Electronically Delivered

July 14, 2026

Licensee
Sister Support LLC
10805 South Shore Drive
Medicine Lake, MN 55441

RE: Project Number(s) SL37126016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 11, 2026, 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 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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.

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.

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTER SUPPORT LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(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 COMMENT SL37126016-0 On June 8,2026, through June 11, 2026, 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 two (2) residents; 2 receiving services under the Assisted Living Facility license. On June 8, 2026, an immediate correction order was issued for tag identification 2310. During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630		

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0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of two residents (R1, R2). 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 R1 was admitted to the licensee on October 30, 2025, with a change of ownership. R1's Service Plan Waiver signed on February 26, 2026, indicated R1's services included assistance with dressing, grooming, ambulation, behavior management, blood glucose monitoring, and	0 630		

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0 630	Continued From page 2 medication administration. R1's IAPP completed on February 2, 2026, lacked a statement of R1's risk of abusing other vulnerable adults. R2 R2 was admitted to the licensee on October 30, 2025, with a change of ownership. R2's Service Plan Waiver signed on February 26, 2026, indicated R2's services included assistance with medication administration, blood glucose management, and behavior management. R2's IAPP completed on May 5, 2026, lacked a statement of R2's risk of abusing other vulnerable adults. On June 8, 2026, at 2:03 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they did not know they needed to address the resident's risk of abusing others, and it was not addressed in the IAPPs. The licensee's 6.05 Individual Abuse Plan policy dated February 10, 2026, indicated all resident IAPPs would include an assessment of the person's risk of abusing other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a	0 660		

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0 660	Continued From page 3 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. (b) The facility must maintain written evidence of compliance with this subdivision. 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 one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The facility TB risk assessment dated January 5, 2026, indicated the facility was a low risk setting	0 660		

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0 660	Continued From page 4 for TB transmission. ULP-C was hired May 8, 2025, and began providing assisted living services. ULP-C's employee record included an incomplete TB history and screen dated January 1, 2026, and signed by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. ULP-C's record also included a letter from a clinic dated May 7, 2025, indicating ULP-C had a negative chest x-ray on May 7, 2025. On the letter, the dates and ULP-C's first name appear to have been written over a correction tape or fluid. Additionally, ULP-C's first name is a different handwriting than the last name. ULP-C's record also lacked a two-step tuberculin skin test (TST) or TB blood test predating the chest x-ray. On June 9, 2026, at 10:38 a.m., LALD/CNS-A stated she was unable to determine if the x-ray letter had been altered. LALD/CNS-A stated she would ask ULP-C to provide the actual x-ray interpretation and blood test results if a test had been completed. No test results were provided to the surveyor for the duration of the survey. The Minnesota Department of Health (MDH) guidelines Regulations for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, and based on CDC guidelines, read "an employee may begin working with patients (residents) after a negative TB history and symptom screen (no symptoms of active TB disease) and a IGRA (a serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record."	0 660		

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0 660	Continued From page 5 The MDH Assisted Living FAQ's: Staff Requirements updated June 5, 2026, indicated a chest x-ray alone is not acceptable documentation and a positive TST or IGRA test and a chest x-ray with provider evaluation after that date is required. The licensee's 8.16 Tuberculosis Screening policy dated February 10, 2026, indicated new staff would be screened for active signs of TB using the Baseline TB Screening Tool for Health Care Workers. The policy also indicated new staff would have a baseline blood test to two-step Mantoux test. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
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	0 780		

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0 780	Continued From page 6 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.	0 780		

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0 780	Continued From page 7 TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780		
0 800 SS=D	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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated	0 800		

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0 800	Continued From page 8 June 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. 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) 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. (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. (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 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	0 810		

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0 810	Continued From page 9 required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 10, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify	0 950		

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0 950	Continued From page 10 a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to identify a designated representative or document that the resident declined to designate a representative for one of two residents at the time the contract was signed (R1). This practice resulted in a level one violation (a violation that that will cause only minimal impact on the residents and does not affect health or	0 950		

