



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 21, 2025

Licensee

The Caring Sisters Home Care
5339 Queen Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL29360015

Dear Licensee:

On December 27, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the July 24, 2024, survey and October 10, 2024, follow-up 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,

A handwritten signature in black ink, appearing to read 'Tim Hanna'.

Tim Hanna, Supervisor
State Engineering Services Section
Health Regulation Division
Email: Tim.Hanna@state.mn.us
Telephone: 507-208-8982 Fax: 1-866-890-9290

JMD



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

December 5, 2024

Licensee

The Caring Sisters Home Care
5339 Queen Avenue North
Brooklyn Center, MN 55430

RE: Conditional License Number 416571
Health Facility Identification Number (HFID) 29360
Project Number(s) SL29360015

Dear Licensee:

Please Note: This notice amends the Notice of Conditional License dated November 5, 2024. Specifically, the content of tag 0100 was amended and was re-issued, and tags 0780, 0800, 0810, and 0820 were amended to correct the identifier used for licensed assisted living director (LALD) from LALD-B to LALD-C. Also, please note that a request for an informal conference has been included in this amended letter. Refer to this notice and revised state form for additional details.

The Minnesota Department of Health (MDH) completed a follow-up survey on October 10, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **February 3, 2024**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 (a), state correction orders issued pursuant to the last survey, completed on July 24, 2024, found not corrected at the time of the October 10, 2024,

follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00

0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4) - \$500.00

0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - \$500.00

0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on October 10, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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 and immediately correct any reissued orders 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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

CONDITIONAL LICENSE ISSUED:

MDH will issue The Caring Sisters Home Care a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if The Caring Sisters Home Care is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. Health Facility Construction Permit:** The Caring Sisters Home Care, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, The Caring Sisters Home Care, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- b. General Contractor:** Name of Facility must provide the following to Benjamin J. Zwart (Benjamin.Zwart@state.mn.us) via email within 21-days of the date of

this notice:

- i. Name
- ii. License Number
- iii. Contact Information

c. Egress Window Requirements: The Caring Sisters Home Care will replace at least one window in occupied resident sleeping rooms #2 meeting the minimum size requirements.

- i. Must have a minimum openable width of no less than 20 inches
- ii. Must have a minimum openable height of no less than 20 inches
- iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
- iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
- v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if The Caring Sisters Home Care is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines The Caring Sisters Home Care is in substantial compliance on the follow up survey, MDH will remove the conditions from The Caring Sisters Home Care's assisted living facility license, and The Caring Sisters Home Care will correct any outstanding violations identified during the survey. If The Caring Sisters Home Care is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with The Caring Sisters Home Care. Please contact Casey DeVries at 651-201-5917 **on or before Tuesday, December 10, 2024**, to schedule the conference call.

The Caring Sisters Home Care

December 5, 2024

Page 5

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 Casey DeVries directly at: 651-201-5917.

Sincerely,

A handwritten signature in black ink that reads "Rick Michals". The signature is written in a cursive, flowing style.

Rick Michals, J.D.

Executive Regional Operations Manager

Minnesota Department of Health

Health Regulation Division

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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: SL29360015-1 On October 1, 2024, through October 10, 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 3 residents; 3 receiving services under the Assisted Living license. An immediate correction order was identified on October 9, 2024, issued for SL29360015-1, tag identification 0820. On October 10, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged. On November 17, 2024, the content of tag 0100 was amended and was re-issued, and tags 0780, 0800, 0810, and 0820 were amended to correct	{0 000}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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}	Continued From page 1	{0 000}			
{0 100} SS=F	the identifier used for licensed assisted living director (LALD) from LALD-B to LALD-C. 144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies	{0 100}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
{0 100}	Continued From page 2 the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to manage, control, and/or operate the entire building as an assisted living facility. Non-assisted living occupants resided on one side of the two-unit townhome, and the licensee did not have access to all areas of the facility. During the initial survey on July 23, 2024, from 1:30 p.m. to 2:45 p.m., survey staff toured the facility with licensed assisted living director (LALD)-C. During the tour, survey staff observed the two-unit townhome was one building with an occupant/tenant who was not affiliated to the assisted living facility occupying one unit of the two-unit townhome. At 3:15 p.m., LALD-C stated they were not the owner of the property. During the follow up survey on October 9, 2024, at 4:00 p.m., LALD-C stated the licensee had not yet addressed the 0100 citation but intended to sometime during the fall (of 2024). No further information was provided.	{0 100}			
{0 480} SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents:	{0 480}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
{0 480}	Continued From page 3 (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: Not reviewed during this survey.	{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 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:	{0 680}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
{0 680}	Continued From page 4 Not reviewed during this survey.	{0 680}			
{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: (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 are interconnected so that the actuation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors.	{0 780}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 780}	Continued From page 5 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: On October 9, 2024, from 1:00: p.m. to 2:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, the LALD-C tested the smoke alarms and the smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout. The above deficient findings were verified by the LALD-C at the time of discovery. The LALD-C explained that they have bought new smoke alarms that can be interconnected but have not installed them. On October 9, 2024, at approximately 2:15 p.m., the LALD-C acknowledged the above findings at the interview. No further information was provided.	{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	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 800}	Continued From page 6 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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 9, 2024, from 1:00: p.m. to 2:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed the following: -No lighting was provided in the furnace water heater closet for maintenance and emergency use. -The air supply and return duct grilles throughout the common areas of the home were rusty and/or filled with thick dust and debris. -In the furnace room, the make-up air duct was kinked preventing air to enter the room. -On the main-level bathroom, the base of the	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 800}	Continued From page 7 vanity wood cabinet was deteriorating. -No approved smoke receptor and improper disposal of cigarette butts in a small metal container on the wood ramp immediately behind the back exit door. The LALD-C stated that he would provide approved smoke receptor for proper disposal on the driveway near the ramp and the back door. BASEMENT BATHROOM -The basement bathroom was unmaintained and lacked cleanliness as survey staff observed the floor was soiled, inside the light fixture cover was dirty, and improper caulking around the toilet and shower compartment collecting dirt. -No resident and staff provision for privacy on the door hardware for the basement bathroom. -The faucet on the lavatory of the basement bathroom had been altered allowing the altered faucet spout to submerge into the sink basin posing the potential for the home ' s water supply to be submerged in dirty water and contaminated. -The water supply lines to the lavatory in the basement bathroom were shut off and not supplying water when turned on, not allowing for handwashing and would dry out the lavatory drain trap, allowing sewer gas to continuously enter the home environment posing potential health risks to residents and staff. -The wood trim around the flooring and door molding trim were damaged and missing parts. MAIN-LEVEL RESIDENT SLEEPING ROOM 3 -The resident room 3 door was damaged with an approximate 2-inch size hole in the door. -The wall behind the door of resident sleeping room 3 had an approximate 1.5-inch size hole caused by the doorknob pounding on it. -The door of resident room 3 failed to latch when survey staff attempted to close the door multiple	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{0 800}	Continued From page 8 times. The LALD-C stated that the door latch had been repair but when confirmed the finding after mulitple attempts to close and the door failed to positively latch for locking when closed for resident privacy and fire/smoke protection during a fire emergency. BASEMENT RESIDENT SLEEPING ROOM 4 -The door in the basement sleeping room 4 did not have a doorknob to open but rather a lock hardware only. In addition, the lock hardware was located at 28 inches above the floor. All sleeping room hardware for egress must be located at a minimum of 34 inches above the floor. The LALD-C stated that he thought about replacing the door before the survey. -The basement sleeping room 4 lacked maintenance and cleanliness as survey staff observed dirty flooring, walls, and closets. The LALD-C again stated that they do not intend to occupy room 4 any time soon. The above deficient findings were verified by the LALD-C at the time of discovery. During an interview, survey staff explained the deficient conditions to the LALD-C, and they understood and acknowledged the findings. The LALD-C stated that it was his fault that corrections have not been made and would block out the weekend to make sure all defiencies are addressed. No further information was provided.	{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	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 9 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: Based on document and record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required contents and the required employee and resident training on fire safety and evacuation. This had the potential to affect all staff, residents, and	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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 10 visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On October 9, 2024, at approximately 2:00 p.m., document and record review and interview with the LALD-C on the home's fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include the home's evacuation floor plans. The LALD-C presented incomplete hard-drawn evacuation plans and stated that they need to hire someone to draw the plans. -Document review indicated the licensee failed to include and identify in the fire safety and evacuation plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-C confirmed they lack these provisions. -Record review indicated the licensee failed to provide evacuation training to residents at least once per year. The LALD-C was unable to provide records or logs showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 11 provide employee training on the fire safety and evacuation plan upon hire and at least twice per year. The LALD-C reached out to the nurse but was unable to provide the employee training records on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills. The LALD-C provided an evacuation drill record for review dated, August 1, 2024, and failed to meet at least one evacuation drill every other month. The LALD-C stated that he had thought they were required two evacuation drills annually. Survey staff explained to the LALD-C that the licensee must conduct a minimum total of six drills per year, consisting of twice per shift per year with at least one evacuation drill every other month. During the interview, the LALD-C verified the above deficient findings. On October 9, 2024, at approximately 2:15 p.m., the LALD-C acknowledged the above findings at the exit interview. No further information was provided.	{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	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
{0 820}	Continued From page 12 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: 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 the minimum state standard-sized egress window for occupied main-level resident sleeping room 2. This deficient condition had the potential to affect resident in sleeping room 2. 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 October 9, 2024, from 1:00: p.m. to 2:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, the LALD-C explained to survey staff that the window inside the main-level resident resident sleeping 2 (occupied) had not yet been replaced to meet the egress window requirements. The LALD-C further commented that the landlord misunderstood him and did not replace the window in resident sleeping 2. During an interview, survey staff asked the LALD-C for the fire watch plan and records addressing the immediate correction for resident sleeping room 2 for review. No fire watch plan or	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
{0 820}	Continued From page 13 records were provided or available for review. The above finding was verbally verified with the LALD-C accompanying the home tour and during an interview. On October 9, 2024, at approximately 2:15 p.m., survey staff explained to the LALD-C that the distinct hazard tag would be re-issued with an immediate correction order for the above finding. Survey staff further explained that a formal plan of correction for the immediate order must be developed and submitted for approval to lift the immediacy. The LALD-C understood and acknowledged the deficient condition and commented that they would respond to the immediate correction order and pull a permit for the window replacement immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{0 820}			
{0 910} SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 910}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
{0 970}	Continued From page 14	{0 970}			
{0 970} SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{0 970}			
{01650} SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including	{01650}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
{01650}	Continued From page 15 identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01650}			
{01730} SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel;	{01730}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
{01730}	Continued From page 16 (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Not reviewed during this survey.	{01730}			
{01750} SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced	{01750}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{01750}	Continued From page 17	{01750}			
	by: Not reviewed during this survey.				
{01940} SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	{01940}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
{01940}	Continued From page 18 Not reviewed during this survey.	{01940}			



Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF CONDITIONAL LICENSE

Electronically Delivered

November 5, 2024

Licensee

The Caring Sisters Home Care
5339 Queen Avenue North
Brooklyn Center, MN 55430

RE: Conditional License Number 416571
Health Facility Identification Number (HFID) 29360
Project Number(s) SL29360015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a follow-up survey on October 10, 2024, for the purpose of assessing compliance with state licensing statutes. Based on the follow-up survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144G.

As a result, pursuant to Minn. Stat. § 144G.20, MDH is issuing a 90-day conditional license due to expire on **February 3, 2024**.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state 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 (a), state correction orders issued pursuant to the last survey, completed on July 24, 2024, found not corrected at the time of the October 10, 2024, follow-up survey and/or subject to penalty assessment are as follows:

0780 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (1) - \$500.00
0800 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (a) (4) - \$500.00
0810 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (b)-(f) - \$500.00
0820 - Fire Protection And Physical Environment - 144g.45 Subd. 2 (g) - \$3,000.00

The details of the violations noted at the time of this follow-up survey completed on October 10, 2024 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$4,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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 and immediately correct any reissued orders 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>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

CONDITIONAL LICENSE ISSUED:

MDH will issue The Caring Sisters Home Care a conditional assisted living facility license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144G.30, Subd. 6. Based on the results of the follow-up survey, MDH will determine if The Caring Sisters Home Care is in substantial compliance.

The following conditions apply on the conditional assisted living facility license:

- a. Health Facility Construction Permit:** The Caring Sisters Home Care, will contact The Minnesota Department of Labor and Industry (MNDLI) or City with delegated authority to review and inspect State Licensed Facilities in accordance with Minn. Stat. § 326B.103, Subd. 13 and obtain a construction permit for a health facility. Within 21-days from the date of this notice, The Caring Sisters Home Care, will provide MDH with a copy of the permit obtained from MNDLI or City with delegated authority.
- b. General Contractor:** Name of Facility must provide the following to Benjamin J. Zwart (Benjamin.Zwart@state.mn.us) via email within 21-days of the date of this notice:
 - i. Name
 - ii. License Number
 - iii. Contact Information
- c. Egress Window Requirements:** The Caring Sisters Home Care will replace at least one window in occupied resident sleeping rooms #2 meeting the minimum

size requirements.

- i. Must have a minimum openable width of no less than 20 inches
- ii. Must have a minimum openable height of no less than 20 inches
- iii. Must have a total openable area of no less than 648 square inches (4.5 square feet)
- iv. Must have a windowsill height of no more than 48 inches from the floor to the clear opening
- v. All measurements must be achieved under normal operation of opening window without the use of a key, tool or special knowledge

RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL LICENSE PERIOD:

MDH will determine if The Caring Sisters Home Care is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines The Caring Sisters Home Care is in substantial compliance on the follow up survey, MDH will remove the conditions from The Caring Sisters Home Care's assisted living facility license, and The Caring Sisters Home Care will correct any outstanding violations identified during the survey. If The Caring Sisters Home Care is not in substantial compliance on the follow-up survey, MDH may take additional enforcement action, up to and including immediate temporary suspension and revocation, as authorized by Minn. Stat. § 144G.20.

REQUESTING A HEARING:

Pursuant to Minn. Stat. §144G.20, Subd. 18, the licensee may appeal an action against the license under this section. The licensee must request a hearing no later than 15 business days after licensee receives notice of the action.

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRD-Appeals-Form>.

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 Kelly Thorson directly at: 320-223-7336.

Sincerely,



Rick Michals, J.D.

Executive Regional Operations Manager

**Minnesota Department of Health
Health Regulation Division**

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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: SL29360015-1 On October 1, 2024, through October 10, 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 3 residents; 3 receiving services under the Assisted Living license. An immediate correction order was identified on October 9, 2024, issued for SL29360015-1, tag identification 0820. On October 10, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	{0 000}			
{0 780} SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	{0 780}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 780}	Continued From page 1 (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 are interconnected so that the actuation of one alarm causes all alarms in the home to operate for proper notification. This has 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	{0 780}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 780}	Continued From page 2 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 October 9, 2024, from 1:00: p.m. to 2:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the tour, the LALD-B tested the smoke alarms and the smoke alarms in the home were not interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout. The above deficient findings were verified by the LALD-B at the time of discovery. The LALD-B explained that they have bought new smoke alarms that can be interconnected but have not installed them. On October 9, 2024, at approximately 2:15 p.m., the LALD-B acknowledged the above findings at the interview. No further information was provided.	{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.	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 800}	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On October 9, 2024, from 1:00: p.m. to 2:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the tour, survey staff observed the following: -No lighting was provided in the furnace water heater closet for maintenance and emergency use. -The air supply and return duct grilles throughout the common areas of the home were rusty and/or filled with thick dust and debris. -In the furnace room, the make-up air duct was kinked preventing air to enter the room. -On the main-level bathroom, the base of the vanity wood cabinet was deteriorating. -No approved smoke receptor and improper disposal of cigarette butts in a small metal container on the wood ramp immediately behind the back exit door. The LALD-B stated that he would provide approved smoke receptor for	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 800}	Continued From page 4 proper disposal on the driveway near the ramp and the back door. BASEMENT BATHROOM -The basement bathroom was unmaintained and lacked cleanliness as survey staff observed the floor was soiled, inside the light fixture cover was dirty, and improper caulking around the toilet and shower compartment collecting dirt. -No resident and staff provision for privacy on the door hardware for the basement bathroom. -The faucet on the lavatory of the basement bathroom had been altered allowing the altered faucet spout to submerge into the sink basin posing the potential for the home ' s water supply to be submerged in dirty water and contaminated. -The water supply lines to the lavatory in the basement bathroom were shut off and not supplying water when turned on, not allowing for handwashing and would dry out the lavatory drain trap, allowing sewer gas to continuously enter the home environment posing potential health risks to residents and staff. -The wood trim around the flooring and door molding trim were damaged and missing parts. MAIN-LEVEL RESIDENT SLEEPING ROOM 3 -The resident room 3 door was damaged with an approximate 2-inch size hole in the door. -The wall behind the door of resident sleeping room 3 had an approximate 1.5-inch size hole caused by the doorknob pounding on it. -The door of resident room 3 failed to latch when survey staff attempted to close the door multiple times. The LALD-B stated that the door latch had been repair but when confirmed the finding after mulitple attempts to close and the door failed to positively latch for locking when closed for resident privacy and fire/smoke protection during a fire emergency.	{0 800}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{0 800}	Continued From page 5 BASEMENT RESIDENT SLEEPING ROOM 4 -The door in the basement sleeping room 4 did not have a doorknob to open but rather a lock hardware only. In addition, the lock hardware was located at 28 inches above the floor. All sleeping room hardware for egress must be located at a minimum of 34 inches above the floor. The LALD-B stated that he thought about replacing the door before the survey. -The basement sleeping room 4 lacked maintenance and cleanliness as survey staff observed dirty flooring, walls, and closets. The LALD-B again stated that they do not intend to occupy room 4 any time soon. The above deficient findings were verified by the LALD-B at the time of discovery. During an interview, survey staff explained the deficient conditions to the LALD-B, and they understood and acknowledged the findings. The LALD-B stated that it was his fault that corrections have not been made and would block out the weekend to make sure all deficiencies are addressed. No further information was provided.	{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}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 6 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 document and record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required contents and the required employee and resident training on fire safety and evacuation. This 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) and was issued at a	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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 7 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 October 9, 2024, at approximately 2:00 p.m., document and record review and interview with the LALD-B on the home's fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills indicated the following: -Document review indicated the licensee's fire safety and evacuation plan did not include the home's evacuation floor plans. The LALD-B presented incomplete hard-drawn evacuation plans and stated that they need to hire someone to draw the plans. -Document review indicated the licensee failed to include and identify in the fire safety and evacuation plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-B confirmed they lack these provisions. -Record review indicated the licensee failed to provide evacuation training to residents at least once per year. The LALD-B was unable to provide records or logs showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide employee training on the fire safety and evacuation plan upon hire and at least twice per year. The LALD-B reached out to the nurse but was unable to provide the employee training records on the fire safety and evacuation plan. -Record review indicated the licensee failed to	{0 810}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 8 provide the minimum required employee fire evacuation drills. The LALD-B provided an evacuation drill record for review dated, August 1, 2024, and failed to meet at least one evacuation drill every other month. The LALD-B stated that he had thought they were required two evacuation drills annually. Survey staff explained to the LALD-B that the licensee must conduct a minimum total of six drills per year, consisting of twice per shift per year with at least one evacuation drill every other month. During the interview, the LALD-B verified the above deficient findings. On October 9, 2024, at approximately 2:15 p.m., the LALD-B acknowledged the above findings at the exit interview. No further information was provided.	{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.	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
{0 820}	Continued From page 9 This MN Requirement is not met as evidenced by: 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 the minimum state standard-sized egress window for occupied main-level resident sleeping room 2. This deficient condition had the potential to affect resident in sleeping room 2. 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 October 9, 2024, from 1:00: p.m. to 2:00 p.m., survey staff toured the home with the licensed assisted living director (LALD)-B. During the tour, the LALD-B explained to survey staff that the window inside the main-level resident resident sleeping 2 (occupied) had not yet been replaced to meet the egress window requirements. The LALD-B further commented that the landlord misunderstood him and did not replace the window in resident sleeping 2. During an interview, survey staff asked the LALD-B for the fire watch plan and records addressing the immediate correction for resident sleeping room 2 for review. No fire watch plan or records were provided or available for review. The above finding was verbally verified with the LALD-B accompanying the home tour and during an interview. On October 9, 2024, at approximately 2:15 p.m., survey staff explained to the LALD-B that the	{0 820}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 10/10/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
{0 820}	Continued From page 10 distinct hazard tag would be re-issued with an immediate correction order for the above finding. Survey staff further explained that a formal plan of correction for the immediate order must be developed and submitted for approval to lift the immediacy. The LALD-B understood and acknowledged the deficient condition and commented that they would respond to the immediate correction order and pull a permit for the window replacement immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	{0 820}			



