Electronically Delivered

March 25, 2025

Licensee
The Caring Sisters Home Care
2833 Yosemite Avenue South
Saint Louis Park, MN  55416

RE: Project Number(s) SL24801015

Dear Licensee:

On February 24, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine the correction of orders from the survey completed on August 28, 2024, and the follow-up survey completed on November 12, 2024. 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

JMD

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

January 28, 2025

Licensee
The Caring Sisters Home Care
2833 Yosemite Avenue South
Saint Louis Park, MN  55416

RE:  Project Number(s) SL24801015

Dear Licensee:

On November 12, 2024, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 28, 2024. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 24, 2024 survey.

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 24, 2024, found not corrected at the time of the November 12, 2024, follow-up survey and/or subject to penalty assessment are as follows:

**0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g)**

The details of the violations noted at the time of this follow-up survey completed on November 12, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

**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**

**INFORMAL CONFERENCE**

In accordance with Minn. Stat. § 144A.475, Subd. 8 OR Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues. The Department of Health staff would like to schedule a conference call with The Caring Sisters Home Care. Please contact Bob Dehler at 651-201-3710 on or before Friday, January 31, 2025, to schedule the conference call.

We urge you to review these orders carefully. If you have questions, please contact Jess Schoenecker at 651-201-3789.

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

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 |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | R 11/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

| (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<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL#24801015-1<br><br>On November 12, 2024, the Minnesota Department of Health conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on August 28, 2024. At the time of the survey, there were 3 active residents; 3 receiving services under the Assisted Living license. As a result of the revisit, the following orders were reissued and/or issued. | {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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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;<br>(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<br>allowed provided the facility keeps them clean and in good condition;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by: | {0 480} | Not reviewed during this survey. | |
| {0 510} SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by: | {0 510} | Not reviewed during this survey. | |
| {0 680} SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness | {0 680} | | |

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| {0 680} | Continued From page 3<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that 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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by: | {0 680} | Not reviewed during this survey. | |
| {0 780} SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate | {0 780} | | |

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| {0 780} | Continued From page 4<br>sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by: | {0 780} | Not reviewed during this survey. | |
| {0 790} SS=F | 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and | {0 790} | | |

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| {0 790} | Continued From page 5<br>This MN Requirement is not met as evidenced by: | {0 790} | Not reviewed during this survey. | |
| {0 800} SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by: | {0 800} | Not reviewed during this survey. | |
| {0 810} SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Staff of assisted living facilities shall receive | {0 810} | | |

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| {0 810} | Continued From page 6<br><br>training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 least once per year.<br>(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.<br><br>This MN Requirement is not met as evidenced by: | {0 810} | Not reviewed during this survey. | |
| {0 820} SS=D | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(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 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. | {0 820} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| {0 820} | Continued From page 7<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide resident bedrooms with the minimum window opening meeting the minimum state standard for egress. This had the potential to affect two residents and all staff.<br><br>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).<br><br>The findings include:<br><br>On November 12, 2024, surveyor conducted a revisit to follow-up on orders issued pursuant to a survey completed on August 28, 2024.<br><br>On November 12, 2024, at 11:30 p.m. per phone conversation, licensed assisted living director (LALD)-D stated the bedroom 1 window had not been replaced, were working with a contractor, and awaiting delivery of the window in about a week to move forward with the window install.<br><br>On November 12, 2024, at 12:00 p.m. survey staff toured the facility with LALD-D. During the tour, survey staff asked LALD-D to open the window in the resident bedroom 1 for measurement. The noncompliant measurements | {0 820} | | |

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| {0 820} | Continued From page 8<br>were as follows:<br><br>Bedroom 1: window measured 27 inches clear width, 21 inches clear height, and 567 square inches total open area.<br><br>The window in bedroom 1 did not meet the minimum requirements for total openable area.<br><br>Survey staff explained to LALD-D that at least one window in each bedroom in a state-licensed facility must meet the minimum state fire code standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings.<br><br>Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window.<br><br>No further information was provided. | {0 820} | | |
| {01880} SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by: | {01880} | Not reviewed during this survey. | |
| {02320} SS=D | 144G.91 Subd. 4 (b) Appropriate care and services | {02320} | | |

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| {02320} | Continued From page 9<br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by: | {02320} | Not reviewed during this survey. | |

Electronically Delivered

October 3, 2024

Licensee
The Caring Sisters Home Care
2833 Yosemite Avenue South
Saint Louis Park, MN  55416

RE:  Project Number(s) SL24801015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 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.