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0 950	Continued From page 11 safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's contract was signed on February 2, 2026. The contract indicated Addendum D included the designated representative form, including the "Right to Designate a Representative" notice. R1's contract lacked a completed Addendum D: Designated Representative Form. On June 8, 2026, at 12:25 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the designated representative form was not applicable to either of her residents, so it was not completed. LALD/CNS-A stated she was unaware of the designated representative requirement. On June 9, 2026, at 10:48 a.m., LALD/CNS-A stated she had completed the designated representative form with both clients the previous day after discussing with surveyor. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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SISTER SUPPORT LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

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01290	Continued From page 12 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 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated with the licensee's health facility identification number (HFID) for three of seven employees (unlicensed personnel (ULP)-C, ULP-D, activities coordinator (AC)-E). 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 pattern scope (when more than a limited number of resident's 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: ULP-C ULP-C was hired on May 8, 2025, and began providing assisted living services.	01290		

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01290	Continued From page 13 On June 8, 2026, at 12:22 p.m., a NETStudy Person Summary was run indicating ULP-C had a current background study from another facility owned by the licensee. ULP-D ULP-D was hired on February 2, 2026, and began providing assisted living services. On June 8, 2026, at 12:14 p.m., a NETStudy Person Summary was run, indicating ULP-D had a current background study from another facility owned by the licensee. AC-E AC-E was hired on August 30, 2025, and began providing assisted living services. On June 8, 2026, at 1:33 p.m., a NETStudy Person Summary was run indicating AC-E had separated from the licensee on October 8, 2025, and had a current background study from another facility owned by the licensee. ULP-C, ULP-D, and AC-E did not have current background studies affiliated with the licensee. On June 8, 2026, at 1:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they were unaware that three employee background studies were not affiliated with the licensee's HFID. The licensee's 4.02 Background Studies policy dated February 10, 2026, indicated the licensee would conduct a Minnesota Department of Human Services background study on all employees, volunteers, and contractors.	01290		

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01290	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01320 SS=D	144G.60 Subd. 4 (a) Unlicensed personnel (a) Unlicensed personnel providing assisted living services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the facility and the topics listed in section 144G.61, subdivision 2, paragraph (a); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and on the topics listed in section 144G.61, subdivision 2, paragraph (a); and successfully demonstrated competency on topics in section 144G.61, subdivision 2, paragraph (a), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel who only provide assisted living services listed in section 144G.08, subdivision 9, clauses (1) to (5), shall not perform delegated nursing or therapy tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and/or competencies included all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01320		

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01320	Continued From page 15 cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on May 8, 2025, and began providing assisted living services. ULP-C's personnel record lacked evidence of training and competency evaluations for understanding appropriate boundaries between staff and residents and the residents' family. On June 9, 2026, at 11:28 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS) stated they were unaware the training was missing from ULP-C's record. LALD/CNS-A stated the training would have been assigned in Educare (online training). The licensee's 5.02 Competency Training Evaluations policy dated February 10, 2026, indicated training for ULPs would include training on understanding appropriate boundaries between staff and residents and the residents' family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01320		
01330 SS=D	144G.60 Subd. 4 (b) Unlicensed personnel (b) Unlicensed personnel performing delegated nursing tasks in an assisted living facility must:	01330		

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01330	Continued From page 16 (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in section 144G.61, subdivision 2, paragraphs (a) and (b), and a practical skills test on tasks listed in section 144G.61, subdivision 2, paragraphs (a), clauses (5) and (7), and (b), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and/or competencies included all required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C was hired on May 8, 2025, and began providing assisted living services.	01330		

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01330	Continued From page 17 ULP-C's personnel record lacked evidence of training and competency evaluations for the following required topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the residents. On June 9, 2026, at 11:28 a.m., licensed assisted living director/clinical nursing supervisor (LALD/CNS) stated they were unaware the training was missing from ULP-C's record. LALD/CNS-A stated the training would have been assigned in Educare (online training). The licensee's 5.02 Competency Training Evaluations policy dated February 10, 2026, indicated training for ULPs would include training on the following topics: -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and -recognizing physical, emotional, cognitive, and developmental needs of the residents. understanding appropriate boundaries between staff and residents and the residents' family. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01330		
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440		

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01440	Continued From page 18 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed within 30 calendar days after hire and beginning to provide the delegated tasks to residents for one of two unlicensed personnel ((ULP)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01440		

