



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 19, 2026

Licensee
The Caring Sisters Home Care
1375 Oak Grove Circle
Golden Valley, MN 55422

RE: Project Number(s) SL21932016

Dear Licensee:

On January 28, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on November 5, 2025. 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 'Jess Schoenecker'.

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

KKM

Electronically Delivered

December 8, 2025

Licensee

The Caring Sisters Home Care

1375 Oak Grove Circle

Golden Valley, MN 55422

RE: Project Number(s) SL21932016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 5, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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;

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - \$500.00

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

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,500.00.** You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

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.

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

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

If you have any questions, please contact me.

Sincerely,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)</p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL21932016-0</p> <p>On November 3, 2025, through November 5, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three (3) residents; 3 receiving services under the Assisted Living Facility license.</p> <p>An immediate correction order was identified on November 3, 2025, issued for SL21932016-0, tag identification 1290.</p> <p>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.</p>	0 000	<p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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.</p>	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 2</p> <p>existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition;</p> <p>(6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and</p> <p>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.</p> <p>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.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated November 4, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.</p>	0 480		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	0 480		
0 660 SS=F	<p>144G.42 Subd. 9 Tuberculosis prevention and control</p> <p>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) The facility must maintain written evidence of compliance with this subdivision.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) which included baseline screening and testing for two of two employees (unlicensed personnel (ULP)-D, ULP-E).</p> <p>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</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
0 660	<p>Continued From page 4</p> <p>cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>The licensee's Facility TB Risk Assessment dated July 10, 2025, indicated the facility was a low risk setting for TB transmission.</p> <p>ULP-D ULP-D was hired May 16, 2014, under the licensee's former comprehensive license, and began providing assisted living services on August 1, 2021.</p> <p>ULP-D's employee record included TB history and symptom screens dated April 5, 2019, and August 5, 2025. The symptom screen completed on April 5, 2019, indicated ULP-D had previously had a positive TST.</p> <p>ULP-D's employee record also included a a negative chest X-ray dated May 28, 2014.</p> <p>ULP-D's employee record lacked evidence of a positive two-step tuberculin skin test (TST) or a tuberculin blood test.</p> <p>ULP-E ULP-E was hired May 13, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021.</p> <p>ULP-E's employee record included a TB history and symptom screen dated May 16, 2025, and a negative chest X-ray dated January 27, 2017.</p>	0 660		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
0 660	<p>Continued From page 5</p> <p>ULP-E's employee record lacked evidence of a positive two-step tuberculin skin test (TST) or a tuberculin blood test.</p> <p>On November 4, 2025, at 11:54 a.m., clinical nurse supervisor (CNS)-B stated they were thought the chest X-ray was sufficient. CNS-B stated they were unaware of the TB screening requirements for health care workers and did not work for licensee when ULP-D and ULP-E were hired.</p> <p>The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, indicated health care workers (HCWs) with a verbal (undocumented) history of a previous positive TST or blood test should undergo the same screening procedures as HCWs without previous positive results.</p> <p>The licensee's Tuberculosis Screening/Prevention policy dated August 1, 2021, indicated all employees would undergo baseline testing which included a TST or blood test for TB.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	0 660		
0 775 SS=F	<p>144G.45 Subd. 2. (a) Fire protection and physical environment</p> <p>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter</p>	0 775		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
--------------------	--	---------------	---	--------------------

