Electronically Delivered
April 15, 2024

Licensee
Sisters Home Health Care, LLC
6005 Ewing Avenue South
Edina, MN 55410

RE: Project Number(s) SL37081015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 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 . . ."

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,

Renee L. Anderson

Renee L. Anderson, Supervisor
State Evaluation Team
Email: renee.l.anderson@state.mn.us
Telephone: 651-201-5871 Fax: 1-866-890-9290

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37081	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTERS HOME HEALTH CARE LLC	6005 EWING AVENUE SOUTH EDINA, MN 55410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL37081015-0 On March 11, 2024, through March 13, 2024, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were three residents, all of whom received services under the provider's Assisted Living 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 License Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the	0 480		

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0 480	Continued From page 1 following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated March 12, 2024, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies	0 680		

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0 680	Continued From page 2 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 have a written emergency preparedness (EP) plan with all the required content. 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 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 680		

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0 680	Continued From page 3 The licensee's August, 1, 2023, EP plan, dated August 1, 2023, lacked the following required content: -a plan for evacuation, addressed elements of sheltering in place, and detailed staff assignments in the event of a disaster or an emergency; -a process for cooperation and collaboration with local, tribal, regional, State and Federal emergency preparedness, to maintain integrated response; -documentation of participation in an annual full-scale exercise that was community based OR conducted an annual, individual, facility-based functional exercise OR if the facility experienced an actual emergency requiring activation of plan; -conducted an additional annual exercise that may have included: a second full-scale exercise that was community-based, or an individual, facility-based functional exercise, or mock disaster drill, or table-top exercise; and -analyzed the facility's response to and maintained documentation of all drills, tabletop exercises and emergency events, and revised plan as needed. On March 12, 2024, at 10:30 a.m., during the facility tour with licensed assisted living director (LALD)-B the facility was observed to lack posting of signage and/or information regarding the licensee's emergency disaster or preparedness plan. LALD-B stated the plan was not posted prominently. LALD-B also stated they did not complete drills on the EP plan. The licensee's Emergency Preparedness policy, dated August 1, 2021, indicated the licensee, "will have an identified plan in place to assure the safety and well-being of residents and staff during	0 680		

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0 680	Continued From page 4 periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 730 SS=D	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional;	0 730		

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0 730	Continued From page 5 (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the resident record included documentation of a written discharge summary for one of one resident (R4). 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: R4 was admitted on January 15, 2024, and discharged on January 18, 2024. R4's diagnoses included anxiety disorder.	0 730		

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0 730	Continued From page 6 R4's medical record lacked a written discharge summary, including: A. a summary of the resident's stay that included diagnoses, courses of illnesses, allergies, treatments and therapies, and pertinent lab, radiology, and consultation results; B. a final summary of the resident's status from the latest assessment or review under Minnesota Statutes, section 144G.70, if applicable, that included the resident status, including baseline and current mental, behavioral, and functional status; C. a reconciliation of all predischarge medications with the resident's post-discharge prescribed and over-the-counter medications; and D. a post-discharge plan that was developed with the resident and, with the resident's consent, the resident's representatives, which would help the resident adjust to a new living environment. The post-discharge plan must indicate where the resident plans to reside, any arrangements that have been made for the resident's follow-up care, and any post-discharge medical and nonmedical services the resident would need. During an interview on March 12, 2024, at 10:45 a.m., licensed assisted living director (LALD)-B stated R4 lacked documentation of a discharge summary and that they did not have a policy regarding a resident discharge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780		

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0 780	Continued From page 7 (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; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that functioned and were interconnected so that the actuation of one alarm caused all alarms in the dwelling unit to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 780		

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0 780	Continued From page 8 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 March 11, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. Survey staff tested the smoke alarms throughout the home. Upon testing, it was found that the smoke alarms in the following locations did not sound when the test button was pressed: 1. Bedroom #1 smoke alarm had no battery. 2. Bedroom #3 smoke alarm had no battery. 3. There was no smoke alarm installed in the hallway outside the sleeping area upstairs. 4. There was no smoke alarm installed in the hallway outside the sleeping area downstairs. 5. The smoke alarms were not interconnected throughout the dwelling. These deficient conditions were visually verified by LALD-B accompanying on the tour. During an interview on March 13, 2024, at 3:30 p.m., LALD-B stated they had installed new smoke alarms, but they did not know why the above-listed locations were missing or had the battery removed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		

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0 800	Continued From page 9	0 800		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the 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. This deficient condition had the potential to affect all staff, residents, 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 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 March 11, 2024, at 10:30 a.m., survey staff toured the facility with licensed assisted living director (LALD)-B. It was observed that the back deck was being used by residents as a smoking area. The residents were using a plastic coffee	0 800		