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01440	Continued From page 19 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on September 5, 2025, and began providing assisted living services. ULP-B's Hands On Skills Competency Checklist dated December 17, 2025, indicating ULP-B had passed competency demonstration for medication and treatment administration. The checklist was authenticated by licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A. ULP-B's record included a 30-day performance review dated January 18, 2026, which lacked review of a delegated nursing task. On June 9, 2026, at 11:20 a.m., LALD/CNS-A provided surveyor with a Staff Supervision Summary for ULP-B dated April 6, 2026. The documentation indicated ULP-B had been observed preparing and administering medications. ULP-B's Staff Supervision Summary was completed more than 30 days after their competency validation was complete. On June 9, 2026, at 11:10 a.m., LALD/CNS-A stated they had been using the 30-Day performance review form to document the required 30-day nursing supervision visit. LALD/CNS-A stated they were unaware the 30-day supervision required observation of a delegated nursing task. The licensee's 6.17 Supervision of Staff -	01440		

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01440	Continued From page 20 Delegated Services policy dated February 10, 2026, indicated direct supervision of staff performing delegated tasks would be provided within 30 days after the date on which the individual begins working for the licensee and first performs the delegated task for residents. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01470		

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01470	Continued From page 21 Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to include all required content for one of two employees (unlicensed personnel (ULP)-B).	01470		

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01470	Continued From page 22 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B was hired on September 5, 2025, and began providing assisted living services. ULP-B"s employee record lacked documentation of the following required orientation topics: -overview of assisted living statutes; -consumer advocacy services including information on the Office of the Ombudsman for Long-Term Care, Office of the Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On June 9, 2025, at 11:16 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the online training module containing those orientation topics was not uploaded for ULP-B to complete. LALD/CNS-A stated the former director had assigned the online education incorrectly. The licensee's 5.01 Orientation of Staff and	01470		

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01470	Continued From page 23 Supervisors and Content policy dated February 10, 2026, indicated the following content would be included in orientation: -an overview of the appropriate assisted living statutes and laws; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one resident (R1) with hospital bed rails. This practice resulted in a level three violation (a	02310	During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged.	

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02310	Continued From page 24 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). The findings include: On June 8, 2026, at 11:38 a.m., the surveyor observed R1's room included a hospital-style bed with upper half bed rails on both sides, in the up position. Rails on both sides were secured to the frame but had back and forth and side to side motion when surveyor assessed the rail for stability. R1's Service Plan dated February 26, 2026, indicated R1 received services including assistance with medication management, dressing, bathing, ambulation, and glucose management. R1's Bed Safety Assessment dated May 5, 2026, identified the brand of hospital bed and indicated R1 used one rail for bed mobility. The assessment also erroneously stated the bed zone safety assessment was not applicable as R1 either had no bed rails in use or had portable bed rails that were installed on a consumer bed. R1's record lacked the following content: -physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; -specific measurements of zones of entrapment; -indication if the side rails were Food and Drug Administration (FDA) compliant; and -documentation that education including	02310		

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02310	Continued From page 25 alternatives and risk versus benefits were discussed with the resident or responsible party. On June 8, 2026, at 11:38 a.m., the surveyor and assisted living director/clinical nurse supervisor (LALD/CNS)-A observed R1's hospital bed and noted upper side rails on both sides were in the up position. LALD/CNS-A stated R1 usually used only one side rail. On June 8, 2026, at 2:15 p.m., LALD/CNS-A stated R1 did not have siderail measurements and did not have a risk vs. benefit discussion with resident. LALD/CNS-A stated they would have someone come to secure the bed rails later today. The licensee's 6.28 Side Rail policy dated February 10, 2026, indicated the following actions would be taken when a resident is utilizing side rails: -assess siderail use; -educate the resident, and responsible party when appropriate, on risk vs benefits of using siderails; and -verify the side rail is of a safe design and use is consistent with manufacturer recommendations. The FDA's, A Guide to Bed Safety, revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	37126	A. BUILDING: _____ B. WING _____	06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SISTER SUPPORT LLC	10805 SOUTH SHORE DRIVE MEDICINE LAKE, MN 55441

