Electronically Delivered

December 17, 2024

Licensee
Sisters Home Health Care LLC
7438 Vincent Avenue
Richfield, MN 55423

RE: Project Number(s) SL35863015

Dear Licensee:

On November 12, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the August 28, 2024, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

JMD

Electronically Delivered

October 2, 2024

Licensee
Sisters Home Health Care LLC
7438 Vincent Avenue
Richfield, MN 55423

RE: Project Number(s) SL35863015

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 . . ."

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,

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
	35863	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTERS HOME HEALTH CARE LLC	7438 VINCENT AVENUE RICHFIELD, MN 55423

(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: SL# 35863-015 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 orders are issued. At the time of the survey, there were five residents, five receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on August 27, 2024, issued for SL35863015-0, tag identification 0820. 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 Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 1 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 27, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=D	144G.41 Subd. 3 Infection control program (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 complies with accepted health care, medical, and nursing standards for infection control. (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. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control when the licensee failed to ensure direct care staff performed adequate hand hygiene (HH), glove changes, and proper disinfection of shared medical equipment for one of two employees (unlicensed personnel (ULP)-C). 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-C was hired August 12, 2020, and provided direct care services to residents.	0 510		

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0 510	Continued From page 3 On August 26, 2024, between 12:05 p.m. through 12:15 p.m., the surveyor observed ULP-C assist R2 and R3 with vital signs and medication administration. First, ULP-C donned (applied) gloves, unlocked the medication cart, opened the electronic medical record on the laptop computer, and prepped R3's medications into medication cup. Next, ULP-C gave R3's medications to him in the living room area of the facility, provided R3 with water, and observed R3 take his oral medications. Next, ULP-C obtained the shared blood pressure cuff and pulse oximeter from the medication cart. ULP-C completed BP check and oxygen saturation level for R3. With gloves still on, ULP-C proceeded to assist R2 with taking his temperature, BP, and pulse oximeter reading. The shared BP cuff and pulse oximeter were not wiped down between use for R2 and R3. Next, ULP-C doffed gloves, completed HH for five seconds in the kitchen sink, grabbed the plastic garbage bag from the kitchen area and brought the garbage bag out the back door for removal. Finally, ULP-C donned gloves and went to the shared medical equipment and wiped down the BP cuff and pulse oximeter with a disinfectant wipe. ULP-C prepped and administered R2's medications and doffed gloves. HH was not completed after doffing gloves and ULP-C went into the kitchen area and rinsed some silverware in the kitchen sink. On August 26, 2024, at 12:20 p.m., ULP-C and licensed assisted living director (LALD)-A stated HH training was provided by the licensee and nurse upon hire. Also, LALD-A stated ULP-C was nervous and overwhelmed being observed by the surveyor and should have completed hand hygiene between R2 and R3's blood pressure, oxygen saturation checks, and medication administration.	0 510		

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0 510	Continued From page 4 On August 26, 2024, at 1:15 p.m., clinical nurse supervisor (CNS)-B stated the employees were trained to complete HH before and after completing medication administration, as well as at other points during clinical cares. Also, CNS-B verbalized the shared medical equipment should have been disinfected between the residents' vital signs monitoring. Finally, CNS-B stated training was completed upon hire and annually with all employees. The Centers for Disease Control and Prevention (CDC) guidance titled CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated November 29, 2022, indicated shared medical equipment such as blood pressure cuffs should be cleaned and reprocessed (disinfected or sterilized) prior to use on another patient or when soiled. The CDC guidance further indicated healthcare personnel (HCP) should perform hand hygiene immediately before touching a patient, after touching a patient or the patient's immediate environment and immediately after glove removal. In addition, indicated, standard precautions were to be used to care for all patients in all settings to include HH, and noted, use an alcohol-based hand rub or wash with soap and water for the following clinical indications: a. Immediately before touching a patient; b. Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices; c. Before moving from work on a soiled body site to a clean body site on the same patient; d. After touching a patient or the patient's immediate environment; e. After contact with blood, body fluids or contaminated surfaces; and	0 510		