0 775	<p>Continued From page 6</p> <p>7511, and:</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 4, 2025, from approximately 11:20 a.m. to 12:37 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and clinical nurse specialist (CNS)-B. During the tour the surveyor observed the following:</p> <p>The egress window in resident room 3 was significantly difficult to open and required excessive effort to open. Egress windows should be readily openable for use during emergency situation. LALD-A acknowledged the difficulty opening the window.</p> <p>A multiplug adapter was in use in the office to power multiple items including a computer and office equipment. The supplied adapter was not an approved type and should not be used within the facility</p>	0 775		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
0 775	<p>Continued From page 7</p> <p>An unapproved space heater was in use in resident room 4 and should be removed to prevent risk of fire.</p> <p>An extension cord was in use in the front porch to power a fridge. Extension cords should not be used in lieu of permanent wiring and may pose fire hazard. This extension cord was also run through the door frame and showed signs of wear from being pinched in the door further increasing risk of fire.</p> <p>An extension cord was in use in the office to power multiple electronics. LALD-A confirmed the extension cord is used consistently. Extension cords should not be used in lieu of permanent wiring and may pose fire hazard.</p> <p>Items were stored around and against the electrical panel in the laundry room preventing ready access to the circuits. Clearance around the panel should be maintained.</p> <p>The door to the attached garage was marked as a primary egress route. Due to hazardous storage of fuel, fueled equipment and obstructed walkways the garage is not suitable for a primary egress route. LALD-A acknowledged that the garage was not commonly used for egress and should not be marked as such.</p> <p>TIME PERIOD FOR CORRECTION: Two (2) days</p>	0 775		
0 780 SS=F	<p>144G.45 Subd. 2 (a) (1) Fire protection and physical environment</p> <p>(a) Each assisted living facility must comply with</p>	0 780		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 8</p> <p>the State Fire Code in Minnesota Rules, chapter 7511, and:</p> <p>(1) for dwellings or sleeping units, as defined in the State Fire Code:</p> <p>(i) provide smoke alarms in each room used for sleeping purposes;</p> <p>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;</p> <p>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;</p> <p>(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</p> <p>(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;</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide interconnected smoke alarms throughout the facility. This had the potential to directly affect all residents, staff, and visitors.</p> <p>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</p>	0 780		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 9</p> <p>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).</p> <p>The findings include:</p> <p>On November 4, 2025, from approximately 11:20 a.m. to 12:37 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and clinical nurse specialist (CNS)-B. During the tour the surveyor observed the following:</p> <p>During the tour LALD-A tested smoke alarms by activating alarms with a remote control obtained in the living room. During the testing of the smoke alarms, it was noted that two separate systems of smoke alarms were present, namely a hardwired alarm system and a wireless x-sense system. During the testing, the wireless alarms interconnected and sounded, but the hardwired alarms did not function. The hardwired alarms must be maintained with their power supply and interconnected properly or replaced with other hardwired alarms and interconnected. All smoke alarms in the facility should be interconnected such that the activation of any alarm causes all other alarms to sound.</p> <p>During the facility tour interview on November 4, 2025, LALD-A verified the above listed fire protection and physical environment observations while accompanying on the tour and expressed that they would ensure interconnection and correct the deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 780		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	0 790		
0 790 SS=F	<p>144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment</p> <p>(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, 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</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers. This deficient condition had the potential to affect all staff, residents, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 4, 2025, from approximately 11:20 a.m. to 12:37 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and clinical nurse specialist (CNS)-B. During the tour the surveyor observed the following:</p>	0 790		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 11</p> <p>The fire extinguishers provided throughout the facility, in the kitchen, hallway and laundry room did not have records of monthly inspections by facility staff. Monthly visual inspections are required by staff to ensure extinguishers are in proper condition. LALD-A stated such inspections would begin and would be recorded appropriately.</p> <p>The extinguishers provided throughout the facility in the kitchen, hallway and laundry room did not have records of annual inspection by an approved entity. The extinguishers had no annual service tags and LALD-A stated that no inspection had ever been conducted. The extinguishers in the hallway and laundry room were manufactured in 2023 and 2010 respectively and lacked required annual testing to ensure they were maintained and functioning properly. Annual testing on supplied extinguishers must occur and be recorded.</p> <p>During the tour and interview, LALD-A and CNS-B indicated they were unaware of monthly and annual inspection requirements and would begin conducting and recording such inspections.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days.</p>	0 790		
0 800 SS=F	<p>144G.45 Subd. 2 (a) (4) Fire protection and physical environment</p> <p>(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.</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 12</p> <p>This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all residents,</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 4, 2025, from approximately 11:20 a.m. to 12:37 p.m., the surveyor toured the facility with licensed assisted living director (LALD)-A and clinical nurse specialist (CNS)-B. During the tour the surveyor observed the following:</p> <p>The window screen was missing from the window in resident room 4 and should be replaced.</p> <p>The baseboard heater in resident room 4 was damaged and was missing the protective guard, exposing the heating elements and sharp fins which had been damaged and bent.</p> <p>Multiple light bulbs were missing from the</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 13</p> <p>common bathroom vanity leaving the lighting fixtures exposed. Lighting should be provided and maintained.