH

Electronically Delivered

April 25, 2024

Licensee
Heart Of A Star Homecare
6430 Toledo Avenue North
Brooklyn Center, MN 55429

RE: Project Number(s) SL36654015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 11, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either $1,000 or $5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of $1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a

fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this survey:

St - 0 - 0820 - 144g.45 Subd. 2 (g) - Fire Protection And Physical Environment - $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS
In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a

hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: jess.schoenecker@state.mn.us
Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36654	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART OF A STAR HOMECARE	6430 TOLEDO AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL36654015-0 On April 9, 2024, through April 11, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction orders are issued. At the time of the survey, there were 3 residents services under the Assisted Living license. An immediate correction order was identified on April 9, 2024, issued for SL36654015, tag identification 0820. The immediacy of order 0820 was removed on April 11, 2024. Noncompliance remains and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 9, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 2 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a written emergency disaster preparedness plan with all the required content as required per Minnesota Administrative Rule 4659.0100. This had the potential to affect all visitors, employees, and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	0 680		

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0 680	Continued From page 3 portion or all of the residents). The findings include: On August 1, 2021, the licensee selected to obtain a 144G assisted living license to provide services to residents who lived in licensee's facility. On April 9, 2024, at 10:00 a.m., licensed assisted living director (LALD)-C provided licensee's emergency disaster plan binder. The binder's first pages were the Emergency Management Policy dated 2013, and at the top of the policy read, "Minnesota Statute: 144A.4791, Subd. 12." This statute is a reference to licensee's 144A comprehensive home care license, not 144G the licensee provided services to resident under. The emergency disaster plan included multiple blank areas which were to be completed by the licensee to develop a communication decision tree, delegate of authority decision tree, and information about the licensee. The plan lacked required content for Minnesota Administrative Rule 4659.0100 and State Operations Manual Appendix Z - Emergency Preparedness for All Provider and Certified Supplier Types: Interpretive Guidance. On April 11, 2024, at 10:00 a.m., LALD-C stated licensee was not aware of the required content from the Minnesota Administrative Rule 4659.0100. LALD-C stated plan was in place prior to licensee obtaining the 144G assisted living licensure and licensee had not updated their emergency disaster plan with the 144G requirements. The licensee's undated Communication Plan for	0 680		

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0 680	Continued From page 4 Emergency Preparedness policy indicated licensee would establish and maintain a communication plan that complies with Federal, State, and local laws, but failed to indicate licensee would develop, implement, and maintain an emergency disaster plan per Minnesota Administrative Rule 4659.0100 as required. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the facility's physical environment in a continuous state of good repair and operation regarding the health, safety, and well-being of the residents. This had the potential to affect a limited number of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an	0 800		

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0 800	Continued From page 5 isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). Findings include: On a facility tour on April 9, 2024, at 12:30 p.m., with licensed assisted living director (LALD)-C, the surveyor made the following observations of facility hazards and disrepair: An 8-inch round hole was broken into the drywall on the wall near the window in resident room number 1. The attic access opening was observed without a cover on it and open into the attic in the closet of resident room number 1. The attic access panel is required to be maintained in place as part of the ceiling membrane separating the attic from the habitable living space. During a facility tour on April 9, 2024, at 12:35 p.m., LALD-C, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any	0 820		

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0 820	Continued From page 6 existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide facilities that were not a distinct hazard to life. This had the potential to affect a limited number of residents and staff and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: On a facility tour on April 9, 2024, at 12:30 p.m., with licensed assisted living director (LALD)-C, it was observed that compliant emergency escape and rescue openings were not provided in resident sleeping rooms number 2 and 3. Occupied Resident Rooms Resident sleeping room number 2, occupied by R2, emergency escape and rescue clear window opening measurements are 27 ½ inches wide, 20 inches in height and 550 square inches in	0 820		

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0 820	Continued From page 7 openable area. The window was measured with LALD-C, and survey staff present. The window did not meet the minimum requirements for clear opening area. Resident sleeping room number 4, occupied by R1, emergency escape and rescue opening met the minimum clear opening requirements but the exterior window well cover was screwed in place preventing use of the emergency escape and rescue opening in the event of a fire or similar emergency. Unoccupied Room Resident sleeping room number 3, emergency escape and rescue clear window opening measurements are 27 ½ inches wide, 18 ½ inches in height and 509 square inches in openable area. The window did not meet the minimum requirements for clear opening height and clear opening area. The second emergency escape and rescue opening in room number 3, measurements are 38 inches wide, 20 inches high, 760 square inches in openable area, and 55 ½ inches from the floor to the clear opening sill. The window also would not stay open on its own without falling closed from the open position. The windows were measured with LALD-C, and survey staff present. The window did not meet the minimum requirements for maximum distance of height from the floor to the sill of the clear opening and would not stay open on its own. It was explained to LALD-C, that at least one compliant emergency escape and rescue opening is required within each resident sleeping room.	0 820		

