Electronically Delivered

September 4, 2025

Licensee
EE And E Sisters Caring Home LLC
81 117th Avenue Northeast
Blaine, MN 55434

RE: Project Number(s) SL38433016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 23, 2025, 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.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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.

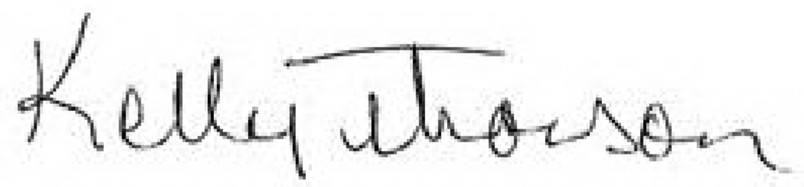
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

AH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	38433	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EE AND E SISTERS CARING HOME LLC	81 117TH AVENUE NE BLAINE, MN 55434

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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: SL38433016-0 On July 21, 2025, through July 23, 2025, 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; 3 receiving services under the Assisted Living Facility license.	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 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 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 evaluators ' 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 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480		

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. 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, 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 portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 23, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 495 SS=F	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the licensee failed to ensure that a registered nurse (RN) was available on-call for current and foreseeable needs 24 hours a day, seven days per week due to licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A holding other full-time employment at another health care provider. This had the potential to affect all three residents and staff of the facility. 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 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 July 21, 2025, through July 23, 2025, the surveyor conducted a routine survey of the licensee and observed LALD/CNS-A assist with the survey process, supervise staff, and answer questions about the residents and operations of	0 495		

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0 495	Continued From page 4 the facility. On July 21, 2025, at 10:00 a.m. during the entrance conference, LALD/CNS-A stated they are the only nurse for this facility. LALD/CNS-A stated he has another full-time job; however, they have an appointment tomorrow with another RN to discuss becoming the facility back up nurse. LALD/CNS-A stated he is always available by phone even when he is at his other job and has not taken any vacations in the last few years. The current employee list dated February 14, 2023, provided by the licensee, indicated LALD/CNS-A was the only RN listed. On July 22, 2025, at 9:00 a.m., unlicensed staff (ULP)-D stated she has never had an issue with getting in touch with LALD/CNS-A for any nursing related questions or concerns that need to be reported. On July 23, 2025, at 9:00 a.m., owner (O)-B stated they had completed an interview with registered nurse applicant (RNA)-E last evening, and she had accepted the position to be the back up nurse for the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 495		
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 5 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 interview and record review the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all 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, 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 6 portion or all the residents). The findings include: The licensee's undated emergency preparedness plan (EPP), lacked the required content: - development and maintenance of the EPP; - maintained annual updates and risk assessment; - a quarterly review of missing resident policy; - a description of the population served by the licensee; - the development of policies/procedures to address: - subsistence needs for staff and patients; - procedures for tracking of staff and patients; - use of volunteers; and - arrangement with other facility. - development of a communication plan; - names and contact information for staff entities providing services; residents physicians, other facilities, and volunteers; - contact information for federal, state, tribal, local EP staff, state licensing and certification agency, or the ombudsman for long term care; - primary and alternative means for communicating with facility staff, or federal, state, regional and local emergency management agencies; - methods for sharing medical documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means to provide information about the facility's occupancy, needs, and its ability to provide assistance to the authority having jurisdiction, the incident command center, or a designee; and - evidence of conducted exercises to test the EP at least twice per year.	0 680		

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0 680	Continued From page 7 On July 21, 2025, at 12:15 p.m., licensed assisted living facility/clinical nurse supervisor (LALD/CNS)-A stated he agreed the EPP had not been reviewed annually, the missing person had not been reviewed quarterly, some of the required information required in the EPP is missing, and they did not have records to show testing of the EPP plan twice annually, they had talked about it but it was not documented. The licensee's Emergency Preparedness policy dated September 6, 2022, indicated the licensee will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services. A disaster drill is conducted at the residence at the residence at least annually. Results of the drill will be documented. The licensee's Missing Resident policy dated September 6, 2022, indicated the missing resident procedure will be reviewed by the director and clinical nurse supervisor at least quarterly. Changes to the plan will be documented. Per Assisted Living Facilities: Minnesota Rules Chapter 4659, 4659.0110, Subd. 4. Review missing resident plan. The assisted living director and clinical nurse supervisor must review the missing person plan at least quarterly and document any changes to the plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		

