Electronically Delivered

February 29, 2024

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

RE: Project Number(s) SL21932015

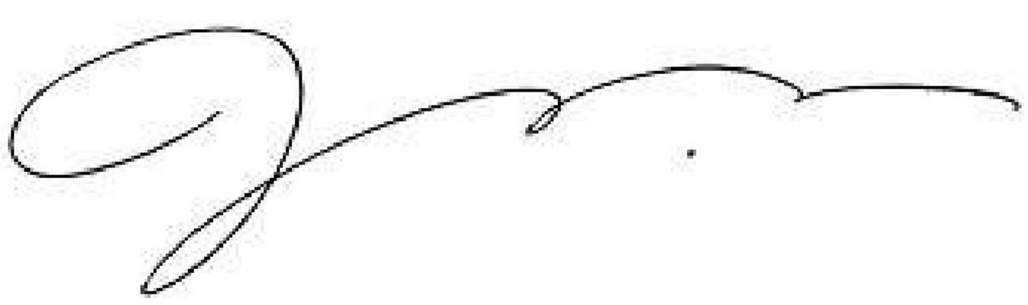
Dear Licensee:

On February 14, 2024, the Minnesota Department of Health completed a follow-up survey of your facility to determine if orders from the December 14, 2023, survey were corrected. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,



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

PMB

Electronically Delivered

January 23, 2024

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

RE: Project Number(s) SL21932015

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 14, 2023, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

Level 1: no fines or enforcement.
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

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

also may impose a fine of $5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

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

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

St - 0 - 1620 - 144g.70 Subd. 2 (c-E) - Initial Reviews, Assessments, And Monitoring = $3,000.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services = $3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $6,000.00**. 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

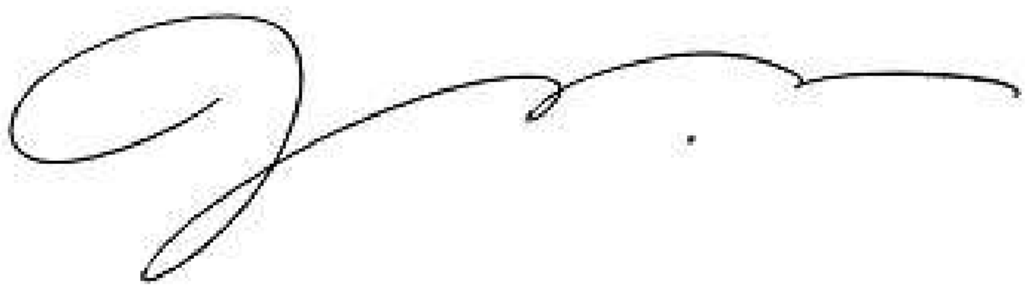
correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor. to submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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.