Protecting, Maintaining and Improving the Health of All Minnesotans

AMENDED

Electronically Delivered

December 5, 2024

Licensee

The Caring Sisters Home Care
5339 Queen Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL29360015

Dear Licensee:

Please Note: This notice amends the enforcement letter dated August 30, 2024. Specifically, correction order tags 0100, 0780, 0790, and 0800, were amended to correct the identifier used for licensed assisted living director (LALD) from LALD-A to LALD-C. Also, please note that an additional request for an informal conference has been included in this amended letter. Refer to this notice and revised state form for additional details.

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or

\$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Providence Villa LLC. Please contact Casey DeVries at 651-201-5917 **on or before Tuesday, December 10, 2024**, to schedule the conference call.

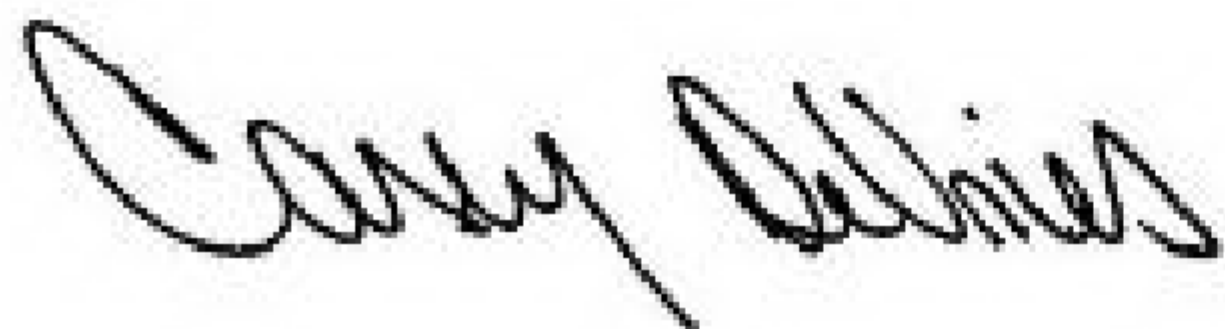
You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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: SL29360015-0 On July 22, 2024, through, July 24, 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 three resident(s); all of whom were receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 22, 2024, issued for SL29360015-0, tag identification 1290. On July 24, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on July 23, 2024, issued for SL29360015-0, tag	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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	Continued From page 1 identification 0820. On July 24, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged. On November 17, 2024, tags 0100, 0780, 0790, and 0800, were amended to correct the identifier used for licensed assisted living director (LALD) from LALD-A to LALD-C.	0 000			
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
0 100	Continued From page 2 building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when they applied for licensure for a single residential dwelling, despite sharing one roof with an adjoining town home, without having an approved two-hour fire wall separating the two dwellings. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from 1:30 p.m. to 2:45 p.m.,	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 100	Continued From page 3 survey staff toured the home with licensed assisted living director (LALD)-C. During the tour, survey staff observed the two-unit townhome as one building and asked LALD-C about the construction of the common wall and the fire-resistant rating of the wall separating this licensed assisted living and the adjacent unlicensed townhome. LALD-C showed survey staff the common wall separation between the two homes inside the lower-level laundry room. Survey staff inspected the wall and explained to LALD-C that based on the observation of the wood beams on top of the cinder blocks of the common wall, the home does not have the required separation between the licensed and unlicensed homes. On July 23, 2024, at 3:15 p.m., during an interview with LALD-C, survey staff again asked LALD-C about the construction of the licensed assisted living and the unlicensed adjacent townhome and supporting documentation that may substantiate the home was constructed with a 2-hour fire resistant rated fire barrier for the two homes. LALD-C acknowledged the finding and commented they would contact the property owner for additional information on the two homes. Survey staff stated that additional documentation will be honored for review if received by the end of the following day (July 24, 2024). Additional documentation was received via email on July 24, 2024, at 2:27 p.m., from LALD-C. The email with forwarded content included a picture of a property ID with two homes and two different addresses. The information did not substantiate the required two-hour fire barrier construction between the two homes.	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 100	Continued From page 4 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 July 22, 2024, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 480	Continued From page 5	0 480			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 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 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 plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 680	Continued From page 6 living license. 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: The licensee's emergency disaster preparedness plan dated March 3, 2024, lacked annual review, and evidence of the following required content: -address whether evacuated or shelter in place for staff/residents; -food, water, medical supplies, pharmaceutical supplies, and alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; - and -sewage and waste disposal; -develop policies/procedures (P/P) to address the use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP and must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual,	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 680	Continued From page 7 individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On July 23, 2024, at 12:59 p.m., clinical nurse supervisor (CNS)-D stated, "We don't have a policy on volunteers, we sent over the all the drills we have, and as far as the rest we didn't include those items when we made the plan, but we will add that as a correction." The licensee's Emergency Preparedness policy dated August 1, 2021, read, "The [Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 8 (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 working smoke alarms in the home and failed to provide interconnected smoke alarms so that the actuation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 9 of the residents). The findings include: On July 23, 2024, from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed the following upon testing of the smoke alarms: -The smoke alarms inside the main level sleeping room 3 and outside the hallway failed to operate correctly to produce sound. -The smoke alarm inside sleeping room 4 sounded local inside the room, and failed to cause other alarms in the home to operate and sound. -The smoke alarms in the home were not properly interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout. The above deficient findings were verified by the LALD-C at the time of discovery accompanying the home tour. On July 23, 2024, at approximately 3:30 p.m., the LALD-C understood and acknowledged the above findings at the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=B	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 790	Continued From page 10 extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the proper installation of the main-level portable fire extinguisher. This had the potential to directly affect residents and staff. 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 affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: On July 23, 2024, from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed the portable fire extinguisher located next to the kitchen was incorrectly mounted at 69 inches above the floor. The maximum height allowed by the state standard for extinguishers weighing less than 40 pounds at 60 inches (5 feet) above the floor.	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 790	Continued From page 11 The above deficient finding was verified by the LALD-C at the time of discovery. During an interview, survey staff explained the deficient condition to the LALD-C, and they understood and acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790			
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 12 or has the potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. During the tour, survey staff observed the following: -Improper disposal of cigarette butts in a small metal can located outside on the wood ramp immediately behind the back door. The LALD-C acknowledged the deficient condition and commented they would relocate the smoking area to the driveway and provide an approved smoke receptor for proper disposal. -Insufficient lighting was observed in the basement common area. The LALD-C attempted to turn on the light but was not able to. The LALD-C verified the finding and commented that they don't use the basement much. -The abandoned floor drain inside the basement office was not capped and did not receive any indirect drain discharges from appliances or equipment allowing sewer gas to continuously enter the home environment posing health risks to residents and staff. -No lighting was provided in the furnace water heater closet for maintenance and emergency use. -The air supply and return duct grilles throughout the home were rusty and/or filled with thick dust throughout the home. -In the furnace room, the make-up air duct was kinked preventing air to enter the room. -On the main-level bathroom, the base of the vanity wood cabinet was deteriorating. BASEMENT BATHROOM -The basement bathroom was unmaintained and lacked cleanliness as survey staff observed the floor was soiled, inside the light fixture cover was dirty, and improper caulking around the toilet and	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
0 800	Continued From page 13 shower compartment. -No resident and staff provision for privacy on the door hardware for the basement bathroom. -The faucet on the lavatory of the basement bathroom had been altered allowing the altered faucet spout to submerge into the sink basin posing the potential for the home's water supply to be submerged in dirty water and contaminated. -The water supply lines to the lavatory in the basement bathroom were shut off and not supplying water when turned on, not allowing for handwashing and would dry out the lavatory drain trap, allowing sewer gas to continuously enter the home environment posing potential health risks to residents and staff. -The wood trim around the flooring and door molding trim were damaged and missing parts. RESIDENT SLEEPING ROOM 4 -The door in the basement sleeping room 4 did not have a doorknob to open but rather a lock hardware only. In addition, the lock hardware was located at 28 inches above the floor. All sleeping room hardware for egress must be located at a minimum of 34 inches above the floor. The LALD-C stated that he thought about replacing the door before the survey. -The basement sleeping room 4 lacked maintenance and cleanliness as survey staff observed dirty flooring, walls, and closets. The LALD-C stated that they do not intend to occupy room 4 any time soon. RESIDENT SLEEPING ROOM 1 -The resident room 1 door was damaged with an approximate 2-inch size hole in the door. -The wall behind the door of resident sleeping room 1 had an approximate 1.5-inch size hole caused by the doorknob pounding on it. -The door of resident room 1 failed to latch when survey staff attempted to close the door multiple times. Survey staff explained to the LALD-C that	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 14 the door must latch positively for locking when closed for resident privacy and fire/smoke protection during a fire emergency. The LALD-C stated that they would fix it. The above deficient findings were verified by the LALD-C at the time of discovery accompanying the home tour. During an interview, survey staff explained the deficient conditions to the LALD-C, and they understood and acknowledged the findings. No further information was provided. 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 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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 15 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, document and record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required contents and the required employee and resident training on fire safety and evacuation. This 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, at approximately 1:15 p.m., at the beginning of the home tour, survey staff observed the licensed assisted living director (LALD)-C had hand-drawn papers of the home's evacuation floor plans in his hands, and no plans were posted as required. The LALD-C explained they were currently working on developing the	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 16 evacuation floor plans. On July 23, 2024, at approximately 3:00 p.m., document and record review and interview with the LALD-C on the home's fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills indicated the following: -The licensee's fire safety and evacuation plan did not include the home's evacuation floor plans. The LALD-C stated they are currently working on the plans. -The licensee's fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. -The licensee failed to include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-C stated that they train the residents verbally. -Record review indicated the licensee failed to provide evacuation training to residents at least once per year. The LALD-C was unable to provide records or logs showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide employee training on the fire safety and evacuation plan upon hire and at least twice per year. The LALD-C was unable to provide records	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 17 to indicate any employee training provided on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. No drill records for calendar years 2022 and 2023 were provided or available for review. The above deficient findings were verified by the LALD-C during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	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: Based on observation and interview, the licensee	0 820	This immediate correction order identified		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 820	Continued From page 18 failed to ensure physical facility elements did not constitute a distinct hazard to life. The licensee failed to provide the minimum state standard-sized egress windows for occupied main-level resident sleeping rooms 1 and 2. This deficient condition had the potential to affect residents in sleeping rooms 1 and 2 and all staff. 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from, 1:20: p.m. to 2:40 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. Survey staff measured the clear openings of the double-hung windows inside the main-level resident sleeping rooms 1 and 2. Both sleeping room windows (1 and 2) failed to have at least one state standard-sized window in each room with a minimum width and height of no less than 20 inches of clear opening and a minimum total open area of 648 inches required for safe egress. The largest window in sleeping room 1 measured dimensions, height at 14.75 inches, and width at 32 inches, totaling a clear opening area of 472 square inches. The largest window in sleeping room 2 measured with dimensions, height at 15.25 inches and width at 31.75 inches, totaling a clear opening area of 484 square inches. Survey staff explained to the LALD-C that at least one of the two windows in sleeping rooms 1 and 2 must	0 820	on July 23, 2024, has had the immediacy lifted as of July 24, 2024, however non-compliance remained a scope and level of I.