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

**0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. 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.

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**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**

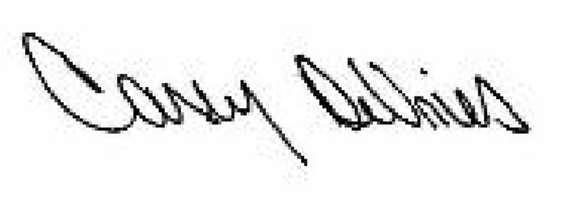
To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms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



Casey DeVries, Supervisor
State Evaluation Team
Email: casey.devries@state.mn.us
Telephone: 651-201-5917 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 |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

| (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 |
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| 0 000 | Initial Comments<br><br>******ATTENTION******<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br>SL24801015-0<br><br>On August 26, 2024, through August 28, 2024, the Minnesota Department of Health conducted a full survey at the above provider, and the following correction are issued. At the time of the survey there were three residents living at the facility, all three residents received services under the Assisted Living license.<br><br>An immediate correction order was identified on August 27, 2024, issued for SL24801015-0, tag identification 0820.<br><br>On August 27, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2). | |
| 0 480 SS=F | 144G.41 Subd 1 (13) (i) (B) Minimum requirements | 0 480 | | |

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| 0 480 | Continued From page 1<br><br>(13) offer to provide or make available at least the following services to residents:<br>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all residents of the assisted living facility.<br><br>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).<br><br>The findings include:<br><br>Please refer to the included document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 26, 2024, for the specific Minnesota Food Code deficiencies. The Inspection Report was provided to the licensee on August 29, 2024.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 510 SS=F | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and maintain an infection control program that | 0 510 | | |

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| 0 510 | Continued From page 2<br><br>complies with accepted health care, medical, and nursing standards for infection control.<br>(b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities.<br>(c) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain an infection control program that complied with accepted health care, medical and nursing standards for infection control. The deficient practice had the potential to affect all residents, employees, and visitors.<br><br>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).<br><br>The findings include:<br><br>On August 28, 2024, at 7:58 a.m., the surveyor observed the furnace room located in the basement level of the house; the door to the furnace room did not have a locking mechanism. The surveyor observed 13 one-gallon milk jugs, some with lids and some without lids, and one | 0 510 | | |

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| 0 510 | Continued From page 3<br><br>five-gallon bucket, with no lid, filled with used syringes. The milk jugs were covered with a thick layer of dust.<br><br>On August 28, 2024, at 8:15 a.m., the surveyor observed unlicensed personnel (ULP)-B wash their hands and apply clean gloves. ULP-B used a lancet (finger pricking needle) to puncture R2's skin for a blood sample. ULP-B used R2's glucometer to collect a droplet of blood from R2's finger to check their blood glucose (BG) level with a result of 112. ULP-B removed their soiled gloves but did not perform hand hygiene. With soiled hands, ULP-B handled R2's BG log kept in a three ring binder; ULP-B wrote down R2's BG in the log. ULP-B then washed their hands. ULP-B stated they were trained by one of the nurses about infection control and hand hygiene when checking BG and medication administration. ULP-B stated they could not remember which nurse it was as it was a long time ago, and they (ULP-B) had worked at the facility since 2007. ULP-B stated after checking R2's BG, they did not wash their hands after removing their gloves. ULP-B stated they usually washed their hands after removing their gloves and understood the infection control concerns. ULP-B stated they were nervous with someone observing them.<br><br>On August 28, 2024, at 8:49 a.m., licensed assisted living director (LALD)-D stated they knew about the milk jugs in the furnace room and planned to take them to the police department today (August 28, 2024). LALD-D stated the last resident they had who used needles was approximately three years ago. LALD-D stated they had been through a lot of nurses over the past few years which was a part of the problem with things like this. The surveyor explained the furnace room door did not have a locking | 0 510 | | |