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26 determine how best to keep the patient safe." On page 21, Table 3 Summary of FDA Hospital Bed Dimensional Limit Recommendations indicated specific measurement limits for each entrapment zone. The Minnesota Department of Health's (MDH) Assisted Living: Resources and FAQ's website updated April 17, 2026, read under Bed Rails, documentation about a resident's bed rails includes, but is not limited to: -an assessment was completed; -measurements were completed and documented; -the rails were FDA compliant; -and the risk vs. benefits were discussed and documented with the resident/responsible party. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	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

Establishment Info

Sister Support LLC
10805 SOUTH SHORE DRIVE
Plymouth, MN 55441
Hennepin County
Parcel:

Phone:

License Info

License: HFID 37126

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F8087261119
Inspection Type: Full - Single
Date: 6/9/2026 Time: 4:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN ANNOUNCED AND SCHEDULED FULL INSPECTION.

INSPECTION CONDUCTED IN THE PRESENCE OF HRD NURSE EVALUATOR MICHELLE WINTERS.

THE FOLLOWING OBSERVATIONS WERE MADE:

CEILING: PAINTED, SMOOTH, APPEARS TO BE DURABLE - COMPLIANT
FLOORS: LAMINATE - NON COMPLIANT
COUNTERTOPS: LAMINATE - NON COMPLIANT
CABINETS: WOOD - NON COMPLIANT
REFRIGERATOR/FREEZER: FRIGIDARE
DISHWASHER: UNKNOWN
STOVE/RANGE: GE
MICROWAVE: GE
HAND WASHING SINK: YES - RIGHT SIDE OF 2-BIN STAINLESS STEEL KITCHEN SINK

NON COMPLIANT FLOOR, COUNTERTOP AND CABINETS ARE FOUND TO BE IN GOOD CONDITION AND WILL BE MONITORED AT FUTURE INSPECTIONS. IF AT SUCH A TIME THEY ARE FOUND TO BE A CONCERN OR RISK OF CONTAMINATION, THEY WILL BE ORDERED TO BE REPLACED AND BROUGHT UP TO CODE.

DISHWASHER IS RESIDENTIAL BUT HAS SANITIZING RINSE CYCLE OPTION. TEMPERATURE PROBE USED TO ENSURE UTENSIL SURFACE TEMPERATURES REACH 165.

HOT WATER TEMPERATURE AT THE KITCHEN SINK REACHED 120 DEGREES.

INSPECTION REPORT EMAILED TO FACILITY AND HRD NURSE SURVEYOR.

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 F8087261119 from 6/9/2026

John Boettcher

AISHA ALY
NURSE/MANAGER/LALD

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Sister Support LLC
Plymouth
County/Group: Hennepin County

Inspection Info

Report Number: F8087261119
Inspection Type: Full
Date: 6/9/2026
Time: 4:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: DELI MEAT**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HUMMUS**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR**; Temperature Process:** Ambient Air
Location: Upright Freezer at 3 Degrees F.
Comment:
Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL37126016	**Date:** 6/10/2026
Facility Name: Sister Support LLC	
Facility Address: 10805 South Shore Dr., Plymouth, MN 55441	

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Smoke alarms shall be interconnected so that actuation of one alarm causes all alarms in the individual dwelling or sleeping unit to operate where more than one smoke alarm is required within an individual dwelling or sleeping unit. [Minn. Stat. 144G.45 subd.2]

   Comments: The smoke alarms were not properly interconnected when tested by facility staff during the survey. Smoke alarms on the main floor did not interconnect with smoke alarms installed in the basement. Smoke alarms must be interconnected such that the activation of any soke alarm causes all other alarms in the facility to sound. Smoke alarms should be properly interconnected and that interconnection should be maintained to ensure proper operation during an emergency.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The window in the door leading from resident room 1 to the exterior was broken, with the glass completely shattered. The broken glass should be removed, and the door should be repaired or replaced and maintained in a state of good repair.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide staff actions for an evacuation due to a fire or similar emergency to the surveyor during the survey. Documents provided to the surveyor included information that was not accurate or relevant for the facility. Site-specific staff actions should be provided and easily accessible within the facility as part of the FSEP for use during an emergency.

2. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to provide adequate record of evacuation drills for the facility. Records were provided to the surveyor during survey which indicated that no drills had occurred since March 2026. The records provided were not adequate to show sufficient frequency of drills. Evacuation drills are required at least twice per shift per year and at least once every other month.