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 820	Continued From page 19 have the required state-standard minimum width and height of no less than 20 inches of clear opening and a minimum total area of 648 inches (4.5 square feet) for existing sleeping rooms in assisted living homes. The above finding was verbally verified with the LALD-C accompanying the home tour. On July 23, 2024, at approximately 3:00 p.m., survey staff explained to the LALD-C that an immediate correction order was issued for the above findings. Survey staff explained that a plan of correction for the immediate order must be developed and submitted for approval to lift the immediacy. The LALD-C understood and acknowledged the deficient condition and did not have questions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility.	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 910	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content 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 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: The licensee began providing services under their assisted living facility license on August 1, 2021. R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's record included a [Licensee] Assisted Living Contract signed by R1 on October 20, 2022. R1's written contract lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On July 23, 2024, at 8:47 a.m., licensed assisted living director (LALD)-C stated, " Yes, I believe they do all have the same contract." On July 23, 2024, at 1:03 p.m., clinical nurse supervisor (CNS)-D stated, "Yes I will change that, I thought we made that correction, but I will	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 910	Continued From page 21 change that." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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 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 potential to affect a large portion or all of the residents). The findings include:	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 970	Continued From page 22 The licensee began providing services under their assisted living facility license on August 1, 2021. R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's record included a [Licensee] Assisted Living Contract signed by R1 on October 20, 2022, which included the following language, indicating a waiver of liability: "Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and the other insurance coverages and shall provide evidence other same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents." The contract also read, "Indemnification: The [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, for any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely hi	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
0 970	Continued From page 23 negligence of [Licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident. Liability: the resident agrees to be liable and responsible for all obligations hearing referenced, monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On July 23, 2024, at 8:47 a.m., licensed assisted living director (LALD)-C stated, "Yes, I believe they do all have the same contract. I will need to look at the wording in the contract closely." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01290	Continued From page 24 (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for one of one licensed practical nurse (LPN)-A. In addition, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of ten employees (unlicensed personnel (ULP)-E, ULP-F, ULP-G). This had the potential to affect all three residents residing in the assisted living facility and resulted in an immediate correction order on July 22, 2024. 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 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: LPN-A LPN-A was hired November 21, 2016, to provide direct care to the licensee's residents.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01290	Continued From page 25 On July 22, 2024, at 10:35 a.m., LPN-A participated in the entrance conference. LPN-A's employee record included a Minnesota Board of Nursing Licensed Practical Nurse license issued December 9, 2005. LPN-A's employee record contained a Background Study Clearance form dated November 21, 2016, affiliated to the licensee's closed comprehensive home care license HFID 20820. LPN-A's employee record lacked evidence of a cleared background study as required. The licensee's NETStudy 2.0 record included a background study clearance for LPN-A dated November 21, 2016, affiliated to a closed comprehensive home care license HFID 20820. On July 22, 2024, at 11:58 a.m., the surveyor observed LPN-A in the facility living room alone with R1 and R2 while other facility staff were in other areas of the facility not within eyesight of LPN-A or the residents. On July 22, 2024, at 12:35 p.m., the licensed assisted living director (LALD)-C stated, "So I found her here under 20820 which is an old HFID that we no longer have so I can't pull her up on a roster." ULP-E ULP-E was hired on May 9, 2024, to provide direct care to the licensee's residents. The licensee's NETStudy 2.0 record included a background study clearance for ULP-E dated May 9, 2024, affiliated to a sister facility, HFID 23620. ULP-E's record lacked evidence the	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01290	Continued From page 26 licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the licensee's HFID number. ULP-F ULP-F was hired on July 17, 2021, to provide direct care to the licensee's residents. The licensee's NETStudy 2.0 record included a background study clearance for ULP-F dated July 17, 2021, affiliated to a sister facility, HFID 23620. ULP-F's record lacked evidence the licensee submitted a background study for ULP-F under the current assisted living license and affiliated to the licensee's HFID number. ULP-G ULP-G was hired on May 21, 2024, to provide direct care to the licensee's residents. The licensee's NETStudy 2.0 record included a background study clearance for ULP-G dated May 9, 2024, affiliated to a sister facility, HFID 23620. ULP-G's record lacked evidence the licensee submitted a background study for ULP-G under the current assisted living license and affiliated to the licensee's HFID number. On July 22, 2024, at 11:53 a.m., LALD-C stated, "I have a couple that I need to get affiliated to our HFID, but they have a background study done under one of the other homes (a sister facility with a different HFID)." The licensee's Recruitment and Hiring policy dated August 1, 2021, read, " The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS:	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01290	Continued From page 27 i. The director or designee is responsible for initiating the criminal background study for new employees ii. NetStudy 2.0 (or current version) will be used for the background check iii. The employee will be directed to locations established by DHS to obtain fingerprint scans iv. Employees will be instructed that photographic identification will be required v. Employees/study subjects may enter their own background study demographic information using the facility identification code provided vi. Results of the background study will be maintained in the employee's personnel file*" No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01650	Continued From page 28 the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included all the required content for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's diagnoses included Diabetes type 2, glaucoma, and schizoaffective features. R1's Service Plan dated October 22, 2022, indicated R1's services included assistance with	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01650	Continued From page 29 dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R3 R3 was admitted to the licensee and began receiving assisted living services on October 1, 2021. R3's diagnoses included Diabetes type 2, generalized anxiety disorder, and schizophrenia. R3's Service Plan dated October 10, 2022, indicated R3's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R1 and R3's current service plans lacked evidence of the following required content: -a description of the fees for services; and -a contingency plan that includes the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. The licensee's Service Plan policy, dated August 1, 2021, read, "The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party b. The fees for services and the frequency of each service, according to the resident ' s current review or assessment and resident preferences	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
01650	Continued From page 30 c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident e. The schedule and method of monitoring staff providing services**. f. A contingency plan that includes the following i. Action to be taken if the scheduled service cannot be provided ii. Information and method for a resident or resident ' s representative to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident ' s condition iv. The identification of and information as to who has the authority to sign for the resident in an emergency v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives" On July 23, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-D stated, "We will get it added to the service plan, we do have our number in the contract, but we can get the info added to the service plan. Yeah, I will correct it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01730	Continued From page 31	01730			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes.	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01730	Continued From page 32 (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's diagnoses included Diabetes type 2, glaucoma, and schizoaffective features. R1's Service Plan dated October 22, 2022, indicated R1's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R1's Medication Management Plan dated June 18, 2024, lacked a description of storage of medications based on the resident's needs and	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01730	Continued From page 33 preferences, risk of diversion, and consistent with the manufacturer's directions. On July 23, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing content and stated all service plans would be missing the same information. CNS-D stated, "Oh I see, yeah, I didn't fill that out for anyone. I will fix it it's an easy fix." The licensee's Assessment of Medications policy, dated August 1, 2021, read, " Based on the results of the assessment, the RN (registered nurse) will document an individualized medication management plan, including the following elements i. Description of medication management services to be provided ii. Description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction iii. Documentation procedures" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 34 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure specific medication administration instructions for each resident was documented in the resident's record for one of two residents (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 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: R3 was admitted to the licensee and began receiving assisted living services on October 1, 2021. R3's diagnoses included Diabetes type 2, generalized anxiety disorder, and schizophrenia. R3's Service Plan dated October 10, 2022, indicated R3's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R3's Medication Administration Record, dated July 1, 2024, through July 31, 2024, indicated R3	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 35 received 35 units (U) of insulin glargin injected subcutaneously daily at 12:00 p.m. R3's records lacked specific medication administration instructions for when to hold the medication or update the nurse. On July 23, 2024, at 11:48 a.m., the surveyor asked the clinical nurse supervisor (CNS)-D how the unlicensed personnel (ULP) would know when to hold the medication, such as for low blood sugar, and where the ULPs would find that information. CNS-D stated, "No, it is not in any of the MAR's They are trained on all of it, but it isn't written on any of the resident's charts, but I can get that added for each of them." The licensee's Medication Administration policy, dated August 1, 2021, read, "The Registered Nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medication routes to be administered b. The Registered Nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident c. The Registered Nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01940	Continued From page 36 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R3).	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01940	Continued From page 37 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: R1 R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's diagnoses included Diabetes type 2, glaucoma, and schizoaffective features. R1's Service Plan dated October 22, 2022, indicated R1's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R1's Medication Administration Record (MAR), dated July 1, 2024, through July 31, 2024, indicated R1 received blood glucose monitoring three times daily. R1's records lacked an individualized treatment plan to include the following required content for blood sugar monitoring: - resident specific instructions related to the treatments/therapy administration; and - process for notifying an RN or appropriate licensed health professional when an issue or concern arises. R3	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01940	Continued From page 38 R3 was admitted to the licensee and began receiving assisted living services on October 1, 2021. R3's diagnoses included Diabetes type 2, generalized anxiety disorder, and schizophrenia. R3's Service Plan dated October 10, 2022, indicated R3's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R3's Medication Administration Record, dated July 1, 2024, through July 31, 2024, indicated R3 received blood glucose monitoring three times daily. R3's records lacked an individualized treatment plan to include the following required content for blood sugar monitoring: - resident specific instructions related to the treatments/therapy administration; and - process for notifying an RN or appropriate licensed health professional when an issue or concern arises. On July 23, 2024 between 9:08 a.m. through 9:39 a.m., in an interview together, the surveyor asked licensed assisted living director (LALD)-C and unlicensed personnel (ULP)-B how they would know what to update the nurse about and when to update the nurse for treatments and therapies. The LALD-C stated, "I will have to call the nurse and ask about that because that is what the nurses do." The ULP-B stated, "[Guidelines] used to be in the office, but I can't find it, so I think I need to update the nurse to re-print it. I don't know where they would be, maybe they got misplaced when they moved houses but as I said	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01940	Continued From page 39 I have not seen them here, but we know the instructions are to call a nurse if there is a rash or something is not right." On July 23, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-D stated, "No, it is not in any of the MARs. They are trained on all of it, but it isn't written on any of the resident's charts, but I can get that added for each of them." The licensee's Treatment and Therapy Management policy dated August 1, 2021, read, "The RN (registered nurse) or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