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0 800	Continued From page 10 can as an ashtray and the facility did not have a non-combustible ashtray. Survey staff explained to the licensee that a fire-rated ashtray should be provided for resident use and that the discarded cigarette butts were a potential fire hazard if cigarettes were not completely extinguished before discarding them. It was observed that the switch plate in bedroom #1 was not attached to the wall and could be moved to the side exposing the electrical box and wiring behind it. It was observed that the doorbell at the front entry was missing and the electrical wires were exposed and accessible from the outside. It was observed that the laundry room had electrical wires stapled to one of the ceiling beams without any caps or an electrical box. During interview on March 13, 2024, at 3:30 p.m., LALD-B stated they understood the above-listed deficiencies. 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) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for	0 810		

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0 810	Continued From page 11 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) Employees 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 least once per year. (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. 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 the required content and provide the required training. 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	0 810		

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0 810	Continued From page 12 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 March 11, 2024, licensed assisted living director (LALD)-B 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's FSEP, titled "9.06 Fire Policy", dated August 1, 2023, lacked the following: 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 plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate) but the plan was designed for a building with life safety systems such as fire doors and smoke compartments. The policy had not been updated to provide complete actions for employees to take in the event of a fire or similar emergency at the licensed facility which did not have life safety systems or a fire-resistant construction type. The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. The FSEP included standard resident evacuation procedures but failed to provide specific procedures for resident movement and	0 810		

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	37081	A. BUILDING: _____ B. WING _____	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTERS HOME HEALTH CARE LLC	6005 EWING AVENUE SOUTH EDINA, MN 55410

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0 810	Continued From page 13 evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation. During an interview on March 13, 2024, at 3:30 p.m., LALD-B stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. The policy reviewed was an unedited policy purchased from a third-party provider that was not specific to the facility. TRAINING Record review indicated the licensee failed to provide evacuation training to residents at least once per year. LALD-B provided a training record for one staff member completed on 11/17/2023 but was unable to provide documentation showing the correct amount of training for all staff members. During an interview on March 13, 2024, at 3:30 p.m., LALD-B stated they were doing the training for staff upon hire and annually, which does not meet statute requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility	0 950		

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0 950	Continued From page 14 must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on the interview and record review, the licensee failed to identify a designated representative or document that the resident declined to designate a representative for one of one resident (R1). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not	0 950		

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0 950	Continued From page 15 affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's service plan, dated October 10, 2023, indicated R1 received services including assistance with activities of daily living, housekeeping and medication management. R1's contract, dated September 26, 2023, lacked documentation R1 was given the opportunity to designate a representative, and also lacked the required verbiage notifying R1 of their "right to designate a representative for certain purposes". On March 13, 2024, at 10:10 a.m., licensed assisted living director (LALD)-B stated R1's record lacked the required verbiage for the designated representative. LALD-B stated the required verbiage was missing from all residents' contracts. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination.	01060		

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01060	Continued From page 16 (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the	01060		

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01060	Continued From page 17 licensee failed to provide a written notice with required content for an emergency relocation for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included pneumonia (infection in the lungs) and lumbago (back pain). R1's Service Plan, dated October 10, 2023, indicated R1 received services including assistance with medication management, dressing and grooming, and behavior management. R1's record included a nursing note dated March 1, 2024, indicating R1 was admitted to the hospital on March 1, 2024. A nursing note dated March 5, 2024, indicated R1 returned from the hospital on March 5, 2024. R1's record lacked documentation of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of	01060		

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01060	Continued From page 18 Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On March 12, 2024, at 11:00 a.m., licensed assisted living director (LALD)-B stated a written notice had not been provided with the required content. LALD-B stated he was not aware of the requirement to provide an emergency relocation notice to R1. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff	01440		

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01440	Continued From page 19 administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) supervised unlicensed personnel (ULP) within 30 calendar days of beginning to provide delegated tasks for one of one employee (ULP-D). 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: ULP-D was hired December 20, 2023, and provided direct cares for residents. On March 12, 2024, ULP-D was observed administering medications to R3. ULP-D's employee file lacked documentation of direct supervision within 30 days of performing	01440		

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01440	Continued From page 20 delegated tasks. On March 12, 2024, at 11:15 a.m., licensed assisted living director (LALD)-B stated ULP-D's record lacked documentation the RN performed a 30-day supervision for a delegated task. The licensee's Supervision of Staff - Delegated Services policy, dated August 1, 2023, indicated RN supervision would be completed within 30 calendar days from the day the task was first delegated and would be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) 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.	01620		

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01620	Continued From page 21 (e) 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 a registered nurse (RN) conducted ongoing resident monitoring and reassessment, 14 calendar days from the initiation of services and with a change of condition 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: 14-DAY ASSESSMENT R1's Service Plan, dated October 10, 2023, indicated R1 received services including assistance with medication management, dressing and grooming, and behavior management. R1's record included documentation of an initial assessment completed on September 30, 2023, and a subsequent assessment dated November 11, 2023, forty-two days later.	01620		