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

PMB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL21932015 On December 11, 2023, through December 14, 2023, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were four (4) active resident received services under the Assisted Living license. On December 12, 2023, at approximately 10:44 a.m. an immediate order was issued for 2310. On December 13, 2023, at approximately 3:39 p.m. an immediate order was issued for 1620. At the time of exit, the immediacy for 1620 and 2310 was removed. Noncompliance remains, and the scope and level will remain the same.	0 000	Minnesota Department of Health is documenting the State Licensing 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.	
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure licensed assisted living director (LALD)-D was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: LALD-D started employment with licensee on May 2, 2004, under the comprehensive home care license and began providing assisted living services on August 1, 2021. On December 11, 2023, at approximately 11:30 a.m., the Board of Executives for Long-Term Services and Support (BELTSS) indicated LALD-D held a current assisted living director license but was not listed as Director of Record for the licensee. On December 13, 2023, at 11:30 a.m., LALD-D	0 110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 110	Continued From page 2 acknowledged they were not listed as Director of Record with BELTSS and stated they would contact BELTSS for correction. No further information provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions;	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 470	Continued From page 3 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the required staffing plan was developed as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During a facility tour on December 11, 2023, at 10:20 a.m., no posted staff schedule was observed in the main entry area of the facility. The licensee failed to develop and implement a staffing plan for determining its staffing level based on the following: -each resident's needs, as identified in the resident's service plan and assisted living contract; -each resident's acuity level, as determined by the most recent assessment or individualized review; and -the ability of staff to timely meet the resident's scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises. On December 13, 2023, at 11:00 a.m., licensed	0 470		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 470	Continued From page 4 assisted living director (LALD)-D stated a staffing plan had not been developed to address the content listed above. Also, LALD-D stated they have developed a daily staffing schedule and acknowledged the daily staffing was not posted central location. The licensee's Staffing policy dated August 1, 2021, indicated "The Clinical Nurse Supervisor will prepare and implement a 24-hour daily staffing plan that ensures adequate staffing to meet resident's needs at all times. The schedule is posted at the beginning of the shift in a central location in each building, if applicable, accessible to staff, residents, volunteers and the public." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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 5 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 11, 2023, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental,	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 490	Continued From page 6 and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have a daily program of social and recreational activities. This had the potential to affect all four residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a program of daily social and recreational activities. During a tour of the facility on December 11, 2023, at 10:15 a.m., there was no calendar of recreational or social activities observed. On December 12, 2023, at 9:00 a.m., unlicensed personnel (ULP)-E confirmed there was no calendar of recreational or social activities. For the duration of the survey from December 11, 2023, through December 13, 2023,, no programs of social or recreational activities were observed to be provided to the residents. Residents were observed to be watching television (TV) most of the days in their rooms or lying in bed.	0 490		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 490	Continued From page 7 On December 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D acknowledged daily programs of social and recreational activities had been created or implemented for any of the residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the contact information for the Office of Ombudsman for Long-Term Care and Mental	0 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 550	Continued From page 8 Health and Developmental Disabilities. This had the potential to affect all four (4) residents receiving assisted living services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 10:15 a.m., an observation was made of the facility's common areas and the surveyor did not observe a posting in a common area of the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. During an interview on December 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D verified the required information regarding the ombudsman contact information was not posted in the common areas of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 640	Continued From page 9 The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to support protection and safety by not posting information and phone numbers for reporting to the Minnesota Adult Abuse Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near telephones provided by the assisted living facility. This had the potential to affect all four (4) residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 10:20 a.m., during	0 640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 640	Continued From page 10 observation of the facility's main entry area and common areas, the surveyor did not observe a posting of 911 emergency number in common areas and near telephones provided by the Assisted Living facility or a posting of information and the reporting number for the MAARC to report suspected maltreatment of a vulnerable adult under section 626.557. On December 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D verified the required information regarding to the Minnesota Adult Abuse Reporting Center (MAARC) and 911 emergency number was not posted in the common areas of the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 640		