</p> <p>The door frame of the common bathroom was damaged and degraded. The door frame should be restored to proper condition and maintained in proper condition.</p> <p>There was a hole in the drywall near an electrical outlet on the back wall of resident room 3. The wall should be properly repaired and maintained free of holes.</p> <p>A cabinet handle was broken and missing on a cabinet in the kitchen. The cabinet should be repaired and maintained in proper condition.</p> <p>Drop tiles were missing from the office ceiling. The missing ceiling tiles should be restored and maintained.</p> <p>A protective globe was missing from the lighting fixture on the front porch. The supplied globe should be replaced and maintained.</p> <p>The ceiling above the furnace in the mechanical room was damaged and cracked. The ceiling should be repaired and maintained.</p> <p>The threshold at the base of the door in resident room 5 was loose and should be properly secured to prevent tripping hazard.</p> <p>LALD-A and CNS-B acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	0 800		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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 SS=F	<p>144G.45 Subd. 2 (b-f) Fire protection and physical environment</p> <p>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.</p> <p>(c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.</p> <p>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.</p> <p>(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.</p> <p>(f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview and record</p>	0 810		
---------------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 15</p> <p>review, the licensee failed to develop the fire safety and evacuation plan with required content. This had the potential to directly affect all residents, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 4, 2025, at approximately 12:00 p.m., licensed assisted living director (LALD)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility.</p> <p>The licensee FSEP failed to include the following:</p> <p>Staff had difficulty locating the FSEP binder when requested by the surveyor and took at least five minutes to locate the plans. LALD-A stated they were unsure where the binder was normally stored. The plan was located stored in a locked office, which is not readily available.</p> <p>No appropriate facility diagrams were located in the FSEP binder nor on the walls of the facility. No facility diagrams or information identifying the location and number of resident rooms was provided to the surveyor. LALD-A stated they believed such documents existed but could not locate them during survey.</p>	0 810		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 16</p> <p>The FSEP failed to include appropriate employee actions to take during a fire or similar emergency. Provided homecare consultant documents were not specific to the building and contained general information on fire safety, but did not contain specific employee actions for evacuation or fire.</p> <p>The FSEP failed to include appropriate resident actions to take during a fire or similar emergency. Provided homecare consultant documents were not specific to the building and contained general information on fire safety, but did not contain specific employee actions for evacuation or fire.</p> <p>The FSEP failed to identify any unique resident needs for evacuation. LALD-A stated they were unaware of requirements for identifying resident needs but would develop and maintain documentation in the future.</p> <p>The FSEP failed to include records of employee training on the FSEP upon hire and at least twice a year thereafter. The records provided indicated annual training for staff on 8/1/23, 8/11/24, and 8/15/25. No other records were provided. All employees should be provided FSEP training at least twice a year and upon hire. LALD-A stated they believed once a year trainings were sufficient previously, but that they understood requirements.</p> <p>The FSEP failed to include records of resident training on the FSEP offered at least once a year. No records were provided during the record review. LALD-A stated that resident trainings were conducted during fire drills.</p> <p>During an interview on November 4, 2025, at approximately 12:30 p.m., the surveyor explained</p>	0 810		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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 the requirements for site specific policies and FSEP documentation. LALD-A stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=I	<p>144G.60 Subdivision 1 Background studies required</p> <p>(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.</p> <p>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.</p> <p>(c) Termination of a staff member 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.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to obtain a cleared Minnesota Department of Human Services (DHS) background study affiliated with the licensee's health facility identification (HFID) for one of two employees (unlicensed personnel (ULP)-D). This resulted in an immediate correction order issued on November 3, 2025.</p> <p>This practice resulted in a level three violation (a</p>	01290	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 18</p> <p>violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), 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).</p> <p>The findings include:</p> <p>ULP-D was hired May 6, 2014, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021.</p> <p>The licensee's NETStudy 2.0 roster dated November 3, 2025, and provided upon request of the surveyor, did not include ULP-D.</p> <p>The NETStudy 2.0 database on November 3, 2025, at 2:48 p.m., indicated ULP-D previously had a background study completed December 14, 2023, but was separated and removed from the licensee's roster as of December 29, 2023.</p> <p>ULP-D's employee record lacked evidence of a current cleared DHS background study affiliated with the licensee's HFID.</p> <p>The licensee's weekly schedule dated October 30, 2025, indicated ULP-D was the single employee scheduled on the 11:00 p.m. to 7:00 a.m., shift on October 31, 2025, and November 4, and 5, 2025.</p> <p>On November 3, 2025, during the entrance conference, at 11:25 a.m., licensed practical nurse (LPN)-C stated they staffed two employees on the day and evening shifts and one employee on the night shift.</p>	01290		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 19</p> <p>On November 3, 2025, at 1:21 p.m., licensed assisted living director (LALD)-A stated they completed a background study in 2014 under another name for ULP-D. LALD-A confirmed that ULP-D's name and background clearance did not appear on the NETStudy Roster dated November 3, 2025.</p> <p>The licensee's Recruitment and Hiring policy dated August 1, 2021, indicated background studies completed in NETStudy 2.0 were part of the employment screening process.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Immediate</p>	01290		
01530 SS=F	<p>144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-</p> <p>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5),</p>	01530		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
--------------------	--	---------------	---	--------------------