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01620	Continued From page 22 R1's record lacked documentation that an RN completed a reassessment within 14-days after start of services. CHANGE OF CONDITION R1's record included a nursing note, dated March 1, 2024, indicating R1 was admitted to the hospital on March 1, 2024. A nursing note dated March 5, 2024, indicated R1 returned from the hospital on March 5, 2024. R1's record included a signed after visit summary (AVS) dated March 5, 2024, that included an order to "wear oxygen 2 [liters per minute] at night". R1's record lacked documentation of a change of condition assessment completed after the March 5, 2024, hospital discharge. On March 12, 2024, at 12:30 p.m., clinical nurse supervisor (CNS)-A stated they were unable to locate the 14-day assessment documentation for R1. CNS-A stated that an RN did not complete a change of condition assessment after the hospitalization. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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

Type: Full
Date: *03/12/24*
Time: 11:00:00
Report: 1005241070

Food and Beverage Establishment Inspection Report

Location:
Sisters Home Health Care Llc
6005 Ewing Avenue South
Edina, MN55410
Hennepin County, 27

Establishment Info:
ID #: 0037933
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 6122427436
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

TCS FOODS ON THE MIDDLE AND BOTTOM SHELVES OF THE REFRIGERATOR WERE 43 - 44 DEGREES F. REFRIGERATOR WAS TURNED TO A COLDER SETTING.

Comply By: 03/12/24

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.

THE DISHWASHER IS CURRENTLY BROKEN, AND DISHES ARE BEING WASHED IN THE SINK WITHOUT BEING SANITIZED AFTERWARDS. DISCUSSED SANITIZING IN 50-100 PPM CHLORINE (BLEACH) UNTIL DISHWASHER IS REPAIRED.

Comply By: 03/12/24

2-100 Supervision

2-102.12AMN

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

DIRECTOR HAS A COPY OF HIS CFPM CERTIFICATE POSTED, WHICH HE SAID IS ALSO USED AT THEIR OTHER LOCATION. AN INDIVIDUAL CAN ONLY BE THE CFPM FOR ONE LOCATION. DESIGNATE AN ADDITIONAL EMPLOYEE TO BECOME A MN CFPM.

Comply By: 04/12/24

4-500 Equipment Maintenance and Operation

4-501.11AB

MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

THE DISHWASHER IS BROKEN AND NOT CURRENTLY IN USE. DIRECTOR SAYS THEY HAVE REQUESTED REPAIR AND HOPE TO HAVE IT FIXED IN THE COMING WEEKS.

Comply By: 03/26/24

Food and Equipment Temperatures

Process/Item: Cold Hold/MILK
Temperature: 38 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: No

Process/Item: Cold Hold/CHEESE
Temperature: 43 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

Process/Item: Cold Hold/LETTUCE
Temperature: 44 Degrees Fahrenheit - Location: KITCHEN REFRIGERATOR
Violation Issued: Yes

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

INSPECTION COMPLETED WITH HOUSING DIRECTOR AND EMAILED TO HRD NURSE EVALUATOR, ANGEL WOEHLER.

DISCUSSED ORDERS ON REPORT AS WELL AS DATE-MARKING, COOKING TEMPERATURES, CROSS-CONTAMINATION, GLOVE USE, AND EMPLOYEE ILLNESS.

ESTABLISHMENT HAS CHLORINE TEST STRIPS ON SITE, SO THEY CAN SANITIZE DISHES IN 50-100 PPM CHLORINE UNTIL DISHWASHER IS REPAIRED. ESTABLISHMENT ALSO HAS IRREVERSIBLE TEMPERATURE STICKERS ON SITE AND WILL EMAIL INSPECTOR SHOWING THE DISHWASHER IS PROVIDING A UTENSIL SURFACE TEMPERATURE OF 160 DEGREES F OR ABOVE, ONCE THE DISHWASHER IS REPAIRED.

KITCHEN IS RESIDENTIAL AND FOOD IS PREPARED FOR SAME DAY SERVICE.

FLOORING IS WOOD, CABINETS ARE WOOD WITH HOLLOW BASE, AND COUNTERS ARE GRANITE. ALL ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

Type: Full
Date: *03/12/24*
Time: 11:00:00
Report: 1005241070
Sisters Home Health Care Llc

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1005241070 of 03/12/24.

Certified Food Protection Manager: AHMED A. FARAH

Certification Number: FM111970 Expires: 02/11/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
AHMED FARAH
HOUSING DIRECTOR

Signed: _____
Jessica Davis
Public Health Sanitarian III
651-201-3961
jessica.davis@state.mn.us