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| 0 510 | Continued From page 4<br><br>mechanism. LALD-D stated there were no residents living on the basement floor so no one ever went into the furnace room. The surveyor inquired if they could say with 100% certainty no residents could walk downstairs and enter the room. LALD-D nodded their head and stated, "now I understand." LALD-D and ULP-B stated they did not know the reason why milk jugs should not be used for used needle disposal.<br><br>On August 28, 2024, at 9:45 a.m., clinical nurse supervisor (CNS)-A stated they did not know the milk jugs were in the furnace room. CNS-A stated the milk jugs were an infection control concern and dangerous for their cognitively impaired resident who may have been able to access the room since the door did not lock. CNS-A stated the needles should have been disposed of in appropriate containers and then properly disposed. CNS-A stated ULP-B should have washed their hands after removing their gloves. CNS-A stated they trained ULP-B a while ago and probably needed retraining on hand hygiene.<br><br>The Center for Disease Control (CDC) Clinical Safety: Hand Hygiene for Healthcare Workers website, last reviewed on February 27, 2024, indicated,<br>"When to clean your hands<br>- Immediately before touching a patient<br>- Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices<br>- Before moving from work on a soiled body site to a clean body site on the same patient<br>- After touching a patient or the patient's immediate environment<br>- After contact with blood, body fluids or contaminated surfaces<br>- Immediately after glove removal | 0 510 | | |

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| 0 510 | Continued From page 5<br><br>Gloves are not a substitute for hand hygiene.<br>- If your task requires gloves, perform hand hygiene before donning gloves and touching the patient or the patient's surroundings.<br>- Always clean your hands after removing gloves.<br>- Remember to remove gloves carefully to prevent hand contamination as dirty gloves can soil hands."<br><br>The OSHA FactSheet for Protecting Yourself When Handling Contaminated Sharps website document, dated January 2011, indicated:<br>"A needlestick or a cut from a contaminated sharp can result in a worker being infected with human immunodeficiency virus (HIV), hepatitis B virus (HBV), hepatitis C virus (HCV), and other bloodborne pathogens. The standard specifies measures to reduce these types of injuries and the risk of infection.<br>Careful handling of contaminated sharps can prevent injury and reduce the risk of infection. Employers must ensure that workers follow these work practices to decrease the workers ' chances of contracting bloodborne diseases."<br><br>The Food and Drug Administration (FDA) Sharps Disposal Containers website, current as of April 29, 2021, indicated, "Sharps disposal containers are marked with a line to indicate when the container is about three-fourths (3/4) full. Following the manufacturer ' s instructions, close and seal sharps disposal containers when about three-fourths (3/4) full. Follow the health care facility's policy and procedures, medical waste disposal vendor instructions, and local medical waste disposal guidelines. To prevent injury to health care personnel, do not open, empty, or manually clean full sharps disposal containers." | 0 510 | | |

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| 0 510 | Continued From page 6<br><br>The licensee's Infection Control policy dated August 1, 2021, indicated, " All sharp instruments and needles are discarded in a puncture-resistant container. The CDC recommends needles be disposed of without capping or that a mechanical device be used for recapping."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 510 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that 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;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(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.<br>(c) The facility must meet any additional | 0 680 | | |

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| 0 680 | Continued From page 7<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content and to post it prominently in a conspicuous place for staff, residents, and visitors to view.<br><br>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).<br><br>The findings include:<br><br>On August 13, 2024, at 9:00 a.m., the surveyor reviewed the licensee's Emergency Preparedness Manual last updated on March 3, 2024, which lacked evidence of the following required information:<br>- development of strategies for addressing facility & community-based risks (i.e.: evacuation plans, staffing surges/shortages, back-up plans);<br>- quarterly review of the missing resident plan;<br>- designation of a qualified person, who is authorized in writing, to act in the absence of the administrator;<br>- identification of which staff would assume specific roles in another's absence through succession planning and delegation of authority.<br>- shelter in place needs;<br>- development of P/P (policy/procedure) for at | 0 680 | | |