01530	<p>Continued From page 20</p> <p>and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received the required two hours of mental illness and de-escalation training as required for two of two employees (unlicensed personnel (ULP)-D, ULP-E).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large</p>	01530		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
01530	<p>Continued From page 21</p> <p>portion or all of the residents).</p> <p>The findings include:</p> <p>ULP-D was hired on May 6, 2014, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021.</p> <p>ULP-E was hired on May 13, 2020, under the licensee's former comprehensive license and began providing assisted living services on August 1, 2021.</p> <p>ULP-D and ULP-E's employee records lacked the required initial 2 hours of mental illness and de-escalation training.</p> <p>On November 4, 2025, at 12:54 p.m., clinical nurse supervisor (CNS)-B stated ULP-D and ULP-E did not receive the required training for mental illness and de-escalation topics. CNS-B stated they were unaware of the required training.</p> <p>The licensee did not have a policy addressing required training for mental illness and de-escalation topics.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01530		
01640 SS=D	<p>144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to</p> <p>(a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan.</p>	01640		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
--------------------	--	---------------	---	--------------------

01640	<p>Continued From page 22</p> <p>(b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.</p> <p>(c) The facility must implement and provide all services required by the current service plan.</p> <p>(d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable.</p> <p>(e) Staff providing services must be informed of the current written service plan.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R1).</p> <p>This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1 was admitted on October 27, 2021, and</p>	01640		
-------	---	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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
01640	<p>Continued From page 23</p> <p>began receiving assisted living services.</p> <p>R1's Service Plan signed on October 27, 2025, indicated R1's services included assistance with dressing, grooming, bathing, medication administration, and blood glucose monitoring.</p> <p>R1's record included annual physician orders signed on November 7, 2024. R1's physician orders lacked an order for blood glucose monitoring.</p> <p>On November 4, 2025, at 10:10 a.m., licensed practical nurse (LPN)-C stated they did not check blood glucose for R1. LPN-C stated R1 did not have a diagnosis requiring blood glucose management and they did not know why the service was added to R1's Service Plan.</p> <p>On November 4, 2025, at 1:01 p.m., clinical nurse supervisor (CNS)-B stated they did not monitor blood glucose for R1. CNS-B stated the service was added to R1's service plan in error.</p> <p>The licensee's Service Plan policy dated August 1, 2021, indicated an individualized service plan would be implemented for all residents and [licensee] would provide all services required by the current service plan.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p>	01640		
01730 SS=F	<p>144G.71 Subd. 5 Individualized medication management plan</p> <p>(a) For each resident receiving medication</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 24</p> <p>management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse 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:</p> <ul style="list-style-type: none"> (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. <p>(b) The medication management record must be current and updated when there are any changes.</p> <p>(c) Medication reconciliation must be completed when a licensed nurse, licensed health</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 25</p> <p>professional, or authorized prescriber is providing medication management.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individualized medication management plan with all required content for two of two residents (R1, R2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>R1 R1 was admitted October 27, 2021, and began receiving assisted living services.</p> <p>R1's Service Plan signed October 27, 2025, indicated R1's services included medication administration.</p> <p>R1's record included a Resident Evaluation dated September 6, 2025. R1's Medication Management Plan was part of the Resident Evaluation (page 13). R1's Medication Management Plan dated September 6, 2025, lacked the identification of medication management tasks that may be delegated to unlicensed personnel.</p>	01730		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(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	<p>Continued From page 26</p> <p>R2 R2 was admitted on October 3, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.</p> <p>R2's record included a Resident Evaluation dated October 25, 2025. R2's Medication Management Plan was part of the Resident Evaluation (page 20). R2's Medication Management Plan dated October 25, 2025, lacked the identification of medication management tasks that may be delegated to unlicensed personnel.</p> <p>On November 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated the medication management plans were updated with each assessment. CNS-B stated they were unaware that required content was missing from R1 and R2's medication management plans.</p> <p>The licensee's Service Plan for Medication Management policy dated August 1, 2021, indicated medication management plans would include a description of medication management tasks to be delegated to unlicensed personnel.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	01730		
02310 SS=F	<p>144G.91 Subd. 4 (a) Appropriate care and services</p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