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0 510	Continued From page 5 f. Immediately after glove removal. The licensee's 8.03 Cleaning of Shared Medical Equipment policy dated August 1, 2024, included "1. All equipment must be cleaned immediately if visibly soiled, and immediately after use on residents with contact precautions (e.g., MRSA, VRE, and C-Difficile) regardless of cleaning schedule." The licensee's 8.07 Gloves policy dated August 1, 2024, included "Gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed." The licensee's 8.09 Handwashing policy dated August 1, 2024, included "Hand washing will be performed by all employees, as necessary, between tasks and procedures, and after bathroom use, to prevent cross-contaminations." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person	0 630		

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0 630	Continued From page 6 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include review or assessment of the person's risk of abusing other vulnerable adults and statements of the specific measures to be taken to minimize the risk of abuse for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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 finding include: On August 26, 2024, at 12:05 p.m., the surveyor observed ULP-C assist R2 and R3 with vital signs and medication administration. R2 R2 was admitted December 13, 2021, and had diagnoses including schizoaffective disorder with bipolar disorder (a chronic mental health condition with hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), disassociate episodes (mental health conditions that involve experiencing a loss of connection between thoughts, memories, feelings, surroundings, behavior, and identity),	0 630		

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0 630	Continued From page 7 and spinal stenosis (abnormal spinal narrowing). R2's service plan dated January 15, 2024, indicated R2 received services including assistance meals, housekeeping, laundry, personal cares, bathing, toileting, behavior management, vital signs, and medication administration. R2's Individual Abuse Prevention Plan (IAPP) completed on June 11, 2024, noted under the Safety section, Vulnerability indicated, "Is not at risk to be abused." R2's IAPP failed to include the following required content: -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. R3 R3 was admitted February 26, 2022, and had diagnoses including traumatic brain injury (a head injury causing damage to the brain by external force or mechanism). R3's service plan dated August 15, 2024, indicated R3 received services including assistance meals, housekeeping, laundry, behavior management, vital signs, blood glucose testing, and medication administration. R3's IAPP completed on June 28, 2024, noted under the Safety section, Vulnerability indicated, "Resident is at risk to be abused (physically, verbally, emotionally, financially, and/or sexually)." R3's IAPP failed to include the following required content: -the person's risk of abusing other vulnerable adults; and	0 630		

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0 630	Continued From page 8 -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On August 27, 2024, at 1:26 p.m., clinical nurse supervisor (CNS)-B stated, she was not aware R2 and R3's IAPPs did not include an assessment and specific measure for the resident's risk to abuse other vulnerable adults. In addition, CNS-B verbalized she planned to follow up with the licensee's electronic medical record provider to have the additional required content to be added to the program for the nurse to ensure the IAPP was updated with all the required content. The licensee's 6.05 Individual Abuse Prevention Plan policy dated August 1, 2024, indicated, 1. The plan will contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including: a. other vulnerable adults; b. the person's risk of abusing other vulnerable adults; and c. statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780		

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0 780	Continued From page 9 (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 outside and in the immediate vicinity of sleeping room on the main level. This affected 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 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).	0 780		

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0 780	Continued From page 10 The findings include: On August 27, 2024, at 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the tour, it was observed a smoke alarm was not installed immediately outside and in the immediate vicinity of sleeping room 3 on the main level. During the interview on August 27, 2024, at 1:30 p.m., LALD-A verified the smoke alarm was not installed outside and in the immediate vicinity of sleeping room 3 on the main level. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
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 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. This practice resulted in a level two violation (a	0 800		