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| 0 680 | Continued From page 8<br>minimum food, water and pharmaceutical supplies;<br>- development of P/P for sewage and waste disposal;<br>- development of P/P for system to track the location of on-duty staff and sheltered residents;<br>- development of P/P for if on-duty staff and sheltered residents are relocated, how the licensee must document the specific name/location of the receiving facility or other location;<br>- development of P/P for a system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records;<br>- development of P/P to address: use of volunteers, including the process/role for integration;<br>- development of P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act;<br>- development of a communication plan to include all of the following: method for sharing information from the emergency plan, that the facility has determined appropriate, with residents and their families/representatives; and<br>- development of a communication plan which included:<br>- method for sharing information and medical documentation for residents under the facility's care, as necessary, with other HCPs to maintain continuity of care<br>-means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii)<br>-means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4) | 0 680 | | |

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| 0 680 | Continued From page 9<br><br>On August 28, 2024, at 11:31 a.m., clinical nurse supervisor (CNS)-A stated they were aware there were missing items from the EPP as they were missing the same items from it at some of their other recently surveyed sister facilities. CNS-A stated they were in the process of correcting their EPPs at all of their licensed facilities.<br><br>The licensee's Emergency Preparedness* policy dated August 1, 2023, indicated:<br>"[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. The plan considers the organization's commitment to provide services while ensuring the safety of its employees and residents. [Licensee] will implement the Emergency Management program* as soon as the agency becomes aware of the existence of an emergency."<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 680 | | |
| 0 780 SS=F | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity | 0 780 | | |

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| 0 780 | Continued From page 10<br><br>of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to provide smoke alarms outside and in the immediate vicinity of sleeping rooms on both levels. This affected all staff and residents.<br><br>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).<br><br>The findings include:<br><br>On August 27, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D. During the tour, it was observed a smoke alarm was not installed immediately outside of sleeping rooms 1, 2, 3 and | 0 780 | | |

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| (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 |
|---|---|---|---|---|
| 0 780 | Continued From page 11<br>4 on the main level.<br><br>It was also observed a smoke alarm was not installed immediately outside of sleeping rooms 5 and 6 on the lower level.<br>During the interview on August 27, 2024, at 11:00 a.m., LALD-D verified the smoke alarm was not installed outside and in the immediate vicinity of sleeping rooms on both levels.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 780 | | |
| 0 790 SS=F | 144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br><br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to perform the required monthly maintenance on fire extinguishers and failed to provide adequately rated portable fire extinguishers as required. This had the potential to affect all current residents, staff, and visitors. | 0 790 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 0 790 | Continued From page 12<br><br>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).<br><br>The findings include:<br><br>On August 27, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D. During the facility tour, it was observed the portable fire extinguisher on the main level was tagged, showing the required annual service but lacked records to show the required monthly visual inspections were performed or recorded.<br><br>It was also observed the fire extinguisher installed on the lower level was 1-A:10-BC (size) rated and did not have at least 2-A:10-B:C rated fire extinguisher as required.<br><br>On August 27, 2024, at 11:00 a.m., LALD-D verified required maintenance had not been completed and the facility did not have an appropriate size fire extinguisher on the lower level.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 790 | | |
| 0 800 SS=F | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(4) keep the physical environment, including | 0 800 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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| 0 800 | Continued From page 13<br><br>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.<br><br>This MN Requirement is not met as evidenced by:<br>The licensee failed to maintain 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 had the potential to directly affect all residents and staff.<br><br>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).<br><br>The findings include:<br><br>On August 27, 2024, at 10:00 a.m., survey staff toured the facility with licensed assisted living director (LALD)-D. During the facility tour, survey staff observed the following items:<br><br>In resident sleeping room 3 on the main level, it was observed that the ceiling plaster was bubbled, and the ceiling had stains with evidence of water damage.<br><br>On the wooden deck outside of the exit door to the backyard, it was observed that burnt, used cigarettes were being disposed of without a | 0 800 | | |