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0 775	Continued From page 8	0 775		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 21, 2025, at 2:20 p.m., the surveyor toured the facility with owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following: - Carbon monoxide alarms were not installed within ten feet of all sleeping rooms. - The egress window in occupied resident sleeping room 1 was obstructed by the placement of a dresser and mirror in front of the window. - When the egress window in unoccupied resident sleeping room 4 was opened by the licensee, the bottom of the casement window came in contact with the soil at the base of the window well, making it difficult to open. - There were exposed electrial wires and a mounting bracket for a light fixture on the exterior	0 775		

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0 775	Continued From page 9 of the facility near the top corner of the front door. - There was paint on an electrical wall outlet in unoccupied resident room 4. During the facility tour interview, O-B and LALD/CNS-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;	0 780		

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0 780	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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 a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 21, 2025, at 2:20 p.m., the surveyor toured the facility with owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed a hardwired smoke alarm installed in the basement at the bottom of the stairs. When the wireless smoke alarms were tested, this hardwired smoke alarm was not actuated. During the facility tour interview, O-B and LALD/CNS-A verified the above listed observation. All dwelling unit smoke alarms must be interconnected so actuation of one alarm causes all alarms in the dwelling unit to operate. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment	0 800		

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0 800	Continued From page 11 (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 provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 21, 2025, at 2:20 p.m., the surveyor toured the facility with owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed the following: - One section of base trim was loose in the main floor living room. - The wall surface was peeling behind the bathroom sink in the basement. - In resident room 2, one side of the closet was	0 800		

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EE AND E SISTERS CARING HOME LLC	81 117TH AVENUE NE BLAINE, MN 55434

(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
0 800	Continued From page 12 off the track. - In resident room 3, the knob for the closet door was missing. - There was a small hole in the exterior siding of the building. During the facility tour interview, O-B and LALD/CNS-A verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at	0 810		

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0 810	Continued From page 13 least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with required content, make all parts of the plan readily available, and provide required training and drills. This had the potential to directly affect all 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 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 July 21, 2025, owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee failed to identify the location and number of resident sleeping rooms evident by the following: On July 21, 2025, at 2:20 p.m., the surveyor toured the facility with O-B and LALD/CNS-A.	0 810		

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0 810	Continued From page 14 During the facility tour, the surveyor observed: - Resident sleeping rooms 4 and 5 were located in the basement. The posted evacuation floor plans labeled these resident sleeping rooms as storage and an office. - A room number identifier was not posted at the door for the resident sleeping room verbally identified as one (1) by O-B and LALD/CNS-A during the facility tour. - Record review of the available documentation indicated the licensee failed to identify the number of resident sleeping rooms on the posted evacuation floor plan. Resident sleeping room numbers are required to be included on the fire safety and evacuation floor plan and used with the numbers installed on the resident sleeping room doors to provide efficient communication for exiting in the event of a fire or similar emergency. The licensee failed to develop the fire safety and evacuation plan with required content evident by the following: - On July 21, 2025, at 2:20 p.m., the surveyor toured the facility with O-B and LALD/CNS-A. During the facility tour, the surveyor observed an exit sign was posted at the door leading into the attached garage from the kitchen. The posted evacuation floor plans labeled the door leading into the attached garage from the home as an exit. Emergency exits are required to lead directly to the exterior of the building and not through a higher-hazard room. - The front door was not labeled as the primary exit on the posted evacuation floor plan. Exit labels are required to be included on the floor plan to direct occupants to the exits in the event of an emergency. - Egress windows were inaccurately labeled in the bathroom, kitchen, and living room on the evacuation floor plan. - Record review of the available documentation	0 810		