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0 820	Continued From page 8 Existing emergency escape and rescue openings are required to meet a minimum clear opening area of 648 square inches and have a minimum dimension of 20 inches in height and a minimum dimension of 20 inches in width. And have a windowsill height from the floor to the clear opening of not more than 48 inches. These deficient conditions were visually verified by LALD-C, accompanying on the tour. Survey staff explained that an immediate correction order was issued for the above findings. TIME PERIOD FOR CORRECTION: Immediate The immediacy of order 0820 was removed on April 11, 2024. Noncompliance remains and the scope and level remain unchanged.	0 820		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney	0 950		

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0 950	Continued From page 9 ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included the designation of representatives verbatim statutory language notice. This had the potential to affect all residents who signed an assisted living contract. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 10, 2024, at 8:45 a.m., licensed assisted living director (LALD)-C provided licensee's blank Resident Agreement and indicated document was licensee's assisted living contract used by all residents who signed an assisted living contract. On the first page of licensee's assisted living	0 950		

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0 950	Continued From page 10 contract dated May 3, 2021, a place for the resident to identify a designated representative was present. Additionally, a box was present for the resident to initial to decline to identify a designated representative. The assisted living contract lacked the required verbatim notice on a document separate from the contract. On April 10, 2024, at approximately 8:45 a.m., LALD-C stated licensee was not aware of the verbatim notice language for the designated representative. LALD-C stated licensee would need to create an addendum to licensee's assisted living contract to include the verbatim notice. The licensee's undated Assisted Living Contracts policy indicated the verbatim notice would be included in licensee's assisted living contract. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by:	0 970		

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	36654	A. BUILDING: _____ B. WING _____	04/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEART OF A STAR HOMECARE	6430 TOLEDO AVENUE NORTH BROOKLYN CENTER, MN 55429

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 970	Continued From page 11 Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On April 10, 2024, at 8:45 a.m., licensed assisted living director (LALD)-C provided licensee's blank Resident Agreement and indicated document was licensee's assisted living contract used by all residents who signed an assisted living contract. On page 16, section 27. Miscellaneous Provisions of the assisted living contract dated May 3, 2021, it read, "Indemnification. Resident will indemnify and hold harmless Landlord, its employees, and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property." Additionally, it read, "Liability. Landlord is not liable to resident ... for any injury, death or property damage." On April 10, 2024, at approximately 8:45 a.m., LALD-C stated licensee was not aware the assisted living contract could not include a waiver of liability for the health and safety or personal property of a resident. LALD-C stated licensee	0 970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	36654	A. BUILDING: _____ B. WING _____	04/11/2024

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0 970	Continued From page 12 would edit the assisted living contract to remove any liability waiver. The licensee's undated Assisted Living Contracts policy indicated the assisted living contract would not include a waiver of liability. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970		
01470 SS=F	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 13 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide orientation to assisted living licensing requirements and regulations prior to providing services for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01470		

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01470	Continued From page 14 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-A and ULP-B were hired October 16, 2021, and May 15, 2023, respectively. ULP-A's Staff Orientation Outline and Sign-Off dated October 12, 2021, indicated the licensee provided orientation to 144A home care requirements, not 144G assisted living requirements licensee operated under. ULP-A's orientation lacked assisted living specific orientation including assisted living statutes, assisted living bill of rights, and handling emergencies related to licensee's assisted living emergency preparedness plan. ULP-B's Staff Orientation Outline and Sign-Off dated May 24, 2023, indicated the licensee provided orientation to 144A home care requirements, not 144G assisted living requirements licensee operated under. ULP-B's orientation lacked assisted living specific orientation including assisted living statutes, assisted living bill of rights, and handling emergencies related to licensee's assisted living emergency preparedness plan. On April 10, 2024, at 9:00 a.m., licensed assisted living director (LALD)-C stated employees were orientated based on the Staff Orientation Outline and Sign-Off document. LALD-C stated employees had been orientated to 144A home	01470		

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01470	Continued From page 15 care topics and not 144G assisted living topics as required. LALD-C stated licensee would need to review all training and re-assign training to all employees for 144G assisted living content. The licensee's undated Facility Employee Orientation policy referenced 144G statute for orientation at the top of the policy, but the content of the policy indicated employees were orientated to 144A home care content. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01530 SS=F	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor	01530		

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	36654	A. BUILDING: _____ B. WING _____	04/11/2024