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|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 0 800 | Continued From page 14<br><br>proper disposal container, creating a possible fire hazard.<br><br>In the bathroom on the main level, it was observed there was a hole in the gypsum wall behind the door.<br><br>In resident sleeping rooms 5 and 6 on the lower level, it was observed that the window opening hardware was broken and prevented the window from closing after opening.<br><br>During the tour, LALD-D visually verified these deficient findings at the time of discovery.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 800 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 0 810 | Continued From page 15<br><br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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 least once per year.<br>(f) Evacuation drills are required for employees 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a fire safety and evacuation plan with the required elements, failed to provide required employee training on fire safety and evacuation. This had the potential to affect all staff, residents, and visitors.<br><br>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).<br><br>The findings include:<br><br>On August 27, 2024, at 11:00 a.m., licensed assisted living director (LALD)-D and clinical nurse supervisor (CNS)-A provided | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 0 810 | Continued From page 16<br><br>documentation on the fire safety and evacuation plan (FSEP), fire safety and evacuation training for the facility, and fire safety and evacuation drills for the facility.<br><br>FIRE SAFETY AND EVACUATION PLAN<br>During the facility tour with LALD-D at 10:00 a.m., it was observed that the evacuation plan was not posted on the lower level.<br><br>The FSEP 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 FSEP was provided by a third-party consultant, and it was not updated to meet the facility-specific layout. The FSEP included the RACE (Remove, Alarm, Confine and Extinguish or Evacuate) acronym as the fire safety procedure and instructed staff to pull the nearest fire alarm in case of fire, but the facility did not have a fire alarm system. The FSEP also instructed staff to close all doors to contain the fire, but the facility did not have a fire rated door and wall assembly.<br><br>Record review of the available documentation indicated that the licensee did not have fire protection procedures necessary for residents included in the fire safety and evacuation plan.<br><br>During interview on August 27, 2024, at 11:30 p.m., LALD-D stated the fire safety and evacuation plan was from a third-party provider and verified the facility needed to update the fire safety and evacuation plan, including the facility-specific fire safety protocols.<br><br>TRAINING<br>Record review of the available documentation | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 0 810 | Continued From page 17<br><br>indicated employees did not receive training twice yearly after initial hire. In the provided FSEP, the facility policy required the staff training to be conducted at orientation and annually after. Employee training records were requested, and no training records were provided.<br><br>During the interview on August 27, 2024, 2024, at 11:30 p.m., CNS-A stated that the facility provided two fire safety training to staff, and the staff training record would be provided via email as a follow-up. But no follow-up email has been received from the facility.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 810 | | |
| 0 820 SS=G | 144G.45 Subd. 2 (g) Fire protection and physical environment<br><br>(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 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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation and interview, the licensee failed to ensure physical facility elements did not | 0 820 | This immediate correction order identified on August 27, 2024, has had the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 0 820 | Continued From page 18<br><br>constitute a distinct hazard to life. The licensee failed to provide a resident bedroom with the minimum window opening meeting the minimum state standard for egress. This affected the occupied resident in bedroom 1 on the main level.<br><br>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).<br><br>The findings include:<br><br>On August 27, 2024, at 10:00 a.m., survey staff toured the facility with the licensed assisted living director (LALD)-D. During the facility tour, survey staff observed the following items:<br><br>It was observed that occupied resident bedroom 1 on the main level did not have windows that met the minimum size requirements for egress escape. The clear openable area of the opened windows measured 21 inches in height and 27 inches in width, with a total openable area of 567 square inches. The windows did not meet the minimum requirements for total openable area.<br><br>Egress windows in existing sleeping rooms must have a minimum openable width of 20 inches and minimum openable height of 20 inches with no less than 648 square inches total of openable area (4.5 square feet) for the window. Survey staff explained to LALD-D that at least one egress window in each bedroom must be provided to meet the minimum state standard for an egress | 0 820 | immediacy lifted as of August 27, 2024, however non-compliance remained a scope and level of G. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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| 0 820 | Continued From page 19<br><br>window to be a complying bedroom for resident occupancy. LALD-D verbally confirmed the findings.<br><br>On August 27, 2024, at 11:00 a.m., during the interview, survey staff explained to LALD-D that an immediate correction order was issued for the above finding. LALD-D acknowledged the above finding.<br><br>No Further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate. | 0 820 | | |
| 01880 SS=F | 144G.71 Subd. 19 Storage of medications<br><br>An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to store prescription medication securely to permit only authorized personnel to have access for one of one resident (R2).<br><br>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). | 01880 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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| 01880 | Continued From page 20<br>The findings include:<br><br>R2 was admitted to the licensee on December 6, 2006.<br><br>R2's Service Plan dated October 22, 2022, indicated R2 received services for medication management.<br><br>On August 28, 2024, at 7:58 a.m., the surveyor observed the basement office door unlocked and open; the office was unattended. The surveyor observed the medication cabinet in the office which had two doors with unlocked padlocks on them. The surveyor was able to open the medication cabinet and observe R2's medications; there were no staff members on the basement level at the time of the observation.<br><br>On August 28, 2024, at 8:15 a.m. during medication administration observations with unlicensed personnel (ULP)-B, the surveyor and ULP-B entered the basement office. The office was unattended by staff, the office door was unlocked and open and both padlocks on the medication cabinet were unlocked. The surveyor observed ULP-B prepare R2's medication then leave the office to go upstairs. ULP-B did not lock the medication cabinet or office door before going upstairs and left them unattended. The surveyor observed ULP-B administer R2's medication and then return downstairs where the office door and medication cabinet remained unlocked and unattended by staff. The surveyor observed ULP-B leave the office and return upstairs again. ULP-B did not lock the medication cabinet or office door, which left the office and medication cabinet unattended by staff. ULP-B stated they were the one who unlocked the basement office door and medication cabinet at the beginning of | 01880 | | |