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0 810	Continued From page 15 indicated the licensee had not developed and maintained the FSEP fire safety policy with site specific procedures evident by the following: The FSEP fire safety template, dated May 31, 2025, included standard employee procedures, but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) acronym and pull fire alarms were inaccurately referenced. The FSEP fire safety template dated May 31, 2025, failed to include fire safety and evacuation instructions for residents evident by the lack of these procedures in the plan. The FSEP instructions were limited to directing residents to stoop or crawl to avoid smoke. The FSEP failed to include procedures for the individualized unique needs of residents evident by a lack of these procedures in the plan. During an interview on July 21, 2025, at 3:45 p.m., O-B and LALD/CNS-A stated there was another copy of the FSEP that they were unable to locate, and this documentation would be emailed to the surveyor. The fire evacuation policy and training procedure dated April 14, 2024, was emailed to the surveyor by O-B on July 22, 2025, at 2:42 p.m. This part of the FSEP was not maintained as readily available on July 21, 2025, when the surveyor was onsite at the facility. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by the lack of documentation to support this training had been completed. The surveyor requested records from O-B and LALD/CNS-A for resident fire safety and evacuation training completed between July 2024 and July 2025. Fire drill logs were provided.	0 810		

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0 810	Continued From page 16 O-B and LALD/CNS-A stated resident names were recorded on the fire drill logs when they participated and verified additional training records were not available. Record review indicated the licensee failed to provide training to employees on the FSEP upon hire and at least twice per year evident by the lack of documentation to support this training had been completed. The surveyor requested records from O-B and LALD/CNS-A for employee FSEP training completed between July 2024 and July 2025, and at the time of hire. No FSEP training documentation was provided. During an interview on July 21, 2025, at 3:45 p.m., O-B and LALD/CNS-A verified these training records were not available and stated if located, this documentation would be emailed to the surveyor no later than 4:00 p.m. on July 22, 2025. No completed training records were received. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill logs lacking the required frequency and documentation. Three fire drills were recorded in 2025, completed in February, April, and June. Two fire drills were recorded in 2024, completed in January and August. The time and/or shift of the drill was not recorded on the 2024 drill records. The time and/or shift of the drill was not recorded on the April and June 2025 drill records. During an interview on July 21, 2025, at 3:45 p.m., O-B and LALD/CNS-A verified the evacuation drill frequency was not met and the required documentation was lacking. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		

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0 830 SS=E	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation and record review, the licensee failed to submit a plan review application for the addition of two resident sleeping rooms in the basement. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On July 21, 2025, at 2:20 p.m., the surveyor toured the facility with owner (O)-B and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. During the facility tour, the surveyor observed resident sleeping rooms 4 and 5 were located in the basement.	0 830		

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0 830	Continued From page 18 Record review indicated that a plan review application had not been submitted to Minnesota Department of Health (MDH) Engineering Services for the addition of these two basement sleeping rooms. In an MDH engineering services inspection letter addressed to the licensee, dated February 25, 2022, the occupany was approved for three sleeping rooms located on the main floor. No sleeping rooms had been approved for the basement. TIME PERIOD FOR CORRECTION: Seven (7) days	0 830		
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation	01620		

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01620	Continued From page 19 of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure the registered nurse (RN) used the uniform assessment tool for ongoing assessments and monitoring 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) and was issued at a	01620		

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01620	Continued From page 20 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: R1 was admitted and began receiving services on April 18, 2025. R1's record included an initial comprehensive assessment dated April 18, 2025, a 14-day assessment dated May 2, 2025, and a 90-day assessment dated July 17, 2025. R1's 14-day and 90-day assessments did not include the following required elements on the uniform assessment tool: - the residents personal lifestyle preferences, including sleep schedule, dietary and social needs, leisure activities, and any other customary routine that is important to the resident's quality of life, spiritual and cultural preferences, and advance health care directives and end-of-life preferences; - activities of daily living, including toileting pattern, dressing, grooming, bathing, and personal hygiene, mobility, including ambulation, transfers, and assistive devices and eating, dental status, oral care, and assistive devices and dentures; - instrumental activities of daily living, including housework and laundry and transportation; - physical health status, including a review of relevant health history and current health conditions including medical and nursing diagnoses, allergies and sensitivities related to medication, seasonality, environment, and food and if any of the allergies or sensitivities and life threatening, infectious conditions, a review of medications, a review of medical, dental, and	01620		