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01530	Continued From page 16 meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required initial eight (8) hours of dementia care training for two of two employees (unlicensed personnel (ULP)-A, ULP-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: ULP-A and ULP-B were hired October 16, 2021, and May 15, 2023, respectively and had provided services to residents since those dates. On April 10, 2024, at 9:00 a.m., licensed assisted living director (LALD)-C provided ULP-A and ULP-B's training transcripts which included training completed on April 9, 2024, after the initiation of licensee's survey. LALD-C stated ULPs had failed to complete the trainings required and LALD-C had the ULPs complete the trainings after the initiation of the survey. ULP-A's My Transcript dated April 10, 2024,	01530		

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01530	Continued From page 17 indicated ULP-A had completed five and a quarter (5.25) hours of dementia care training prior to the initiation of licensee's survey. ULP-B's My Transcript dated April 10, 2024, indicated ULP-A had completed four (4) hours of dementia care training prior to the initiation of licensee's survey. On April 11, 2024, at 11:00 a.m., LALD-C stated licensee believed ULPs had completed dementia care training as ULPs had taken a dementia care training through licensee's contracted education program. LALD-C stated licensee was not aware of the 8 hours of dementia care training within 160 working hours for the ULPs. LALD-C stated licensee would need to assign training to all employees to ensure they all competed the number of hours of dementia care training to meet statute requirements. The licensee's undated Dementia Care Training policy indicated the accurate amount of dementia care training hours within the correct timeframes to meet statute requirements. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		

Minnesota Department of Health
Food, Pools, & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *04/09/24*
Time: 12:55:00
Report: 1043241083

Food and Beverage Establishment Inspection Report

Location:
Heart Of A Star Homecare
6430 Toledo Avenue North
Brooklyn Center, MN55429
Hennepin County, 27

Establishment Info:
ID #: 0038115
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 7632830671
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) ***** Priority 1 *****

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

RAW BACON STORED DIRECTLY BESIDE/ON CHEESE IN KITCHEN COOLER. CARTON OF EGGS STORED ABOVE BUTTER AND JUICE IN DOWNSTAIRS COOLER. PROVIDED STAFF WITH PROPER FOOD STORAGE OPTIONS. COMPLY WITH ABOVE RULE.

Comply By: 04/09/24

2-100 Supervision

2-102.12AMN

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

PER STAFF, CFPM IS ALSO THE CFPM AT ANOTHER FACILITY. CFPM SHOULD NOT BE USED ACROSS MULTIPLE LOCATIONS. ADVISED STAFF TO DESIGNATE A DIFFERENT CFPM AT EACH LOCATION. COMPLY WITH ABOVE RULE.

Comply By: 04/09/24

3-300C Protection from Contamination: equipment/utensils, consumers

3-304.14B

MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.

WET CLOTH STORED ON KITCHEN SINK COUNTER. ADVISED STAFF TO STORE WET CLOTHS IN A SANI BUCKET OR TO USE A NEW, DRY CLOTH EACH TIME. SANI SOLUTION FOR QUATERNARY AMMONIA SHOULD MEASURE 200-400 PPM. COMPLY WITH ABOVE RULE.

Comply By: 04/09/24

Surface and Equipment Sanitizers

Hot Water: = at 160 Degrees Fahrenheit
Location: DISH MACHINE
Violation Issued: No

Food and Equipment Temperatures

Process/Item: MILK
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: No

Process/Item: BACON
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: No

Process/Item: CHEESE
Temperature: 41 Degrees Fahrenheit - Location: KITCHEN COOLER
Violation Issued: No

Process/Item: HOT DOGS
Temperature: 38 Degrees Fahrenheit - Location: DOWNSTAIRS COOLER
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	2

Discussed date marking, illness policy, sanitizer use, ware washing, temperature control, hand washing, cleaning, pest control, vomit/fecal procedures, test kits, food storage, and food handling procedures.

Inspection was completed with Jessica Gray. Brandon Mueller was the lead Health Regulation Division Nurse Evaluator on site completing the site survey.

**Foods cooked by the facility staff for clients should be fully cooked and prepared for same day service with leftovers discarded.

**This facility has a residential kitchen with residential equipment and wooden cabinetry. Contact Health Regulation Division for plan review when facility undergoes remodeling.

Type: Full
Date: *04/09/24*
Time: 12:55:00
Report: 1043241083
Heart Of A Star Homecare

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 1043241083 of 04/09/24.

Certified Food Protection Manager: Jessica Gray

Certification Number: FM110110 Expires: 03/16/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Jessica Gray
PIC

Signed: Blia Lor
Blia Lor
Public Health Sanitarian I
651-355-0641
blia.lor@state.mn.us