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0 800	Continued From page 11 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On August 27, 2024, at 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following items: On the wood deck outside the kitchen, it was observed that the wood deck board and edge board were rotten and broken. On the broken board, the nails were exposed and were a hazard to residents. In resident sleeping room 4 on the lower level, it was observed that black-colored dust was on the supply air grille. It was also observed the carpet was damaged badly with thick stains. In the hallway outside resident sleeping room 4 on the lower level, it was observed that the return air grille was covered with thick black dust. In the living room on the lower level, it was observed there was a hole in the ceiling at the perimeter of the supply air fan. During the tour, LALD-A visually verified these deficient findings at the time of discovery. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTERS HOME HEALTH CARE LLC	7438 VINCENT AVENUE RICHFIELD, MN 55423

(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
0 810	Continued From page 12	0 810		
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 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:	0 810		

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0 810	Continued From page 13 Based on the interview and record review, the licensee failed to develop a fire safety and evacuation plan with required elements and failed to provide required employee training on fire safety and evacuation as required. 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, 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 August 27,2024, at 2:00 p.m., licensed assisted living director/clinical nurse supervisor (LALD)-A provided 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. EMERGENCY EVACUATION PLAN On the facility tour with the LALD-A on August 27, 2024, at 1:00 p.m., it was observed that the posted fire safety and evacuation plans on both levels did not accurately depict the actual layout of the facility. The sleeping room locations shown in the evacuation plans did not match the current locations, and the egress routes shown on both levels did not match the facility's egress procedures. This deficient condition was visually verified by LALD-A accompanying the tour.	0 810		

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0 810	Continued From page 14 TRAINING Record review of the available documentation indicated employees did not receive training twice per year after initial hire. Provided documentation indicated that the employee training was conducted on 6/11/2024 only, with no further employee training being documented. During the interview on August 27,2024, at 2:30 p.m., LALD-A confirmed that the licensee provided annual training to employees, not twice per year after the initial hire, and confirmed that there was no further documented training for the staff on the fire safety and evacuation plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
0 820 SS=G	144G.45 Subd. 2 (g) Fire protection and physical environment (g) Existing construction or elements, including assisted living facilities that were registered as housing with services establishments under chapter 144D prior to August 1, 2021, shall be permitted to continue in use provided such use does not constitute a distinct hazard to life. Any existing elements that an authority having jurisdiction deems a distinct hazard to life must be corrected. The facility must document in the facility's records any actions taken to comply with a correction order, and must submit to the commissioner for review and approval prior to correction. This MN Requirement is not met as evidenced by:	0 820		

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0 820	Continued From page 15 Based on observation and interview, the licensee failed to ensure physical facility elements did not 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 2 on the main level. 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). The findings include: On August 27, 2024, at 1:00 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the following items: It was observed that occupied resident bedroom 2 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 25 inches in width, with a total openable area of 525 square inches. The windows did not meet the minimum requirements for total openable area. 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-A that at least one egress	0 820	This immediate correction order identified on August 27, 2024, has had the immediacy lifted as of August 27, 2024, however non-compliance remained a scope and level of G.	

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0 820	Continued From page 16 window in each bedroom must be provided to meet the minimum state standard for an egress window to be a complying bedroom for resident occupancy. LALD-A verbally confirmed the findings. On August 27, 2024, at 2:00 p.m., during the interview, survey staff explained to LALD-A that an immediate correction order was issued for the above finding. LALD-A acknowledged the above finding. No Further information was provided. TIME PERIOD FOR CORRECTION: Immediate On August 27, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained at an scope and level of G.	0 820		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;	01470		

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01470	Continued From page 17 (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the employee will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01470		

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01470	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-C). 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: On August 26, 2024, at 12:05 p.m., the surveyor observed ULP-C assist R2 and R3 with vital signs and medication administration. ULP-C was hired August 12, 2020, and provided direct care services to residents. ULP-C's employee record lacked documentation the following orientation topics were completed: -an overview of 144G statutes; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints;	01470		