0 650 SS=D	144G.42 Subd. 8 Employee records (a) The facility must maintain current records of each paid employee, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 650	Continued From page 11 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain records one of two employees (unlicensed personnel (ULP)-B) completed all training and competency evaluations prior to providing delegated nursing tasks to residents. Also, the licensee failed to maintain current employees records at least eight hours of annual training for each 12 months of employment for one of two employees (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 a limited number of staff are involved or the situation has occurred only occasionally). ULP-B had a hire date of May 6, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record lacked evidence of training and demonstrated competency in the following areas:	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 650	Continued From page 12 -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -dressing and assisting with toileting; -standby assistance techniques and how to perform them; -reading and recording temperature, pulse, and respirations of the client; -safe transfer techniques and ambulation; and -range of motioning and positioning. ULP-B's employee training records also lacked evidence ULP-B had successfully completed annual training as required in the following areas: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and	0 650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 650	Continued From page 13 service delivery and how they apply to direct support services provided by the staff person. On December 13, 2023, at 11:00 a.m., registered nurse (RN)-A acknowledged ULP-B's employee record lacked evidence of completed training and competency testing in topics listed above. Licensed assisted living director (LALD)-D stated the nurse did training throughout the year and ULP-B had demonstrated competency. RN-A also acknowledged ULP-B's employee record was missing the required annual training. RN-A stated all staff have completed annual training through the online program but did not provide documentation of the annual training for ULP-B to the surveyor. The licensee's Staff Competency policy dated August 1, 2021, indicated training and competency evaluations for all ULP included all areas as mentioned above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently;	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 680	Continued From page 14 (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the facility tour on December 11, 2023, at 10:20 a.m., the surveyor did not observe emergency exit diagrams posted in common	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 680	Continued From page 15 areas. The licensee's undated Assisted living Emergency Preparedness Manual lacked individualized emergency procedures to include the following content: - maintain a comprehensive EP, documented date of reviews/updated annually; - how they would coordinate with other health care facilities and community during an emergency or disaster (natural, man-made, facility, etc.), reviewed/updated annually; - risk assessment with documentation; - consider duration of interruptions; - take an all-hazards approach; - categorize the various probable risks/hazards by likelihood of occurrence; - an assessment of at-risk population's needs including maintaining independence, communication, transportation, supervision, and medical care; - develop and implement EP policies/procedures and review/update annually; - must develop P/P to address safe evacuation from the facility, including consideration of care/tx needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); primary/alternate communication means with external sources of assistance; - a tracking system used to document locations of residents, staff, and relocation of staff; - develop a written communication plan and review/update annually; - must develop and maintain EP training and testing program, review/update annually; - training program must include initial EP training to policies and procedures to all new and existing staff and volunteers; - provide EP training at least annually; - maintain documentation of EP training; and	0 680		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
0 680	Continued From page 16 - must conduct exercises to test the EP plan at least twice per year including unannounced staff drills using the EP. On December 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D stated the EP plan was missing the required content and they are working on updating the EP plan. The licensee's Emergency Preparedness policy dated August 1, 2021, indicated "[Licensee] will have an identified plan in place to assure the safety and well-being of residents and staff during periods of an emergency or disaster that disrupts services." No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each 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	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 17 required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide smoke alarms that are interconnected throughout the facility so actuation of one alarm will cause all alarms in the dwelling to actuate. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On a facility tour on December 12, 2023, at 10:26 a.m., with licensed assisted living director (LALD)-D, survey staff observed smoke alarms throughout the facility were not interconnected so actuation of one alarm will cause all alarms in the dwelling to actuate. This was discovered when LALD-D tested the smoke alarms.	0 780		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 18 On December 12, 2023, at 10:26 a.m., LALD-D verbally confirmed survey staff observations during the facility tour. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide required annual and monthly inspections of all the fire extinguishers. Also failed to provide adequately rated portable fire extinguishers as required for the facility. This deficient condition had the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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 19 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 a facility tour on December 12, 2023, at 10:26 a.m., with licensed assisted living director (LALD)-D, survey staff observed the fire extinguishers throughout the facility, did not have current tags or documentation to indicate annual and monthly inspections had been performed as required. Annual and monthly inspections of the fire extinguishers are required to ensure that all systems are maintained and remain in working order. It was also observed each of the fire extinguishers provided were 1-A:10-BC (size) rated and did not have at least one 2-A:10-B:C rated fire extinguisher as required by MN Statute 144G.45. On December 12, 2023, at 10:26 a.m., LALD-D verbally confirmed the lack of maintenance of the fire extinguishers and the facility did not have an appropriate size fire extinguisher. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 790		
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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 20 a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on a interivew and record review, the licensee failed to develop a fire safety and evacuation plan with required elements, failed to provide required employee and resident training on fire safety and evacuation, and failed to conduct required evacuation drills. This had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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 21 safety but had the potential to have harmed a resident 's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On December 11, 2023, at 3:40 p.m., the surveyor sent an email to licensed assisted living director (LALD)-D requesting documentation on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. On December 12, 2023 at 10:33 a.m., the surveyor called LALD-D again requesting documentation on the fire safety and evacuation plan, training and drills. No documentation was provided on the fire safety and evacuation plan, fire safety and evacuation training, and evacuation drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		