August 30, 2024

Licensee

The Caring Sisters Home Care
5339 Queen Avenue North
Brooklyn Center, MN 55430

RE: Project Number(s) SL29360015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 24, 2024, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.31, Subd. 4(a)(5), MDH may impose fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. MDH may impose a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. MDH also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the resident(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's resident(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14 and Subd. 18, a request for a hearing must be in writing and received by the Department of Health within 15 business days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

INFORMAL CONFERENCE

In accordance with Minn. Stat. § 144G.20, Subd. 20, the Commissioner of Health is authorized to hold a conference to exchange information, clarify issues, or resolve issues.

The Department of Health staff would like to schedule a conference call with Providence Villa LLC. Please contact Casey DeVries at 651-201-5917 **on or before Thursday, September 5, 2024**, to schedule the conference call.

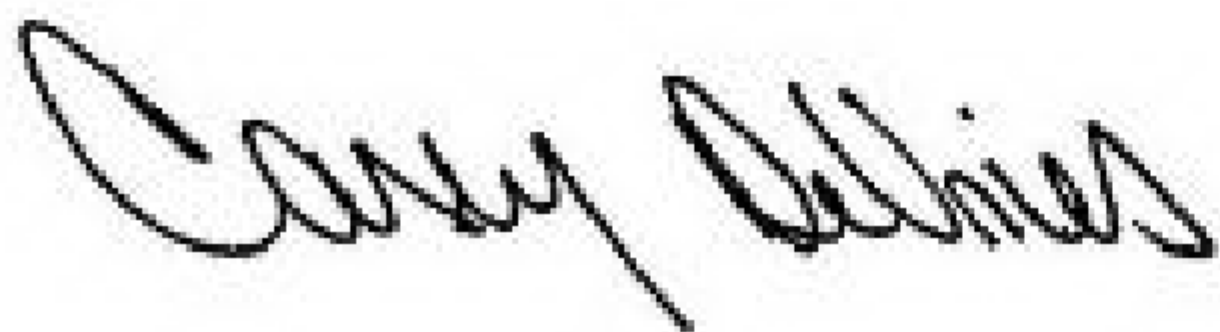
You are encouraged to retain this document for your records. It is your responsibility to share the information contained in the letter and state form with your organization's Governing Body.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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: SL29360015-0 On July 22, 2024, through, July 24, 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 three resident(s); all of whom were receiving services under the provider's Assisted Living Facility license. An immediate correction order was identified on July 22, 2024, issued for SL29360015-0, tag identification 1290. On July 24, 2024, the immediacy of correction order 1290 was removed, however non-compliance remained, and the scope and level remained unchanged. An immediate correction order was identified on July 23, 2024, issued for SL29360015-0, tag	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.		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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	Continued From page 1 identification 0820. On July 24, 2024, the immediacy of correction order 0820 was removed, however non-compliance remained, and the scope and level remained unchanged.	0 000			
0 100 SS=F	144G.10 Subdivision 1 License required (a)(1)Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b)The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted living facility license, the commissioner may: (1) issue a single license for two or more	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 100	Continued From page 2 buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain accurate licensure when they applied for licensure for a single residential dwelling, despite sharing one roof with an adjoining town home, without having an approved two-hour fire wall separating the two dwellings. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from 1:30 p.m. to 2:45 p.m., survey staff toured the home with licensed assisted living director (LALD)-A. During the tour, survey staff observed the two-unit townhome as one building and asked LALD-A about the construction of the common wall and the	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 100	Continued From page 3 fire-resistant rating of the wall separating this licensed assisted living and the adjacent unlicensed townhome. LALD-A showed survey staff the common wall separation between the two homes inside the lower-level laundry room. Survey staff inspected the wall and explained to LALD-A that based on the observation of the wood beams on top of the cinder blocks of the common wall, the home does not have the required separation between the licensed and unlicensed homes. On July 23, 2024, at 3:15 p.m., during an interview with LALD-A, survey staff again asked LALD-A about the construction of the licensed assisted living and the unlicensed adjacent townhome and supporting documentation that may substantiate the home was constructed with a 2-hour fire resistant rated fire barrier for the two homes. LALD-A acknowledged the finding and commented they would contact the property owner for additional information on the two homes. Survey staff stated that additional documentation will be honored for review if received by the end of the following day (July 24, 2024). Additional documentation was received via email on July 24, 2024, at 2:27 p.m., from LALD-A. The email with forwarded content included a picture of a property ID with two homes and two different addresses. The information did not substantiate the required two-hour fire barrier construction between the two homes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 480	Continued From page 4	0 480			
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (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 July 22, 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			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 680	Continued From page 5 (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 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 plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 680	Continued From page 6 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: The licensee's emergency disaster preparedness plan dated March 3, 2024, lacked annual review, and evidence of the following required content: -address whether evacuated or shelter in place for staff/residents; -food, water, medical supplies, pharmaceutical supplies, and alternate sources of energy to maintain: -temperatures to protect resident health/safety; -safe/sanitary storage of provisions; -emergency lighting; -fire detection, extinguishing, alarm systems; - and -sewage and waste disposal; -develop policies/procedures (P/P) to address the use of volunteers, including the process/role for integration; -develop P/P to address role of facility under a waiver declared by the Secretary in accordance with section 1135 of the Act; -conduct exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP and must include the following: -participate in an annual full-scale exercise that is community based OR conduct an annual, individual, facility-based functional exercise OR if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -conduct an additional annual exercise that may include: a second full-scale exercise that is	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 680	Continued From page 7 community-based or an individual, facility based functional exercise OR mock disaster drill OR table-top exercise; and -analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. On July 23, 2024, at 12:59 p.m., clinical nurse supervisor (CNS)-D stated, "We don't have a policy on volunteers, we sent over the all the drills we have, and as far as the rest we didn't include those items when we made the plan, but we will add that as a correction." The licensee's Emergency Preparedness policy dated August 1, 2021, read, "The [Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (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	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 8 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 working smoke alarms in the home and failed to provide interconnected smoke alarms so that the actuation of one alarm causes all alarms in the home to operate for proper notification. This has the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 780	Continued From page 9 assisted living director (LALD)-A. During the tour, survey staff observed the following upon testing of the smoke alarms: -The smoke alarms inside the main level sleeping room 3 and outside the hallway failed to operate correctly to produce sound. -The smoke alarm inside sleeping room 4 sounded local inside the room, and failed to cause other alarms in the home to operate and sound. -The smoke alarms in the home were not properly interconnected so the actuation of one alarm would cause all alarms to operate and sound throughout. The above deficient findings were verified by the LALD-A at the time of discovery accompanying the home tour. On July 23, 2024, at approximately 3:30 p.m., the LALD-A understood and acknowledged the above findings at the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 790 SS=B	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code,	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 790	Continued From page 10 located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the proper installation of the main-level portable fire extinguisher. This had the potential to directly affect residents and staff. 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 affect health or safety) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found to be pervasive). The findings include: On July 23, 2024, from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour, survey staff observed the portable fire extinguisher located next to the kitchen was incorrectly mounted at 69 inches above the floor. The maximum height allowed by the state standard for extinguishers weighing less than 40 pounds at 60 inches (5 feet) above the floor. The above deficient finding was verified by the LALD-A at the time of discovery. During an interview, survey staff explained the deficient condition to the LALD-A, and they	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 790	Continued From page 11 understood and acknowledged the finding. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 790			
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 of the facility in a continuous state of good repair and operation. This has the potential to directly affect the health, safety, and well-being of residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from 1:15 p.m. to 2:45 p.m., survey staff toured the home with the licensed assisted living director (LALD)-A. During the tour,	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 12 survey staff observed the following: -Improper disposal of cigarette butts in a small metal can located outside on the wood ramp immediately behind the back door. The LALD-A acknowledged the deficient condition and commented they would relocate the smoking area to the driveway and provide an approved smoke receptor for proper disposal. -Insufficient lighting was observed in the basement common area. The LALD-A attempted to turn on the light but was not able to. The LALD-A verified the finding and commented that they don ' t use the basement much. -The abandoned floor drain inside the basement office was not capped and did not receive any indirect drain discharges from appliances or equipment allowing sewer gas to continuously enter the home environment posing health risks to residents and staff. -No lighting was provided in the furnace water heater closet for maintenance and emergency use. -The air supply and return duct grilles throughout the home were rusty and/or filled with thick dust throughout the home. -In the furnace room, the make-up air duct was kinked preventing air to enter the room. -On the main-level bathroom, the base of the vanity wood cabinet was deteriorating. BASEMENT BATHROOM -The basement bathroom was unmaintained and lacked cleanliness as survey staff observed the floor was soiled, inside the light fixture cover was dirty, and improper caulking around the toilet and shower compartment. -No resident and staff provision for privacy on the door hardware for the basement bathroom. -The faucet on the lavatory of the basement bathroom had been altered allowing the altered faucet spout to submerge into the sink basin	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 13 posing the potential for the home ' s water supply to be submerged in dirty water and contaminated. -The water supply lines to the lavatory in the basement bathroom were shut off and not supplying water when turned on, not allowing for handwashing and would dry out the lavatory drain trap, allowing sewer gas to continuously enter the home environment posing potential health risks to residents and staff. -The wood trim around the flooring and door molding trim were damaged and missing parts. RESIDENT SLEEPING ROOM 4 -The door in the basement sleeping room 4 did not have a doorknob to open but rather a lock hardware only. In addition, the lock hardware was located at 28 inches above the floor. All sleeping room hardware for egress must be located at a minimum of 34 inches above the floor. The LALD-A stated that he thought about replacing the door before the survey. -The basement sleeping room 4 lacked maintenance and cleanliness as survey staff observed dirty flooring, walls, and closets. The LALD-A stated that they do not intend to occupy room 4 any time soon. RESIDENT SLEEPING ROOM 1 -The resident room 1 door was damaged with an approximate 2-inch size hole in the door. -The wall behind the door of resident sleeping room 1 had an approximate 1.5-inch size hole caused by the doorknob pounding on it. -The door of resident room 1 failed to latch when survey staff attempted to close the door multiple times. Survey staff explained to the LALD-A that the door must latch positively for locking when closed for resident privacy and fire/smoke protection during a fire emergency. The LALD-A stated that they would fix it. The above deficient findings were verified by the LALD-A at the time of discovery accompanying	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 800	Continued From page 14 the home tour. During an interview, survey staff explained the deficient conditions to the LALD-A, and they understood and acknowledged the findings. No further information was provided. 