STATE LICENSING COMPLIANCE REPORT

Report #: HL358756483C

Date Concluded: October 4, 2024

Name, Address, and County of Facility Investigated:
Morning Star Health Care Services
6400 Georgia Avenue North
Minneapolis, MN 55428
Hennepin County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit: https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35875	A. BUILDING: _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNING STAR HEALTH CARE SERVICES	6400 GEORGIA AVENUE NORTH MINNEAPOLIS, MN 55428

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0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER CORRECTION ORDER In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation. Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: #HL358756483C On September 11, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were two residents receiving services under the provider's Assisted Living license. The following correction orders are issued for #HL358756483C, tag identification 1060, 1070.	0 000		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 1 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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01060	Continued From page 2 licensee failed to provide written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R1). 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 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). The findings include: R1's diagnoses included bipolar disorder, phobic disorder, depression, post traumatic stress disorder, and schizoaffective disorder. R1's service plan was requested, but not provided. R1's assessment was requested, but not provided. R1's progress notes indicated on July 9, 2024, police were called after the resident threw a chair at staff and was displaying aggressive behaviors. The resident "punched staff. The police arrested resident..." No additional progress notes were entered after July 9, 2024. Hospital records indicated the resident was brought to the emergency room by police officers	01060		

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01060	Continued From page 3 on July 10, 2024, and later admitted to inpatient behavioral health. Facility staff picked up the resident from the hospital on July 28, 2024, and drove the resident to the airport. The resident boarded a flight to New York to return to his mother's home. R1's record contained a Notice of Termination of Assisted Living Contract dated July 22, 2024. The expedited termination for housing and services indicated the resident was being terminated for "violent, aggressive toward staff and other clients. Punched staff on the eye leading to ER visit, staff still recovering, destroyed facility's property." The notice included "As a resident you have the right to appeal the termination by requesting a hearing. You must submit the request by (insert time frame) to (insert contact information)..." The record lacked evidence on how the resident or hospital was notified of the termination notice dated July 22, 2024. R1's record contained a Cover Sheet for Notices from Assisted Living Facilities to the Office of Ombudsman for Long Term Care dated July 22, 2024. The type of notice sent was noted to be notice of contract termination, not an emergency relocation. R1's record lacked a written notice that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident has been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 4 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On September 17, 2024, at 12:45 p.m., administrator (AD)-A confirmed an emergency relocation notice was not sent. The licensee's Discharge and Transfer of Residents policy dated January 24, 2022, indicated a resident may be removed in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident posed to the health or safety of another resident or staff member. In the event of an emergency relocation, the facility would, as soon as possible, provide a written notice of emergency relocation to the resident, their legal representative, designated representative, and case manager. If the resident was relocated and had not returned within four days, the OOLTC would be notified. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01070 SS=D	144G.52 Subd. 10 Right to return If a resident is absent from a facility for any reason, including an emergency relocation, the facility shall not refuse to allow a resident to	01070		

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01070	Continued From page 5 return if a termination of housing has not been effectuated. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to allow the return of one of one resident (R1) after they were sent to the emergency room. Hospital records indicated the licensee would not accept R1 back after being medically cleared to return. The licensee failed to offer any option for R1 to return as a housing-only resident with the necessary services provided by another agency. 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 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). The findings include: R1's diagnoses included bipolar disorder, phobic disorder, depression, post traumatic stress disorder, and schizoaffective disorder. R1's service plan was requested, but not provided. R1's assessment was requested, but not provided. R1's progress notes indicated on July 9, 2024, police were called after the resident threw a chair at staff and was displaying aggressive behaviors. The resident "punched staff. The police arrested	01070		

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01070	Continued From page 6 resident..." No additional progress notes were entered after July 9, 2024. Hospital records indicated the resident was brought to the emergency room by police officers on July 10, 2024, and later admitted to inpatient behavioral health. Hospital records indicated the resident was medically stable to discharge however the facility was not able to take the resident back. Hospital documentation indicated the facility was going to hire more staff to care for the resident and anticipated taking him back on July 26, 2024, but "although it was previously stated by home that they'd consider patient for a return, they are deciding to file for termination of care today [July 25, 2024]. GH [group home/assisted living facility] feels they are not equip to continue providing care for patient and feels he needs further treatment and supports..." The hospital worked with the resident's mom to coordinate air travel to get the resident to her home out of state. R1's record contained a Notice of Termination of Assisted Living Contract dated July 22, 2024. The expedited termination for housing and services indicated the resident was being terminated for "violent, aggressive toward staff and other clients. Punched staff on the eye leading to ER visit, staff still recovering, destroyed facility's property." The notice included "As a resident you have the right to appeal the termination by requesting a hearing. You must submit the request by (insert time frame) to (insert contact information)..." The record lacked evidence on how the resident or hospital was notified of the termination notice dated July 22, 2024. Hospital records indicated facility staff picked up	01070		

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01070	Continued From page 7 the resident from the hospital on July 28, 2024, and drove the resident to the airport. The resident boarded a flight to New York to return to his mother's home. On September 17, 2024, at 12:45 p.m., administrator (AD)-A stated they had sent a termination notice but were told by the resident's case manager that was not the right procedure and other steps needed to be taken prior to terminating his housing or services. AD-A stated the resident chose to go to New York and she was waiting for him to return before moving forward with the proper procedure for terminating services. AD-A stated the resident's room was still open at the facility and he could return if he wanted to. The licensee's Discharge and Transfer of Residents policy dated January 24, 2022, indicated prior to issuing a notice of termination, the facility "shall schedule and participate in a pretermination meeting with the resident, the resident's legal representative and the resident's designated representative to discuss" the termination notice. Within 24 hours of the pretermination meeting, the resident and the resident's representatives would be provided a written summary of the meeting. The summary was to include any agreements related to accommodations, modification, interventions or alternatives that would be implemented to avoid terminating the resident's contract. The written termination notice was to be delivered by hand or mail. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01070		

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