02310	<p>Continued From page 27</p> <p>standards.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medical oxygen tanks were secured and stored properly in noncombustible racks to prevent injury to all residents who resided in the assisted living facility.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On November 3, 2025, at 11:07 a.m., during the entrance conference, licensed assisted living director (LALD)-A stated there had not been a resident discharged from the facility in greater than six months.</p> <p>On November 3rd, 2025, at 11:07 a.m., licensed practical nurse (LPN)-A stated the licensee would provide oxygen to a resident if ordered by a physician. LPN-A stated there were no current residents in the facility receiving oxygen therapy.</p> <p>On November 4, 2025, at 11:57 a.m., Minnesota Department of Health (MDH) environmental engineer surveyor notified the registered nurse (RN) surveyor they observed an unsecured oxygen tank in a sunroom that was used as a</p>	02310		
-------	--	-------	--	--

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 21932	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/05/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1375 OAK GROVE CIRCLE GOLDEN VALLEY, MN 55422
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	<p>Continued From page 28</p> <p>common area for all residents.</p> <p>On November 4, 2025, at 1:00 p.m., the RN surveyor observed an oxygen tank in the corner of the enclosed sunroom. The oxygen canister was leaning upright against the wall and lacked proper storage security. The oxygen regulator indicated there was oxygen in the cylinder.</p> <p>On November 4, 2025, at 1:00 p.m., clinical nurse supervisor (CNS)-B stated the oxygen cylinder was used by a former resident and had not been picked up by the oxygen supplier. CNS-B stated she would have the oxygen supplier pick up the tank.</p> <p>The Minnesota Department of Health Oxygen Cylinder Storage Requirements dated April 16, 2020, recommended oxygen tanks be secured with racks or by chains.</p> <p>The licensee's Safe Oxygen Use and Storage policy dated August 1, 2021, indicated oxygen containers would be secured in a stand or cart so they could not be knocked over while in use or in storage.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310		



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

THE CARING SISTERS HOME CARE
1375 OAK GROVE CIRCLE
Golden Valley, MN 55422
Hennepin County
Parcel:
Phone:

License Info

License: HFID 21932
Risk:
License:
Expires on:
CFPM: Olaleye A. Beckley
CFPM #: FM28313; Exp: 10/7/2027

Inspection Info

Report Number: F1047251223
Inspection Type: Full - Single
Date: 11/4/2025 Time: 11:00 am
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 4
Delivery:

! New Order: 2-200 Employee Health

2-201.11C *Priority Level: Priority 1 CFP#: 3*

MN Rule 4626.0040C The person in charge must record all reports of diarrhea or vomiting made by food employees and report those illnesses to the regulatory authority at the specific request of the regulatory authority.