01290 SS=D	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 22 (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the licensee's health facility identification number (HFID) prior to providing services to residents for one of one employees (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 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-B had a hire date of May 6, 2014, under the comprehensive home care license and began providing assisted living services on August 1, 2021. ULP-B's employee record contained a background study dated May 6, 2014, that was affiliated with the licensee's previously held Comprehensive Home Care license. ULP-B's employee record lacked evidence the licensee	01290		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 23 affiliated a background study for ULP-B under the current HFID. On December 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D stated the licensee had not affiliated ULP-B's background study to the current HFID. Also, LALD-D stated they are working to ensure all staff background studies were affiliated to the licensee's HFID prior to providing services to residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01620 SS=I	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01620	Continued From page 24 section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive assessment of the resident using the uniform assessment tool for one of one resident (R1) that smoked. This practice resulted in an immediate correction order. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 was admitted on May 14, 2019, with diagnoses including heart failure, acute and chronic respiratory failure with hypercapnia (having too much carbon dioxide in the bloodstream), and chronic obstructive pulmonary disease (COPD). R1's annual assessment dated October 26, 2023, indicated R1 required assistance with bathing, dressing, grooming, and transferring. R1's assessment lacked all of the required areas identified on the Uniform Assessment Tool.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01620	Continued From page 25 R1's Progress Notes dated November 2, 2023, noted "[R1] showing signs of physical decline, appears weak, tired, and SOB [shortness of breath] and requiring maximum usage of hydromorphone." On December 11, 2023, at 11:39 a.m., surveyor observed R1 lying on his bed with nasal cannula tubing in his mouth and oxygen concentrator flow rate was five (5) liters. R1 stated he did not like nasal cannula tubing in his nose, so he always places the tubing in his mouth. Also, R1 stated he forget to change the oxygen concentrator flow rate from five (5) to two (2) liters. On December 11, 2023, at 12: 00 p.m., RN-A stated R1 managed his oxygen independently and R1 was responsible for refilling the oxygen tanks. On December 13, 2023, at 11:39 a.m., the surveyor observed R1's bedroom had an exit door that led directly to the outside from R1's room. The surveyor, licensed assisted living director (LALD)-D, and licensed practical nurse (LPN)-C entered R1's room and observed R1 standing outside his bedroom holding a lit cigarette in his right hand and his oxygen tubing in his left hand. R1 alternated putting the cigarette to his lips and holding the oxygen tubing to his lips. R1's oxygen tubing passed under the closed door and was connected to an oxygen concentrator with a flow rate of 5 liters per minute. R1's oxygen concentrator was approximately four (4) feet away from the exit door in R1's room. LPN-C said to R1 "It's dangerous smoking while oxygen is running." R1 said, "I know I shouldn't be doing that." On December 13, 2023, at 1:39 p.m., RN-A	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01620	Continued From page 26 acknowledged R1's assessment did not include all the required elements on the uniform assessment tool. Also, RN-A verified she did not assess R1 for safe smoke and managing oxygen independently. RN-A stated the licensee was working on transitioning to an electronic charting system to make sure assessments include all the required elements on the uniform assessment tool. RN-A and LALD-D stated they were not aware R1 was smoking while using oxygen. LALD-D stated R1 knows not to smoke while oxygen in use and it is first time staf witnessed R1 smoking while using oxygen. The licensee's Assessment - Comprehensive Services policy dated April 3, 2023, noted the initial nursing assessment would be completed within 5 days, reassessments and monitoring would be conducted no more than 14 days, and reassessments and monitoring would be conducted as needed on changes in needs of the resident and cannot exceed 90 calendar days from the last assessment. The licensee's Assessment - Compressive Services policy did not address uniform assessment tool as required. Minnesota Administrative Rule 4659.0150 dated August 11, 2021, stated the licensee's uniform assessment tool must include assessment of the following risk indicator: smoking (including the ability to smoke without causing burns or injury to the resident or others or damage to property). No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy was removed on December 14, 2023, but noncompliance remains. The scope and level remain unchanged.	01620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (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. (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. (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to finalize a current written service plan within 14 calendar days for one of four residents (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 28 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R4 was admitted on October 3, 2017, with diagnoses including right hemiparesis (weakness or inability to move one side of the body), aphasia (loss of ability to understand or express speech), and glaucoma. R4's annual assessment dated October 26, 2023, indicated R4 required assistance with bathing, dressing, grooming, positioning, and transferring. The assessment indicated R4 used a wheelchair. R4's record lacked a signed service plan with the following required content: (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. (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. (c) The facility must implement and provide all services required by the current service plan. (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. (e) Staff providing services must be informed of the current written service plan	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 29 On December 13, 2023, at 11:30 a.m., registered nurse (RN)-A acknowledged R4's record lacked a signed service plan with the required contents. RN-A stated they completed a service plan for R4, but no documentation provided to the surveyor. The licensee's Service Plan policy dated August 1, 2021, indicated "An individualized service plan is implemented for all residents. [licensee's] will provide all services required by the current service plan." The policy further indicated, "The service plan will be finalized no later than 14 days after the date home care services are first provided, if not already completed. The service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident;	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01650	Continued From page 30 (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan included the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 14, 2019, with	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01650	Continued From page 31 diagnoses including heart failure, acute and chronic respiratory failure with hypercapnia (having too much carbon dioxide in the bloodstream), and chronic obstructive pulmonary disease (COPD). On December 12, 2023, at 10:00 a.m., unlicensed personnel (ULP)-E was observed administering R1's medications. The surveyor observed a Trilogy non-invasive ventilator (a device used to help breathe when it becomes difficult to breathe at any time of the day, not just while resting or sleeping) in R1's room. R1 stated it was supplemental oxygen and he connected oxygen tubing via nozzle at the back of the machine. R1 stated he managed non-invasive ventilation independently. On December 12, 2023, at 12:00 p.m., surveyor observed ULP-E deliver a portable oxygen tank to R1's room. ULP-E stated the portable tank was supplied from Northwest Respiratory. R1's Service Plan dated October 17, 