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 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 15 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, document and record review, and interview, the licensee failed to develop a fire safety and evacuation plan with the required contents and the required employee and resident training on fire safety and evacuation. This 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) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, at approximately 1:15 p.m., at the beginning of the home tour, survey staff observed the licensed assisted living director (LALD)-A had hand-drawn papers of the home ' s evacuation floor plans in his hands, and no plans were posted as required. The LALD-A explained they were currently working on developing the evacuation floor plans. On July 23, 2024, at approximately 3:00 p.m., document and record review and interview with the LALD-A on the home ' s fire safety and evacuation plan, fire safety and evacuation	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 16 training, and evacuation drills indicated the following: -The licensee ' s fire safety and evacuation plan did not include the home ' s evacuation floor plans. The LALD-A stated they are currently working on the plans. -The licensee ' s fire safety and evacuation plan did not include the identification of unique or unusual resident needs for movement or evacuation under procedures for resident movement, evacuation, or relocation during a fire or similar emergency. -The licensee failed to include and identify in the plan the specific fire protection procedures for residents who are capable of self-evacuation on the proper actions to be taken in case of a fire or similar emergency. During the interview, the LALD-A stated that they train the residents verbally. -Record review indicated the licensee failed to provide evacuation training to residents at least once per year. The LALD-A was unable to provide records or logs showing any training offered to residents on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide employee training on the fire safety and evacuation plan upon hire and at least twice per year. The LALD-A was unable to provide records to indicate any employee training provided on the fire safety and evacuation plan. -Record review indicated the licensee failed to provide the minimum required employee fire evacuation drills twice per year, per shift with at least one evacuation drill every other month. No	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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 17 drill records for calendar years 2022 and 2023 were provided or available for review. The above deficient findings were verified by the LALD-A during the interview. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
0 820 SS=I	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: 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 the minimum state standard-sized egress windows for occupied main-level resident sleeping rooms 1 and 2. This deficient condition had the potential to affect residents in sleeping rooms 1 and 2 and all staff.	0 820	This immediate correction order identified on July 23, 2024, has had the immediacy lifted as of July 24, 2024, however non-compliance remained a scope and level of I.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 820	Continued From page 18 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 23, 2024, from, 1:20: p.m. to 2:40 p.m., survey staff toured the home with the licensed assisted living director (LALD)-C. Survey staff measured the clear openings of the double-hung windows inside the main-level resident sleeping rooms 1 and 2. Both sleeping room windows (1 and 2) failed to have at least one state standard-sized window in each room with a minimum width and height of no less than 20 inches of clear opening and a minimum total open area of 648 inches required for safe egress. The largest window in sleeping room 1 measured dimensions, height at 14.75 inches, and width at 32 inches, totaling a clear opening area of 472 square inches. The largest window in sleeping room 2 measured with dimensions, height at 15.25 inches and width at 31.75 inches, totaling a clear opening area of 484 square inches. Survey staff explained to the LALD-C that at least one of the two windows in sleeping rooms 1 and 2 must have the required state-standard minimum width and height of no less than 20 inches of clear opening and a minimum total area of 648 inches (4.5 square feet) for existing sleeping rooms in assisted living homes. The above finding was verbally verified with the	0 820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 820	Continued From page 19 LALD-C accompanying the home tour. On July 23, 2024, at approximately 3:00 p.m., survey staff explained to the LALD-C that an immediate correction order was issued for the above findings. Survey staff explained that a plan of correction for the immediate order must be developed and submitted for approval to lift the immediacy. The LALD-C understood and acknowledged the deficient condition and did not have questions. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 820			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1). This practice resulted in a level one violation (a	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 910	Continued From page 20 violation that has no potential to cause more than a minimal impact on the resident and does not 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: The licensee began providing services under their assisted living facility license on August 1, 2021. R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's record included a [Licensee] Assisted Living Contract signed by R1 on October 20, 2022. R1's written contract lacked the following required content: - the contract must include in a conspicuous place and manner on the contract the Health Facility Identification (HFID) number of the facility. On July 23, 2024, at 8:47 a.m., licensed assisted living director (LALD)-C stated, " Yes, I believe they do all have the same contract." On July 23, 2024, at 1:03 p.m., clinical nurse supervisor (CNS)-D stated, "Yes I will change that, I thought we made that correction, but I will change that." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 970	Continued From page 21	0 970			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal property of a resident. This had the potential to affect all residents. 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 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 potential to affect a large portion or all of the residents). The findings include: The licensee began providing services under their assisted living facility license on August 1, 2021. R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021.	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
0 970	Continued From page 22 R1's record included a [Licensee] Assisted Living Contract signed by R1 on October 20, 2022, which included the following language, indicating a waiver of liability: "Insurance Liability and Release. The resident shall maintain at all times his or her own health, personal property, liability, automobile (if applicable), and the other insurance coverages and shall provide evidence other same by copies of binders or policies provided to [Licensee] upon request. The resident acknowledges that [Licensee] is not an insurer of the resident's person or property. The resident agrees that [Licensee] will not be liable to the resident for any personal injury or property damage (including, without limitation, damage to, or loss or theft of, automobiles or personal property of resident) suffered by the resident or the resident's agents, guests or invitees, unless and to the extent that the injury or damage is caused by the negligence of [Licensee] or its employees or agents. The resident hereby releases [Licensee] from liability for any personal injury or property damage suffered by the resident or the resident's agents, guests, or invitees, unless caused by the negligence of [Licensee] or its employees or agents." The contract also read, "Indemnification: The [Licensee] shall not be liable for any damage or injury to the resident, or any other person, or to any property, occurring on the premises, for any part thereof, or in common areas thereof, and the resident agrees to hold [Licensee] harmless from any claims or damages unless caused solely hi negligence of [Licensee]. It is recommended that renter's insurance be purchased at the resident's expense. Nothing contained herein is intended to create a waiver of facility liability for the health and safety or personal property of a resident. Liability: the resident agrees to be liable and responsible for all obligations hearing referenced,	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
0 970	Continued From page 23 monetary and otherwise, of the resident and where this Contract has been executed by a party designated below. Or where a separate Responsible Party Agreement has been executed by a third party, said third party and the resident shall be jointly and severally liable and responsible for all obligations, monetary and otherwise, of the resident herein referenced." On July 23, 2024, at 8:47 a.m., licensed assisted living director (LALD)-C stated, "Yes, I believe they do all have the same contract. I will need to look at the wording in the contract closely." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01290	Continued From page 24 by: Based on interview and record review, the licensee failed to ensure a background study was current and eligible on NETStudy 2.0 (web-based system for submitting background study requests to the Department of Human Services (DHS)) prior to staff providing services for one of one licensed practical nurse (LPN)-A. In addition, the licensee failed to ensure a background study was submitted and received in affiliation with the assisted living license for three of ten employees (unlicensed personnel (ULP)-E, ULP-F, ULP-G). This had the potential to affect all three residents residing in the assisted living facility and resulted in an immediate correction order on July 22, 2024. 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 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: LPN-A LPN-A was hired November 21, 2016, to provide direct care to the licensee's residents. On July 22, 2024, at 10:35 a.m., LPN-A participated in the entrance conference. LPN-A's employee record included a Minnesota Board of Nursing Licensed Practical Nurse license issued December 9, 2005.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01290	Continued From page 25 LPN-A's employee record contained a Background Study Clearance form dated November 21, 2016, affiliated to the licensee's closed comprehensive home care license HFID 20820. LPN-A's employee record lacked evidence of a cleared background study as required. The licensee's NETStudy 2.0 record included a background study clearance for LPN-A dated November 21, 2016, affiliated to a closed comprehensive home care license HFID 20820. On July 22, 2024, at 11:58 a.m., the surveyor observed LPN-A in the facility living room alone with R1 and R2 while other facility staff were in other areas of the facility not within eyesight of LPN-A or the residents. On July 22, 2024, at 12:35 p.m., the licensed assisted living director (LALD)-C stated, "So I found her here under 20820 which is an old HFID that we no longer have so I can't pull her up on a roster." ULP-E ULP-E was hired on May 9, 2024, to provide direct care to the licensee's residents. The licensee's NETStudy 2.0 record included a background study clearance for ULP-E dated May 9, 2024, affiliated to a sister facility, HFID 23620. ULP-E's record lacked evidence the licensee submitted a background study for ULP-E under the current assisted living license and affiliated to the licensee's HFID number. ULP-F ULP-F was hired on July 17, 2021, to provide direct care to the licensee's residents.	