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|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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| 01880 | Continued From page 21<br><br>their shift. ULP-B stated they forgot to lock the office door and medication cabinets. ULP-B further stated they should have locked the door and medication cabinet, and this was not their normal practice; they were trained to keep medications locked away at all times to prevent unauthorized access to the medication.<br><br>On August 28, 2024, at 9:45 a.m., clinical nurse supervisor (CNS)-A stated ULP-B should have locked the office door and medication cabinet. CNS-A stated their policy and training instructed staff should always keep the office door and medication cabinets locked for medication security.<br><br>The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated, "When [Licensee] is providing storage of medications outside of the resident's private living space, all prescription drugs are securely locked in substantially constructed compartments according to the manufacturer's directions. Only authorized personnel have access to the stored medications.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01880 | | |
| 02320 SS=D | 144G.91 Subd. 4 (b) Appropriate care and services<br><br>(b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 02320 | Continued From page 22<br><br>services agreed to in the assisted living contract and the service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure unlicensed personnel (ULP)-B followed appropriate medication administration procedures for one of one resident (R2).<br><br>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).<br><br>The findings include:<br><br>ULP-B was hired by the licensee on July 17, 2021, to provide direct cares to residents.<br><br>R2 was admitted to the licensee on December 6, 2006.<br><br>R2's Service Plan dated October 22, 2022, indicated R2 received services for medication management.<br><br>On August 26, 2024, at 9:30 a.m. during the entrance conference, clinical nurse supervisor (CNS)-A stated licensed practical nurse (LPN)-C set up medications in pill boxes for unlicensed personnel (ULP) to administer.<br><br>On August 28, 2024, at 8:15 a.m., the surveyor | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

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|---|---|---|---|---|
| 02320 | Continued From page 23<br><br>observed ULP-B administer medication for R2. ULP-B went to the medication cabinet where the medications had been set up in a pill box for administration. ULP-B took the pill box and dumped R2's medications into a cup and brought the medications upstairs to R2. The surveyor observed ULP-B administer the following medications for R2: omeprazole, levothyroxine, Effexor, multivitamin, Fibercon, metformin, Flonase, calcium/vitamin D, loratadine, glimepiride, aspirin and oxcarbazepine. At no time did ULP-B review R2's medication administration record (MAR), administration instructions or verify the pill box contents prior to administration. After R2's medications were administered, ULP-B documented all of R2's morning medications as administered in R2's MAR. The surveyor observed R2's MAR with ULP-B which included administration instructions, pictures of each pill and pill descriptions for each medication. ULP-B stated they did not check R2's MAR, pictures or pill description before they administered R2's medications. ULP-B stated the nurse trained them to perform these checks prior to administering medications but did not during the observed administration.<br><br>On August 28, 2024, at 9:45 a.m., CNS-A stated LPN-C primarily sets up the residents medications in pill boxes. CNS-A stated ULPs should be counting the medications, reviewing pictures of the medications and reviewing the MAR administration instructions before they administered a residents medications. CNS-A and licensed assisted living director (LALD)-D both stated staff may be getting too comfortable with longtime residents and weren't following the procedures anymore.<br><br>The licensee's Medication Administration policy | 02320 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 24801 | A. BUILDING: _____ B. WING _____ | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE CARING SISTERS HOME CARE | 2833 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416 |