2021, indicated R1 was independent with bathing, dressing, grooming, and transferring. R1 received daily assistance with medication management and oxygen. R1's Service Plan lacked identification of treatments of Trilogy non-invasive ventilation and continuous positive airway pressure (CPAP). R1's annual assessment dated October 26, 2023, indicated R1 required assistance with bathing, dressing, grooming, and transferring. On December 13, 2023, at 11:30 a.m., registered nurse (RN)-A acknowledged R1's service plan indicated "R1 received daily assistance with medication management and oxygen" and "R1's	01650		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01650	Continued From page 32 medication administration record (MAR) dated December 2023, indicated oxygen 2 liters via nasal cannula continuous to keep oxygen saturations above 90%. R1's MAR indicated R1 was independent with oxygen. R1's Service plan was not updated after change in the resident's condition. The licensee's Service Plan policy dated August 1, 2021, indicated "The Service Plan includes the description of the services to be provided; the service description may be in the form of the resident's care plan developed with the resident/responsible party." The policy further indicated "The service plan and any revisions shall include a signature or other authentication by [licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01770	Continued From page 33 documentation of medication setup included all the required content for four of four residents (R1, R2, R3, R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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: During the entrance conference On December 11, 2023, at approximately 11:15 a.m., registered nurse (RN)-A stated the licensee provided medication management services which included medication setup by the nurses for the residents. On December 12, 202,3 at 8:00 a.m., 8:30 a.m., 9:00 a.m., and 10:00 a.m., the surveyor observed unlicensed personnel (ULP)-E administer medications to R1, R2, R3 and R4 from respective pill planner seven-day dosage boxes. ULP-E stated she finds the correct resident's name and time on the medication pill planner seven-day dosage boxes and administers those medications. ULP-E documented medication adminstration in the medication adminstration record (MAR). R1, R2, R3 and R4's records lacked medication set-up documentation to include dates of medication setup, names of medications, quantity of doses, times to be administered, routes of administration, and name of person completing medication setup.	01770		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01770	Continued From page 34 On December 13, 2023, at 11:00 a.m., RN-A confirmed the licensee provided weekly medication set-up services for all residents. RN-A acknowledged R1, R2, R3 and R4's records lacked documentation of medication setup included all the required content. The licensee's Medication Documentation policy dated August 1, 2021, indicated [the licensee] would document medication set up according to the following, "a. date of medication setup b. name of medication c. quantity of dose d. times to be administered e. route of administration f. name/title of person completing medication setup." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01940	Continued From page 35 administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop an individualized treatment management plan with the required content for one of one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on May 14, 2019, with diagnoses including heart failure, acute and chronic respiratory failure with hypercapnia (having too much carbon dioxide in the	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01940	Continued From page 36 bloodstream), and chronic obstructive pulmonary disease (COPD). On December 11, 2023, at 11:39 a.m., surveyor observed R1 lying on his bed with nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory assistance). R1 stated he does not like the nasal cannula tubing in his nose. R1 has disconnected the nasal cannula tube that goes to his nose, placing the tubing in his mouth, and oxygen concentrator flow rate was at five (5) liters per minute. R1 stated he forget to change the oxygen concentrator flow rate from 5 to two (2) liters minute. On December 12, 2023, at 12:00 p.m., surveyor observed ULP-E deliver a portable oxygen tank to R1's room. ULP-E stated the portable tank was supplied from Northwest Respiratory. R1's Service Plan dated October 17, 2021, indicated R1 received daily oxygen assistance from unlicensed personnel (ULP). R1's annual assessment dated October 26, 2023, indicated R1 required assistance with bathing, dressing, grooming, and transferring. R1's assessment mentioned "see treatment protocols/flowsheet." R1's Progress Notes dated November 2, 2023, noted "[R1] showing signs of physical decline, appears weak, tired, and SOB [shortness of breath] and requiring maximum usage of hydromorphone." R1's medication administration record (MAR) dated December 2023, indicated oxygen 2 liters via nasal cannula continuous to keep oxygen	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01940	Continued From page 37 saturations above 90%. R1's MAR indicated R1 was independent with oxygen. R1's Treatment or Therapy Services document dated January 6, 2021, indicated R1 managed his own oxygen. R1's record lacked a treatment management plan to include required content noted below: -a statement of the type of services that were provided; - documentation of specific resident instructions relating to the treatments or therapy administration; - identification of treatment or therapy tasks that were delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services; and -any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On December 11, 2023, at 12: 00 p.m., RN-A stated R1 managed his oxygen independently and R1 was responsible for refilling the oxygen tanks. On December 13, 2023, at 11:30 a.m., RN-A and licensed practical nurse (LPN)-C acknowledged R1 showed signs of physical decline and LPN-C stated they have discussed with family and a referral to hospice has been made. RN-A acknowledged R1's nursing assessment did not address if R1 can safely manage treatment oxygen.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
01940	Continued From page 38 The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated "A Registered Nurse (RN) will complete an assessment of all residents receiving treatment or therapy services prior to the initiation of those services." policy further indicated "The Registered Nurse is responsible for assessing and developing the treatment and/or therapy service plan for residents." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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 provide care and services according to acceptable health care standards, medical or nursing standards for four of four residents (R1, R2, R3, R4) who utilized bed rails. This practice resulted in an immediate correction order. In addition to that the licensee failed to ensure the care and services were provided according to a suitable and up-to-date plan, and subject to accepted health care and medical, or nursing standards for one of one resident (R1).