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01620	Continued From page 21 emergency room visits in the past 12 months, including visits to a primary health care provider, hospitalizations, surgeries, and care from a post-acute care facility, a review of any reports from a physical therapist, occupational therapist, speech therapist, or cognitive evaluations within the last 12 months, weight, and initial vital signs if indicated by health conditions or medications; - emotional and mental health conditions, including review of history of and any diagnoses of mood disorders, including depression, anxiety, bipolar disorder, and thought or behavioral disorders, effective medication treatment and non-medication interventions; - cognition, including a review of any neurocognitive evaluations and diagnoses; - communication and sensory capabilities, including speech, assistive communication and sensory devices including hearing aids, and the ability to understand and be understood; - pain, including location, frequency, intensity, and duration; - skin conditions; - nutritional and hydration status and preferences; - list of treatments, including type, frequency, and level of assistance needed; - nursing needs, including potential to receive nursing-delegated services; - risk indicators including risk for falls including history of falls, emergency evaluation ability, complex medication regimen, risk for dehydration, including history of urinary tract infections and current fluid intake pattern, risk for emotional or psychological distress due to personal losses, unsuccessful prior placements, elopement risk including history or previous elopements, smoking, including the ability to smoke without causing burns or injury to the resident or others or damage property and alcohol and drug use, including the resident's	01620		

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01620	Continued From page 22 alcohol use or drug use not prescribed by a physician; - who has decision making authority for the resident including the presence of any advance health care directive or other legal document that establishes a substitute decision maker and the scope of decision-making authority of a substitute decision maker; and - the need for follow-up referrals for additional medical or cognitive care by health professionals. On July 22, 2025, at 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he did not realize the assessment form he was using was missing some of the required elements of the uniform assessment tool but agrees the form he is using does not address all of the required elements and he uses the same form for all the resident assessments. The Minnesota Administrative Rule 4659.0150 dated August 1, 2021, indicated each facility must develop a uniform assessment tool to include all the required elements. The licensee's Comprehensive Nursing Assessment policy dated September 6, 2022, indicated the registered nurse (RN) will conduct a comprehensive assessment for all residents admitted to [the facility] to determine services required and to develop an individualized care plan for staff to implement. The assessment addressed the resident's physical, mental, and cognitive needs. The RN will conduct a comprehensive assessment utilizing a uniform assessment tool. No further information was provided.	01620		

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01620	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01620		
01750 SS=F	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide specific resident instructions related to the administration of medications for two of two residents (R1 and R3). 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:	01750		

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01750	Continued From page 24 R1 R1's diagnoses included diabetes type two, major neurocognitive disorder (a condition characterized by a significant decline in cognitive abilities that interferes with a person's ability to function independently in daily life), traumatic brain injury, and seizure disorder. R1's service plan dated April 18, 2025, indicated R1's services included medication administration, blood glucose checks, bathing, dressing, behavioral interventions, laundry, and housekeeping. R1's electronic medication administration record (EMAR) dated July 1, 2025, through July 31, 2025, included: - glargine 100U/ML INJ - inject subcutaneously twice a day 22 units at 8 am and 15 units at 8pm (12 hours apart). R1's record did not include specific resident instructions relating to the administration of insulin, to include the following: - performing a safety test (making sure insulin is coming out of the needle); - rotation of injection site; and - proper injection techniques The manufacturer's instructions for insulin glargine injection indicated to perform a safety test before each injection. Rotate your injection sites with each dose to reduce your risk of getting lipodystrophy (pitted or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites. Use your thumb to press the injection button all the way down. When the number in the dose window returns to zero (0) as you inject, slowly count to ten (10) before removing. (Counting to 10 will make sure you get	01750		

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01750	Continued From page 25 your full insulin dose.) R3 R3's diagnoses included essential hypertension, psychosis, personality disorder, and depression. R3's service plan dated November 22, 2024, indicated R3's services included medication administration, bathing, dressing, behavioral interventions, laundry, and housekeeping. R3's EMAR dated July 1, 2025, through July 31, 2025, included: - Advair HFA - inhale 2 puffs into the lungs twice a day. On July 22, 2025, at 9:00 a.m., the surveyor observed unlicensed personnel (ULP)-D administer R3's inhaler. ULP-D failed to remind R3 to rinse his mouth after the use of the inhaler. ULP-D stated the EMAR does not indicate to rinse after use of the inhaler. The manufacturer's instructions for Advair Diskus indicate to rinse your mouth with water without swallowing after each dose of Advair Diskus. This will help lessen the chance of getting a yeast infection (thrush) in your mouth and throat. On July 22, 2025, at 9:10 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the pharmacy pushes the prescriptions through to the EMAR and he checks them for accuracy, however, he did not add specific instructions for the unlicensed staff to follow onto the EMAR for the insulin injection or the inhaler and will add them today. The licensee's Medication Administration policy dated September 6, 2022, indicated the	01750		