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01470	Continued From page 19 -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. On August 27, 2024, at 2:40 p.m., licensed assisted living director (LALD)-A stated he would check to see if evidence of this training was in ULP-C's employee record. On August 28, 2024, at 3:00 p.m., LALD-A stated ULP-C had not completed the above listed required orientation topics. Also, LALD-A verbalized the licensee would ensure ULP-C completed this training. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy dated August 1, 2024, included, 3. The orientation must contain the following topics: -An overview of the appropriate Assisted Living statutes and rules; -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -Handling of emergencies and use of emergency services; -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -The assisted living bill of rights and staff responsibilities related to ensuring the exercise	01470		

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01470	Continued From page 20 and protection of those rights; -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; -A review of the types of assisted living services the employee will be providing and the facility's category of licensure; -The staff person's job description upon hire and whenever there is a change to the job description that changes the nature of the job or how the job is to be performed; -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services; and -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		

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01530	Continued From page 21	01530		
01530 SS=D	144G.64 TRAINING IN DEMENTIA CARE REQUIRED (a) All assisted living facilities must meet the following training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on topics specified under paragraph (b) within 120 working hours of the employment start date, and must have at least two hours of training on topics related to dementia care for each 12 months of employment thereafter; (2) direct-care employees must have completed at least eight hours of initial training on topics specified under paragraph (b) within 160 working hours of the employment start date. Until this initial training is complete, an employee must not provide direct care unless there is another employee on site who has completed the initial eight hours of training on topics related to dementia care and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new employee until the training requirement is complete. Direct-care employees must have at least two hours of training on topics related to dementia for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees had completed at least eight (8) hours of initial dementia training for supervisors of direct care staff within 120 working hours of the employment start date for one of two employees (clinical nurse supervisor (CNS)-B).	01530		

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01530	Continued From page 22 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: On August 26, 2024, between 12:15 p.m., and 12:40 p.m., the surveyor observed CNS-B provide nursing education to the licensee's residents. CNS-B had a hire date of September 26, 2023, and provided direct care to the licensee's residents. CNS-B's employee record included six hours of dementia training completed, of training portability within 18 months of CNS-B's hire date with the licensee, missing two hours of the required eight hours within 120 hours of employment start date for supervisors of direct care staff. On August 27, 2024, at 1:26 p.m., CNS-B stated, via phone call, she was not aware of the training portability requirement within 18 months of her hire date with the licensee to transfer her completed dementia training. CNS-B verbalized she agreed she had two hours of missing dementia training in the required time frame. On August 27, 2024, at 3:00 p.m., the surveyor provided information to licensed assisted living director (LALD)-A about CNS-B's missing two hours of dementia training due to the training	01530		

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01530	Continued From page 23 portability requirement. Also, LALD-A verbalized two hours of CNS-B's training were completed in 2019 and 2020, more than 18 months prior to CNS-B's hire date with licensee. The licensee's 5.03 Dementia training policy dated August 1, 2024, included "All staff of [Licensee] are required to complete dementia training at the time of hire and annually thereafter." Also, indicated "1. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
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 24 (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 observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted an ongoing resident monitoring and reassessment no more than 14 days after admission for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: On August 26, 2024, at 10:55 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated the nurse completed assessments upon admission, at 14 days, every 90 days, and with changes in condition. On August 1, 2024, at 12:05 p.m., the surveyor observed unlicensed personnel (ULP)-C assist R2 with vital signs and medication administration. R2 was admitted December 13, 2021, and had diagnoses including schizoaffective disorder with	01620		

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01620	Continued From page 25 bipolar disorder (a chronic mental health condition with hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), disassociate episodes (mental health conditions that involve experiencing a loss of connection between thoughts, memories, feelings, surroundings, behavior, and identity), and spinal stenosis (abnormal spinal narrowing). R2's service plan dated January 15, 2024, indicated R2 received services including assistance meals, housekeeping, laundry, personal cares, bathing, toileting, behavior management, vital signs, and medication administration. R2's medical record included an initial comprehensive nursing assessment dated January 15, 2024, and a subsequent comprehensive nursing assessment dated February 2, 2024, 18 days after the initial comprehensive nursing assessment. On August 27, 2024, at 1:26 p.m., clinical nurse supervisor (CNS)-B stated, via phone call, she understood R2's 14-day nursing assessment was completed more than 14 days from R2's initial comprehensive nursing assessment. The surveyor provided information on the statute and CNS-B verbalized she planned to ensure the 14-day assessments would be completed no more than 14 days from the initial comprehensive nursing assessment. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated August 1, 2024, included "3. 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	01620		