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 39 This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R1 R1 was admitted on May 14, 2019, with diagnoses including heart failure, acute and chronic respiratory failure with hypercapnia (having too much carbon dioxide in the bloodstream), and chronic obstructive pulmonary disease (COPD). R1's annual assessment dated October 26, 2023, indicated R1 required assistance with bathing, dressing, grooming, and transferring. On December 11, 2023, at 2:40 p.m., R1's hospital bed with two bed rails was observed by the surveyor, Registered nurse (RN)-A, and licensed assisted living director (LALD)-D. (RN)-A grasped the bed rails and noted the bed rails was loose and did move when pulled and pushed on with force. R1 was observed lying in bed. R1 stated he does not use the bed rails. R1's medication administration record (MAR) dated December 2023, indicated oxygen two (2) liters via nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory) continuous to keep O2 sats above 90%. (the fraction of oxygen	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 40 saturation in hemoglobin protein in red blood cells that carries oxygen in a person's body relative to total hemoglobin in the blood). MAR indicated R1 is indpendent with oxygen. On December 12, 2023, at 1:40 p.m., the surveyor with engineer on video call conference and licensed assisted living director (LALD)-D during tour of the facility noted an unsecured six (6) portable oxygen tankleaning up against the small table and oxygen concentrator in R1's room. On December 12, 2023, at 1:40 p.m. LALD-D confirmed the portable oxygen tanks in R1's room was not secure. R2 R2 was admitted on January 5, 2012, with diagnoses including multiple sclerosis, hypertension, muscle spasms, obesity, pain, and excessive daytime sleepiness. R2's annual assessment dated October 26, 2023, indicated R2 required assistance with toileting, bathing, dressing, grooming, and transferring. The assessment indicated R2 used a wheelchair and EZ-stand (mechanical lift). On December 11, 2023, at 2:45 p.m., R2's hospital bed with two bed rails was observed by the surveyor, RN-A, and LALD-D, who noted the bed rail on the right side of the bed was loose. RN-A grasped the bed rails and noted the bed rails did move when pulled and pushed on with force. R2 stated he used the bed rails to assist getting in and out of bed. R3 R3 was admitted on October 27, 2021, with	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 41 diagnoses including anemia, seizures, and major depressive disorder. R3's annual assessment dated October 26, 2023, indicated R3 required assistance with bathing, dressing, grooming, positioning, and transferring. The assessment indicated R3 used a wheelchair. On December 11, 2023, at 2:50 p.m., R3's hospital bed with two bed rails was observed by the surveyor, RN-A, and LALD-D. RN-A grasped the bed rails and noted the bed rails did move when pulled and pushed on with force. R4 R4 was admitted on October 3, 2017, with diagnoses including right hemiparesis (weakness or inability to move one side of the body), aphasia (loss of ability to understand or express speech), and glaucoma. R4's annual assessment dated October 26, 2023, indicated R4 required assistance with bathing, dressing, grooming, positioning, and transferring. The assessment indicated R4 used a wheelchair. On December 11, 2023, at 2:55 p.m., R4's hospital bed with two bed rails were observed by the surveyor, RN-A, and LALD-D. RN-A grasped the bed rails and noted the bed rails were loose and did move when pulled and pushed on with force. R4 stated he does not use the bed rails. R1, R2, R3, and R4's records lacked: - a bed rail assessment (including purpose/intention of bed rail); - documentation of the risks versus benefits of bed rail use; - measurements of zones of entrapments; and - documentation of physical inspection of the	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 42 bed rail for stability and correct installation. On December 11, 2023, at approximately 3:00 p.m., RN-A stated she completed bed rail assessment for R1, R2, R3, and R4, but was not able to provide documentation to the surveyor. RN-A and LALD-D acknowledged R1, R2, R3, and R4's records lacked a bed rail assessment, documentation of the risks versus benefits of bed rail use, and measurements of zones of entrapment. The March 10, 2006, Food and Drug Administration (FDA) "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" indicated to reduce the risk of entrapment, zone 1 (space between the rails) should be less than four and three quarters' inches. Zone 2 (space under the rail, between rail supports, or next to a rail support) should be less than four and three quarters' inches. Zone 3 (between the rail and the mattress) should be less than four and three quarters' inches. Zone 4 (under the rail at the ends of the rail) should be less than two and three eighths' inches. The FDA, "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 determine how best to keep the patient safe."	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 43 The licensee's Side Rail Use policy dated August 1, 2021, indicated before implementing bed rails for a resident: 1. The RN will conduct a bed rail assessment that includes the following: a. Level of mobility, including bed mobility b. Level of consciousness c. Level of cognition d. Presence of orthostatic hypotension e. Vision 2. The RN will consider the request of the resident, the resident's legal representative and/or the resident's designated representative request for bed rails during the evaluation. 3. The RN will discuss with the resident/representative(s) alternatives to the use of bed rails. 4. A physical therapy evaluation may be obtained, as appropriate. 5. If the need for bed rails is indicated and the resident/resident representative(s) agree to their use, the RN will provide education related to bed rails. 6. The RN will document the purpose of the bed rails and the education provided. 7. The resident, resident's legal representative or resident's designated representative will co-sign the document agreeing to the benefits and risks of bed rails. The Minnesota Department of Health's Assisted Living Resources and Frequently Asked Questions website dated December 8, 2023, indicated the following documentation should be included in a resident's records regarding bed rails: - purpose and intention of bed rail; - measurements; - the resident's bed rail use/need assessment; - risk vs. benefits discussion (individualized to	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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	Continued From page 44 each resident's risks); - resident's preferences; - physical inspection of the bed rial and mattress for areas of entrapment, stability, and correct installation; and - any necessary information related to interventions to mitigate safety risk or negotiated risk agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediacy was removed on December 14, 2023, but noncompliance remains. The scope and level remain unchanged.	02310		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure a required notice was posted at each entry way of the facility to display statutory language to disclose the potential for electronic monitoring activity. This had the potential to affect all residents, staff, and visitors to the facility. This practice resulted in a level one violation (a violation that has no potential to cause more than	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	21932	A. BUILDING: _____ B. WING _____	12/14/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE CARING SISTERS HOME CARE	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
03090	Continued From page 45 a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On December 11, 2023, at 10:00 a.m., upon entering the facility, the surveyor observed no electronic monitoring notice posted with the statutory required language. On December 13, 2023, at 11:00 a.m., licensed assisted living director (LALD)-D confirmed no posting was available related to the statutory language for electronic monitoring. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