COMMENT: UNABLE TO LOCATE ILLNESS LOG AT TIME OF INSPECTION. SAMPLE LOG PROVIDED WITH REPORT.

Comply By: 11/4/2025 Originally Issued On: 11/4/2025

! New Order: 3-500B Microbial Control: hot and cold holding

3-501.16A2 *Priority Level: Priority 1 CFP#: 22*

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

COMMENT: TCS FOODS IN REFRIGERATOR WERE WARMER THAN 41F. FRIDGE WAS ADJUSTED SO THAT IT WILL BE COLDER DURING INSPECTION. CONTINUE TO MONITOR TEMPERATURE.

Comply By: 11/4/2025 Originally Issued On: 11/4/2025

New Order: 4-200 Equipment Design and Construction

4-204.112A *Priority Level: Priority 3 CFP#: 36*

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: NO THERMOMETER LOCATED IN REFRIGERATOR TO MEASURE TEMPERATURE INSIDE REFRIGERATOR. DISCUSSED NEED TO REPLACE OVEN THERMOMETER WITH ONE MEANT FOR COLD TEMPERATURES.

Comply By: 11/11/2025 Originally Issued On: 11/4/2025

New Order: 4-300 Equipment Numbers and Capacities

4-301.12D *Priority Level: Priority 3 CFP#: 48*

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

COMMENT: FACILITY DOES NOT HAVE A 3 COMP SINK AND IS CURRENTLY USING THEIR TWO COMPARTMENT SINK AND A PLASTIC THIRD BASIN AS THEIR TEMPORARY SET UP.

FACILITY WILL NEED TO INSTALL A PERMANENT 3 COMPARTMENT SINK OR UPDATE THEIR CURRENT DISHWASHER TO ONE THAT CAN ACHIEVE A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F.

Comply By: 5/4/2026 Originally Issued On: 11/4/2025

New Order: 4-300 Equipment Numbers and Capacities4-302.12B *Priority Level: Priority 2 CFP#: 36**MN Rule 4626.0705B* Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.

COMMENT: NO THERMOMETER AVAILABLE ON SITE TO MEASURE TEMPERATURE OF FOOD. DISCUSSED NEED FOR THERMOMETER TO VERIFY FINAL COOKING TEMPERATURES.

*Comply By: 11/11/2025 Originally Issued On: 11/4/2025***New Order: 4-300 Equipment Numbers and Capacities**4-302.14 *Priority Level: Priority 2 CFP#: 48**MN Rule 4626.0715* Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: NO TEST STRIPS AVAILABLE ON SITE FOR CHLORINE SANITIZER SOLUTION. A FEW STRIPS WERE LEFT ON SITE BUT FACILITY WILL NEED TO PURCHASE MORE.

*Comply By: 11/11/2025 Originally Issued On: 11/4/2025***New Order: 4-500 Equipment Maintenance and Operation**4-501.11AB *Priority Level: Priority 3 CFP#: 47**MN Rule 4626.0735AB* All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.

COMMENT: KITCHEN CONTAINED A BROKEN CABINERY DOOR. DISCUSSED NEED TO REPAIR.

*Comply By: 1/1/2026 Originally Issued On: 11/4/2025***New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control**6-501.11 *Priority Level: Priority 3 CFP#: 55**MN Rule 4626.1515* Maintain the physical facilities in good repair.

COMMENT: SECTION OF WALL MISSING IN KITCHEN TO THE LEFT OF THE REFRIGERATOR. DISCUSSED NEED TO REFINISH SECTION OF WALL.

Comply By: 1/1/2026 Originally Issued On: 11/4/2025

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator M. Winters.