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01290	Continued From page 26 The licensee's NETStudy 2.0 record included a background study clearance for ULP-F dated July 17, 2021, affiliated to a sister facility, HFID 23620. ULP-F's record lacked evidence the licensee submitted a background study for ULP-F under the current assisted living license and affiliated to the licensee's HFID number. ULP-G ULP-G was hired on May 21, 2024, to provide direct care to the licensee's residents. The licensee's NETStudy 2.0 record included a background study clearance for ULP-G dated May 9, 2024, affiliated to a sister facility, HFID 23620. ULP-G's record lacked evidence the licensee submitted a background study for ULP-G under the current assisted living license and affiliated to the licensee's HFID number. On July 22, 2024, at 11:53 a.m., LALD-C stated, "I have a couple that I need to get affiliated to our HFID, but they have a background study done under one of the other homes (a sister facility with a different HFID)." The licensee's Recruitment and Hiring policy dated August 1, 2021, read, " The Criminal Background Check will be submitted to Minnesota Department of Human Services (DHS) following the step-by-step procedure established by DHS: i. The director or designee is responsible for initiating the criminal background study for new employees ii. NetStudy 2.0 (or current version) will be used for the background check iii. The employee will be directed to locations established by DHS to obtain fingerprint scans	01290			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01290	Continued From page 27 iv. Employees will be instructed that photographic identification will be required v. Employees/study subjects may enter their own background study demographic information using the facility identification code provided vi. Results of the background study will be maintained in the employee's personnel file*" No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01650	Continued From page 28 medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the current service plan included all the required content for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R1 R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's diagnoses included Diabetes type 2, glaucoma, and schizoaffective features. R1's Service Plan dated October 22, 2022, indicated R1's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R3 R3 was admitted to the licensee and began receiving assisted living services on October 1,	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01650	Continued From page 29 2021. R3's diagnoses included Diabetes type 2, generalized anxiety disorder, and schizophrenia. R3's Service Plan dated October 10, 2022, indicated R3's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R1 and R3's current service plans lacked evidence of the following required content: -a description of the fees for services; and -a contingency plan that includes the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency. The licensee's Service Plan policy, dated August 1, 2021, read, "The service plan includes the following: a. A description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party b. The fees for services and the frequency of each service, according to the resident ' s current review or assessment and resident preferences c. The identification of the staff or categories of staff who will provide the services d. The schedule and methods of monitoring reviews or assessments of the resident e. The schedule and method of monitoring staff	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01650	Continued From page 30 providing services**. f. A contingency plan that includes the following i. Action to be taken if the scheduled service cannot be provided ii. Information and method for a resident or resident ' s representative to contact the facility iii. Names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident ' s condition iv. The identification of and information as to who has the authority to sign for the resident in an emergency v. Circumstances in which emergency medical services are not to be summoned and declarations made by the resident related to health care directives" On July 23, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-D stated, "We will get it added to the service plan, we do have our number in the contract, but we can get the info added to the service plan. Yeah, I will correct it." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01730 SS=F	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, the assisted living facility must prepare and include in the service plan a written statement of the medication management	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01730	Continued From page 31 services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01730	Continued From page 32 licensee failed to develop and maintain a current individualized medication management record for each resident to include all required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's diagnoses included Diabetes type 2, glaucoma, and schizoaffective features. R1's Service Plan dated October 22, 2022, indicated R1's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R1's Medication Management Plan dated June 18, 2024, lacked a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions. On July 23, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-D acknowledged the missing content and stated all service plans would be missing the same information. CNS-D stated, "Oh I see, yeah, I didn't fill that out for anyone. I will fix	01730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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	
01730	Continued From page 33 it it's an easy fix." The licensee's Assessment of Medications policy, dated August 1, 2021, read, " Based on the results of the assessment, the RN (registered nurse) will document an individualized medication management plan, including the following elements i. Description of medication management services to be provided ii. Description of medication storage based on resident need, preference, risk of diversion and per manufacturer's direction iii. Documentation procedures" No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by:	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 34 Based on observation, interview, and record review, the licensee failed to ensure specific medication administration instructions for each resident was documented in the resident's record for one of two residents (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 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: R3 was admitted to the licensee and began receiving assisted living services on October 1, 2021. R3's diagnoses included Diabetes type 2, generalized anxiety disorder, and schizophrenia. R3's Service Plan dated October 10, 2022, indicated R3's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R3's Medication Administration Record, dated July 1, 2024, through July 31, 2024, indicated R3 received 35 units (U) of insulin glargin injected subcutaneously daily at 12:00 p.m. R3's records lacked specific medication administration instructions for when to hold the medication or update the nurse. On July 23, 2024, at 11:48 a.m., the surveyor asked the clinical nurse supervisor (CNS)-D how	01750			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01750	Continued From page 35 the unlicensed personnel (ULP) would know when to hold the medication, such as for low blood sugar, and where the ULPs would find that information. CNS-D stated, "No, it is not in any of the MAR's They are trained on all of it, but it isn't written on any of the resident's charts, but I can get that added for each of them." The licensee's Medication Administration policy, dated August 1, 2021, read, "The Registered Nurse may delegate medication administration to an unlicensed staff member (home health aide) according to the following protocol. a. All home health aides have passed a competency evaluation with respect to all medication routes to be administered b. The Registered Nurse has prepared written instructions for the home health aide in the proper methods to administer medications with respect to each resident c. The Registered Nurse has communicated with/provided orientation to the home health aide regarding the individual needs of the resident." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01940 SS=F	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01940	Continued From page 36 individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of two residents (R1 and R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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).	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01940	Continued From page 37 The findings include: R1 R1 was admitted January 23, 2012, and began receiving assisted living services on August 1, 2021. R1's diagnoses included Diabetes type 2, glaucoma, and schizoaffective features. R1's Service Plan dated October 22, 2022, indicated R1's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R1's Medication Administration Record (MAR), dated July 1, 2024, through July 31, 2024, indicated R1 received blood glucose monitoring three times daily. R1's records lacked an individualized treatment plan to include the following required content for blood sugar monitoring: - resident specific instructions related to the treatments/therapy administration; and - process for notifying an RN or appropriate licensed health professional when an issue or concern arises. R3 R3 was admitted to the licensee and began receiving assisted living services on October 1, 2021. R3's diagnoses included Diabetes type 2, generalized anxiety disorder, and schizophrenia. R3's Service Plan dated October 10, 2022,	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430			
(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
01940	Continued From page 38 indicated R3's services included assistance with dressing, grooming, assist of one with mobility, meals, medication administration, vitals, cleaning, and behavior management. R3's Medication Administration Record, dated July 1, 2024, through July 31, 2024, indicated R3 received blood glucose monitoring three times daily. R3's records lacked an individualized treatment plan to include the following required content for blood sugar monitoring: - resident specific instructions related to the treatments/therapy administration; and - process for notifying an RN or appropriate licensed health professional when an issue or concern arises. On July 23, 2024 between 9:08 a.m. through 9:39 a.m., in an interview together, the surveyor asked licensed assisted living director (LALD)-C and unlicensed personnel (ULP)-B how they would know what to update the nurse about and when to update the nurse for treatments and therapies. The LALD-C stated, "I will have to call the nurse and ask about that because that is what the nurses do." The ULP-B stated, "[Guidelines] used to be in the office, but I can't find it, so I think I need to update the nurse to re-print it. I don't know where they would be, maybe they got misplaced when they moved houses but as I said I have not seen them here, but we know the instructions are to call a nurse if there is a rash or something is not right." On July 23, 2024, at 11:48 a.m., clinical nurse supervisor (CNS)-D stated, "No, it is not in any of the MARs. They are trained on all of it, but it isn't written on any of the resident's charts, but I can	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29360	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/24/2024
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 5339 QUEEN AVENUE NORTH BROOKLYN CENTER, MN 55430		
(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
01940	Continued From page 39 get that added for each of them." The licensee's Treatment and Therapy Management policy dated August 1, 2021, read, "The RN (registered nurse) or licensed professional will prepare an individualized treatment or therapy management plan for each resident receiving ordered or prescribed treatments or therapy services, which addresses: a. Type of service to be provided b. Procedures for documenting treatments or therapies c. Procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions d. Identification of treatment or therapy tasks delegated to unlicensed personnel e. Procedures for notifying the RN or licensed health professional when a problem arises related to the treatment or therapy service." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			