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	38433	A. BUILDING: _____ B. WING _____	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EE AND E SISTERS CARING HOME LLC	81 117TH AVENUE NE BLAINE, MN 55434

(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
01750	Continued From page 26 registered nurse (RN) may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol: - all home health aides have passed a competency evaluation with respect to all medications routes to be administered; - the RN has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident; and - the RN has communicated with/provided orientation to the home health aide regarding the individual needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure current written or electronically recorded prescriptions were obtained for one of two residents (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	01820		

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01820	Continued From page 27 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: R1 was admitted and started receiving services on April 18, 2025, with diagnoses that included diabetes type two, major neurocognitive disorder (a condition characterized by a significant decline in cognitive abilities that interferes with a person's ability to function independently in daily life), traumatic brain injury, and seizure disorder. R1's service plan dated April 18, 2025, indicated R1's services included medication administration. R1's Medication administration record (MAR) dated July 1, 2025 through July 31, 2025, indicated R1 received medications to include: - doxycycline 100 mg by mouth twice daily; - acetaminophen 500 mg by mouth three times a day as needed for pain. R1's signed physician orders dated April 22, 2025, lacked orders for either medication. On July 23, 2025, at 9:00 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he has reached out to the clinic to get orders since the initial orders were signed and has not had any luck getting the orders back, he did not realize he could get the orders from the pharmacy. LALD/CNS-A stated he has the annual orders for all resident's but any orders since they were signed, he will need to get from the pharmacy. The licensee's Medication Orders policy dated	01820		

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01820	Continued From page 28 September 6, 2022, indicated the licensee will maintain a current written or electronically recorded prescription for all prescribed medications managed for the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to date time-sensitive medications with an opened or expired date 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:	01890		

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	38433	A. BUILDING: _____ B. WING _____	07/23/2025

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01890	Continued From page 29 On July 22, 2025, at 8:30 a.m., the surveyor observed the medication box for R1 with unlicensed staff (ULP)- D, which included a insulin glargine pen with no open date. On July 22, 2025, at 8:30 a.m., ULP-D stated insulin pens should be marked with the date they are opened and confirmed this pen did not have an open date but had been used. On July 22, 2025, at 8:35 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the staff normally put an open date on the insulin pens after opening them, it appears this pen must have been opened this morning, and they must have forgotten to put the date on the pen. The manufacturer's instructions dated August 2022, indicated after 28 days, throw your opened insulin glargine pen away even if it still has insulin in it. The licensee's Storage/Control of Medications policy dated September 6, 2022, indicated the licensed nurse is responsible for dating time-sensitive medications when opened. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare	01940		

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01940	Continued From page 30 and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of one resident (R1) with blood glucose monitoring. 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	01940		

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01940	Continued From page 31 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: R1 was admitted and started receiving services on April 18, 2025. R1's diagnoses included diabetes type two, major neurocognitive disorder (a condition characterized by a significant decline in cognitive abilities that interferes with a person's ability to function independently in daily life), traumatic brain injury, and seizure disorder. R1's service plan dated April 18, 2025, indicated R1's services included medication administration, blood glucose checks, bathing, dressing, behavioral interventions, laundry, and housekeeping. R1's physician orders dated April 18, 2025 through April 17, 2026, indicated R1 received blood glucose monitoring twice daily. R1's medication administration record/ treatment administration record (MAR/TAR) dated July 2025, indicated R1 received blood glucose monitoring twice daily. R1's record lacked an individualized treatment plan. R1's individualized treatment plan and TAR/MAR both lacked the following required information: - documentation of specific resident instructions relating to the treatments or therapy administration; - procedures for notifying a registered nurse or	01940		

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01940	Continued From page 32 appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On July 22, 2025, at 1:50 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he did not create an individualized treatment plan for anyone and was not aware of the required components for the treatment plan. The licensee's Treatment and Therapy Management policy dated September 6, 2022, indicated the RN or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: - Type of service to be provided; - Procedures for documenting treatments or therapies; - Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; - Identification or treatment or therapy tasks delegated to unlicensed personnel; and - Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		