The establishment has a residential kitchen and serves food that is prepared that day. The kitchen has wood cabinets, tiled floor, painted and tiled walls, solid counter top, and a painted ceiling.

A two basin sink is located in the kitchen. A residential dish machine is located in the kitchen.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, and food handling procedures.

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

I acknowledge receipt of the Metro District Office inspection report number F1047251223 from 11/4/2025



Olaley Beckley
Operator

Holly Sievers,
Public Health Sanitarian 2
651-201-5946

holly.sievers@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

THE CARING SISTERS HOME CARE
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1047251223
Inspection Type: Full
Date: 11/4/2025
Time: 11:00 am

Food Temperature: Product/Item/Unit: Cheese; **Temperature Process:** Cold-Holding

Location: Refrigerator at 46 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Cut Melon; **Temperature Process:** Cold-Holding

Location: Refrigerator at 47 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

THE CARING SISTERS HOME CARE
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1047251223
Inspection Type: Full
Date: 11/4/2025
Time: 11:00 am

Sanitizing Chemical: Product: Chlorine; **Sanitizing Process:** Sanitizing Container

Location: Kitchen **Equal To** 100 PPM

Comment:

Violation Issued?: No



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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
THE CARING SISTERS HOME CARE 1375 OAK GROVE CIRCLE Golden Valley, MN 55422 Hennepin County Parcel: Phone:	License: HFID 21932 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Report Number: F1047251234 Inspection Type: Follow-up - Single Date: 11/10/2025 Time: 9:30 am Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 3</u> <u>Delivery:</u>

Previous Order: 4-300 Equipment Numbers and Capacities

4-301.12D *Priority Level: Priority 3 CFP#: 48*

MN Rule 4626.0680D Mechanical warewashing equipment in lieu of a 3-compartment sink may be allowed as long as the warewashing equipment is large enough to accommodate the largest piece of equipment to be washed, rinsed and sanitized.

COMMENT: FACILITY DOES NOT HAVE A 3 COMP SINK AND IS CURRENTLY USING THEIR TWO COMPARTMENT SINK AND A PLASTIC THIRD BASIN AS THEIR TEMPORARY SET UP.

FACILITY WILL NEED TO INSTALL A PERMANENT 3 COMPARTMENT SINK OR UPDATE THEIR CURRENT DISHWASHER TO ONE THAT CAN ACHIEVE A UTENSIL SURFACE TEMPERATURE OF AT LEAST 160F.

Comply By: 5/4/2026 Originally Issued On: 11/4/2025

Previous Order: 4-500 Equipment Maintenance and Operation

4-501.11AB *Priority Level: Priority 3 CFP#: 47*

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

COMMENT: KITCHEN CONTAINED A BROKEN CABINETRY DOOR. DISCUSSED NEED TO REPAIR.

Comply By: 1/1/2026 Originally Issued On: 11/4/2025

Previous Order: 6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11 *Priority Level: Priority 3 CFP#: 55*

MN Rule 4626.1515 Maintain the physical facilities in good repair.

COMMENT: SECTION OF WALL MISSING IN KITCHEN TO THE LEFT OF THE REFRIGERATOR. DISCUSSED NEED TO REFINISH SECTION OF WALL.

Comply By: 1/1/2026 Originally Issued On: 11/4/2025

Food & Beverage General Comment

Follow up inspection conducted with facility staff. Facility should continue to resolve remaining items.

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

I acknowledge receipt of the Metro District Office inspection report number F1047251234 from 11/10/2025

Holly Green

Olaleye Beckley
Operator

Holly Sievers,
Public Health Sanitarian 2
651-201-5946
holly.sievers@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

THE CARING SISTERS HOME CARE
Golden Valley
County/Group: Hennepin County

Inspection Info

Report Number: F1047251234
Inspection Type: Follow-up
Date: 11/10/2025
Time: 9:30 am

Food Temperature: Product/Item/Unit: Milk; **Temperature Process:** Cold-Holding

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: Product/Item/Unit: Butter; **Temperature Process:** Cold-Holding

Location: Refrigerator at 39 Degrees F.

Comment:

Violation Issued?: No