Type: Full
Date: 07/22/24
Time: 14:09:45
Report: 8058241164

Food and Beverage Establishment Inspection Report

Page 1

Location:

The Caring Sisters Home Care
5339 Queen Avenue North
Brooklyn Center, MN55430
Hennepin County, 27

Establishment Info:

ID #: 0038340
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 9524264690
ID #:

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

The following orders were issued during this inspection.

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.

ADJUSTED COOLER DURING INSPECTION - COS

Comply By: 07/22/24

2-100 Supervision

2-102.12AMN

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

CFPM NEEDED FOR ESTABLISHMENT

Comply By: 08/30/24

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.

REPAIR/REPLACE NON WORKING DISH WASHER

Comply By: 10/22/24

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.12A

MN Rule 4626.1520A Clean and maintain all physical facilities clean.

GREASE BUILT UP ON WALLS AND CABINET FACES - MAINTAIN VENT FILTERS CLEAN AND CLEAN CABINET FACES AND HANDLES

Comply By: 07/31/24

Type: Full
Date: 07/22/24
Time: 14:09:45
Report: 8058241164
The Caring Sisters Home Care

Food and Beverage Establishment Inspection Report

Food and Equipment Temperatures

Process/Item: TOMATO
Temperature: 47 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

Process/Item: SAUSAGE
Temperature: 46 Degrees Fahrenheit - Location: COOLER
Violation Issued: Yes

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

HRD INSPECTOR: TESA BROWN

RESIDENTIAL KITCHEN WITH NON COMMERCIAL APPLIANCES AND FINISHES

DISH WASHER IS BROKEN AND A PLASTIC BIN IS BEING USED TO SANITIZE DISHES AS A THIRD SINK BASIN STAND IN

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 8058241164 of 07/22/24.

Certified Food Protection Manager:_____

Certification Number: _____ Expires: ____/____/____

Signed:_____
Establishment Representative

Signed:_____
Aaron Gertz
Sanitarian 3
MDH Metro Office
651 201 4500
health.foodlodging@state.mn.us