| (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 |
|---|---|---|---|---|
| 02320 | Continued From page 24<br>dated August 1, 2021, did not address medication administration procedure.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 02320 | | |

Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *08/26/24*
Time: 11:30:21
Report: 1050241153

# Food and Beverage Establishment Inspection Report



**Location:**
The Caring Sisters Home Care
2833 Yosemite Avenue South
St Louis Park, MN55416
Hennepin County, 27

**Establishment Info:**
ID #: 0038045
Risk:
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #: 9524264690
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.

**4-700 Sanitizing Equipment and Utensils**

***4-702.11*** ***** Priority 1 *****

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning.

FACILITY IS WASHING DISHES WITH SOAP AND WATER IN ONE BASIN OF THE TWO BASIN SINK, NO SANITIZE STEP. INSTRUCTED ESTABLISHMENT TO SET UP CONTAINERS TO WASH, RINSE, SANITIZE DISHES WITH 50-100 PPM BLEACH UNTIL UNDER COUNTER DISH MACHINE OR 3 COMP. INSTALL

*Comply By: 08/26/24*

**4-300 Equipment Numbers and Capacities**

***4-302.12B*** ***** Priority 2 *****

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.

FACILITY MISSING FOOD THERMOMETER ON SITE. ESTABLISHMENT COOKS THIN FOODS/MEATS. DISCUSSED THE IMPORTANCE OF HAVING AND HOW TO CALIBRATE PROPERLY. COMPLY WITH RULE ABOVE.

*Comply By: 08/26/24*

**4-600 Cleaning Equipment and Utensils**

***4-602.12***

MN Rule 4626.0850 Clean the food contact surfaces of cooking and baking equipment and interior cavities of microwave ovens at least every 24 hours.

OBSERVED MICROWAVE CAVITY FILLED WITH FOOD DEBRIS FROM PREVIOUS USE. DISCUSSED ESTABLISHING A CLEANING FREQUENCY TO ENSURE REMOVAL OF GRIME IS ACCOMPLISHED. COMPLY WITH RULE ABOVE.

Type: Full
Date: *08/26/24*
Time: 11:30:21
Report: 1050241153
The Caring Sisters Home Care

# Food and Beverage Establishment Inspection Report

*Comply By: 08/26/24*

| Total Orders In This Report | Priority 1 | Priority 2 | Priority 3 |
|---|---|---|---|
| | 1 | 1 | 1 |

Inspection was completed by MDH Andrew Spaulding and Olaleye Beckley. Joey Keen was the lead Health Regulation Division Nurse Evaluator. Facility had three residents with space for six on site at time of inspection. Meals are prepared on site. Discussed to keep a eye out for recalls due to food purchased by staff.

This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and tile flooring. All found to be in good working condition.

A two-basin sink is located in the kitchen and a residential dishwasher that is not currently in service. Leftovers are not kept at the residence as they are disposed after serving.

Establishment is planning to install an under counter dish machine. Ensure it meets ANSI standard 184-residential and achieves a utensil surface temperature of at least 160F. A temperature indictor to measure the utensil surface temperature must also be provided for dish machine.

Discussed the following:
-Employee illness policy and logging requirements
-Hand Washing
-Glove-use and bare hand contact
-Food storage and preventing cross contamination
-Date marking
-Vomit clean up procedures
-Restrictions concerning serving a highly susceptible population

**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 1050241153 of 08/26/24.

Certified Food Protection Manager: Olaleye Akande Beckley

Certification Number: FM28313 Expires: 10/06/24

**Inspection report reviewed with person in charge and emailed.**

Signed: _____
Olaleye Akande Beckley
Owner

Signed: _____
Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us