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02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R2) with hospital-style bed rails. 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: On July 21, 2025, at 11:00 a.m., the surveyor observed R2's bilateral bed rails attached to the hospital bed. R2 was admitted and began receiving services on September 21, 2023. R2's service plan dated February 11, 2025, indicated R2 received assistance with dressing, bathing, toileting, medication administration, transfers, behavioral interventions, laundry and	02310		

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02310	Continued From page 34 housekeeping. R2's bed rail assessment dated September 21, 2023, lacked documented bed rail measurements, risk vs. benefit discussion. On July 23, 2025, at 9:45 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated he missed adding the measurements to the assessment, missed the checkbox to document he had discussed risk vs. benefits, and did the bedrail assessment every 90 days. The Food and Drug Administration's (FDA) A Guide to Bed Safety Bed Rails in Hospitals Nursing Homes and Home Health Care dated December 11, 2017, indicated the following information: "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." Additionally, per FDA recommendations, the need for bed rails must be assessed on a "frequent, regular basis." At a minimum this would include assessment of the bed rail upon initial installation, with each 90-day assessment, or with a change of condition. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated April 3, 2024, indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail	02310		

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02310	Continued From page 35 to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail - The resident's bed rail use/need assessment - Risk vs. benefits discussion (individualized to each resident's risks) - The resident's preferences - Installation and use according to manufacturer's guidelines - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The licensee's Side Rail Use policy dated September 6, 2022, indicated the resident/resident's representative will co-sign the document agreeing to the benefits and risks of the side rails. The registered nurse is responsible to ensure that the side rails in use are of a safe	02310		

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02310	Continued From page 36 design and properly maintained. The need for side rails will be reassessed and the side rails inspected as needed, but not less that every 90 days. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	02310		

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

EE & E Sisters Caring Home LLC
81 117th Ave NE
Blaine, MN 55434
Anoka County
Parcel:

Phone:

License Info

License: 0041261

Risk:
License: -1
Expires on: 12/31/2023
CFPM: Dorcas A Oyetunde
CFPM #: 113466; Exp: 10/13/2025

Inspection Info

Report Number: F1018251025
Inspection Type: Full - Single
Date: 7/22/2025 Time: 3:04:26 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: Raw shell eggs observed to be stored over ready to eat foods in the refrigerator. Discussed with staff to keep eggs below ready to eat foods so as to avoid potential cross contamination. COS
Comply By: Complied On Site Originally Issued On: 7/22/2025

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT: Establishment does not currently have a functional thermometer for checking food temperatures. Comply with rule.
Comply By: 7/22/2025 Originally Issued On: 7/22/2025

! New Order: 4-700 Sanitizing Equipment and Utensils
4-703.11B *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.
COMMENT: Unable to verify dishwasher sanitizing temperature. Comply with rule.
Comply By: 7/22/2025 Originally Issued On: 7/22/2025

Food & Beverage General Comment

ESTABLISHMENT IS A RESIDENTIAL HOME WITH RESIDENTIAL EQUIPMENT.

FLOORS, WALLS AND CEILINGS WERE OBSERVED TO BE IN GOOD CONDITION DURING THIS INSPECTION AND WILL BE MONITORED THROUGH THE YEARS.

KITCHEN HAS A TWO BASIN SINK WITH ONE SINK SPECIFICALLY FOR HAND WASHING.

DISHWASHER HAS SANITIZE FUNCTION AVAILABLE.

DISCUSSED PEST CONTROL AND ILLNESS REPORTING.

VIEWED EMPLOYEE ILLNESS LOG.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Metro District Office inspection report number F1018251025 from 7/22/2025

Rebecca Prestwood

Dorcas Oyetunde
Manager

Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us

Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Establishment Info

EE & E Sisters Caring Home LLC
Blaine
County/Group: Anoka County

Inspection Info

Report Number: F1018251025
Inspection Type: Full
Date: 7/22/2025
Time: 3:04:26 PM

Equipment Temperature: Product/Item/Unit: ; Temperature Process: Cold-Holding
Location: Cooler at 40 Degrees F.
Comment:
Violation Issued?: No