Minnesota Department of Health
Division of Environmental Health, FPLS
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *12/11/23*
Time: 11:45:00
Report: 1025231276

Food and Beverage Establishment Inspection Report

Location:
The Caring Sisters Home Care
1375 Oak Grove Circle
Golden Valley, MN55422
Hennepin County, 27

Establishment Info:
ID #: 0037762
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 9524264690
ID #:

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

The following orders were issued during this inspection.

3-100 Food Characteristics: unadulterated

3-101.11 ***** Priority 1 *****

MN Rule 4626.0125 Remove all unsafe and adulterated foods from the premises.

Simply Juice (labeled Keep Refrigerated [prior to opening]) stored in cabinet; cause to be removed, do not serve to residents. Juice pulled from cabinets for removal.

Comply By: 12/11/23

4-300 Equipment Numbers and Capacities

4-302.12B ***** Priority 2 *****

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.

Provide a food thermometer with a thin-type probe for the facility.

Comply By: 12/13/23

4-300 Equipment Numbers and Capacities

4-302.14 ***** Priority 2 *****

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

Provide a test kit for the sanitizing solution (e.g. chlorine, quat ammonia)

Comply By: 12/13/23

2-100 Supervision

2-102.12AMN

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

Employ a CFPM for the establishment, please search MDH CFPM for information

Comply By: 01/24/24

4-300 Equipment Numbers and Capacities

4-301.12C

MN Rule 4626.0680C Receptacles that substitute for the compartments of a multicompartment sink may be used as alternative manual warewashing equipment if approved.

Provide a container for sanitizing dishes and utensils after washing and rinsing in the dishwasher.

Comply By: 12/11/23

6-300 Physical Facility Numbers and Capacities

6-301.14A

MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands

Post a sign for handwashing at the kitchen sink to designate the handwasing basin.

Comply By: 12/13/23

6-500 Physical Facility Maintenance/Operation and Pest Control

6-501.11

MN Rule 4626.1515 Maintain the physical facilities in good repair.

Repair or remove cabinet doors, repair spaces in wood wall panel where there is a hole between the wall and the floor, repair the missing surface from the backsplash (replace with a cleanable finish, e.g. tile, gloss painted drywall)

Comply By: 01/10/24

Food and Equipment Temperatures

Process/Item: Milk
Temperature: 40 Degrees Fahrenheit - Location: Refrigerator
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	2	4

Provide a food thermometer
Provide a sanitizing solution and container for sanitizing (e.g. chlorine for Food Contact Surfaces)
Provide a test kit (e.g. chlorine)
Signage for handwashing sink
CFPM information
No cooling of TCS leftovers
Add date marking to TCS foods
For personal food and food brought to residents from family – date mark, personal items for that person only
Handwashing – wash hands before entering the kitchen, for staff and residents

Freezer in front room frozen OK
Suggest installing smooth stainless handles for cabinets

PEST CONTROL
Discussed storing dried foods in sealed containers (e.g. rice)
Less targeted remedies can be used if they do not pose a contamination risk for food (e.g. moth balls, mint plants etc) and if they are not effective, then other methods need to be used to control pests