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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
01620	Continued From page 26 as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supplemental oxygen (O2) tanks were stored safely to prevent tipping. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 was admitted December 13, 2021, and had diagnoses including schizoaffective disorder with bipolar disorder (a chronic mental health	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35863	A. BUILDING: _____ B. WING _____	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTERS HOME HEALTH CARE LLC	7438 VINCENT AVENUE RICHFIELD, MN 55423

(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
02310	Continued From page 27 condition with hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), disassociate episodes (mental health conditions that involve experiencing a loss of connection between thoughts, memories, feelings, surroundings, behavior, and identity), and spinal stenosis (abnormal spinal narrowing). R2's medical record included an order from R2's provider dated May 24, 2024, which indicated: -O2 to be administered via nasal cannula (tubing delivering O2 via nostrils) at a rate of four liters (L) per minute one time daily; and -Bilevel positive airway pressure (BIPAP) (a ventilation therapy) 19/10, air touch medium full-face mask with full-face cushion. On August 26, 2024, at 12:25 p.m., R2's room was observed to have two canister-style O2 tanks, standing upright on the floor, and not secured to prevent tipping. Additionally, one O2 tank was lying flat on a stand on R2's side table next to a recliner which was used for his BIPAP treatments during naps and at bedtime. R2 became verbally upset when the surveyor talked to him about the need to store and secure the oxygen tanks safely. Clinical nurse supervisor (CNS)-B also verbalized the importance to store the oxygen tanks safely. R2 stated he did not need a secure stand for the oxygen tanks and stated, "they aren't going to tip over." Next, the surveyor and CNS-B talked with R2 and provided education on the importance to use oxygen safely and store the oxygen tanks properly. Finally, CNS-B stated to R2 she would reach out to the oxygen company. On August 26, 2024, at 12:40 p.m., CNS-B stated she called the oxygen provider and they indicated they would bring out secure stands for the oxygen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35863	A. BUILDING: _____ B. WING _____	08/28/2024

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SISTERS HOME HEALTH CARE LLC	7438 VINCENT AVENUE RICHFIELD, MN 55423

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02310	Continued From page 28 tanks in the next 24 to 48 hours. The licensee's 7.04 Oxygen policy indicated "Oxygen cylinders and vessels must remain upright at all times. Never tip an oxygen cylinder or vessel on its side or try to roll it to a new location." Minnesota Department of Health guidance, Oxygen Cylinder Storage Requirements (based on the National Fire Protection Association, Standard 99 (NFPA 99), Health Care Facilities Code), dated April 16, 2020, indicated the types of hazards associated with oxygen as: 1) General fires and explosions enhanced by oxygen-rich atmospheres 2) Mechanical problems such as physical damage to compressed gas cylinders. The guidance further indicated, "when storing up to 300 cubic feet (ft^3) of oxygen, cylinders must be secured (chains or racks) to prevent them from falling over". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
6512014500

Type: Follow-Up
Date: *08/27/24*
Time: 09:36:30
Report: 1047241227

Food and Beverage Establishment Inspection Report

Location:
Sisters Home Health Care Llc
7438 Vincent Avenue
Richfield, MN55423
Hennepin County, 27

Establishment Info:
ID #: 0039118
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.

No NEW orders were issued during this inspection.

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

Facility has acquired a new thermometer.

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 1047241227 of 08/27/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed:_____
Ahmed Farah
Operator

Signed:_____
Holly Sievers
Public Health Sanitarian 2
Metro Office
6512015946
Holly.Sievers@state.mn.us