FACT SHEETS
Please search "MDH Fact Sheets" for the Food Business fact sheets page
"Cleaning and Sanitizing" https://www.health.state.mn.us/communities/environment/food/docs/fs/cleansanfs.pdf
"Food Cooking Temperatures"
https://www.health.state.mn.us/communities/environment/food/docs/fs/timetempfs.pdf
"Date Marking TCS foods"
https://www.health.state.mn.us/communities/environment/food/docs/fs/datemarkingfs.pdf
"Highly Susceptible Populations" - no service or raw or undercooked animal food, use Pasteurized eggs when preparing eggs raw or undercooked or batching scrambled eggs
https://www.health.state.mn.us/communities/environment/food/docs/fs/highsuspopfs.pdf

SINK USAGE
Facility has a two (2) compartment sink
Facility has a dishwasher which does not meet the requirements of MN 4626.0506
Facility does not have a 3 compartment sink
Facility does not have a food preparation sink
Facility does not have a stand-alone/dedicated handwashing sink

FACILITY
Kitchen has ceramic tile floor, laminate countertops, wood cabinets, acoustic ceiling, hollow enclosed cabinet bases, tile backsplash and wood panel/drywall backsplash
Appliances are residential

DISHWASHING – NON ANSI/NSF 184
Dishwasher is not marked with label/data plate indicating it reaches an internal contact temperature necessarily for sanitizing (NSF/ANSI 184: Residential Dishwasher). Discussed using the dishwasher to wash and rinse dishes and utensils, and providing a bus tub/other basin for a chemical sanitizing (e.g. chlorine bleach 50-100 PPM or other chemical per label for sanitizing "food contact surfaces", submerge utensils for 1-2 minutes and air dry). Sanitize clean dishes and utensils in a container large enough to submerge the largest utensil. Provide an appropriate sanitizer for "food-contact surfaces" (label will include it as a heading) and an appropriate test kit.

4626.0680 Alternative manual warewashing equipment that meets the requirements in parts 4626.0875 and 4626.0880 may be used when there are special cleaning needs or constraints and its use is approved by the regulatory authority. Alternative manual warewashing equipment may include:
[…] (5) receptacles that substitute for the compartments of a multicompartment sink.
https://www.nsf.org/consumer-resources/articles/dishwasher-certification

COUNTERTOPS AND FOOD CONTACT SURFACES
Provide a smooth, non-porous food contact surface (e.g. cutting boards) that can be easily washed, rinsed,

and sanitized (e.g. run through the dishwasher).
Soap and water can be used to clean non-food contact surfaces. By provided a cutting board or other non-porous food contact surface, the countertops can be kept clean but without the use of chemicals which may damage the finish. Do not use wood as a food contact surface.

EQUIPMENT
MN 4626.0506 includes alternate equipment and finish requirements for adult care facilities which serve TCS foods for same-day service only:

MN 4626.0506 G. A food establishment that is an adult care center, child care center, or boarding establishment does not need to comply with item A [certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program for food service equipment] if approved by the regulatory authority and the food establishment:
(1) serves only non-TCS food; or
(2) prepares TCS foods only for same-day service.

Discontinue any service of TCS food for multiple day service (e.g. cooling and reservice of leftovers of prepared and cooked TCS food), or upgrade finishes and equipment in the kitchen

GENERAL COMMENTS
CFPM (Certified Food Protection Manager)
For information, please search "MDH CFPM"

Discussed employee health and hygiene, exclusion for individuals from the kitchen with vomiting and/or diarrheal illness, sore throat with fever, or reportable illness; food cooking and holding temperatures, cross-contamination, allergens, food storage order in refrigerator, separating resident food from medication or staff food, avoiding bare hand contact with foods which will not be cooked (cut fruit, deli sandwiches), pest control

Date marking TCS foods (when packages are opened or food is prepared, date mark and discard after 7 days, except for certain cultured dairy products)
Chemical label, use, and storage
Discussed food source, recalls, and refusing food which has signs of tampering or temperature abuse
Information on food recalls available "MDA Food Recall"
https://www.mda.state.mn.us/food-feed/food-recalls-consumer-advisories-minnesota

Type: Full
Date: *12/11/23*
Time: 11:45:00
Report: 1025231276
The Caring Sisters Home Care

Food and Beverage Establishment Inspection Report

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 1025231276 of 12/11/23.

Certified Food Protection Manager: TBD

Certification Number: _____ Expires: / /

Inspection report reviewed with person in charge and emailed.

Signed: _____
Olaleye

Signed: _____
Casey Kipping
Public Health Sanitarian III
Freeman Building St Paul
651-201-4513
casey.kipping@state.mn.us

Report #: 1025231276

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

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

No. of RF/PHI Categories Out	3	Date	12/11/23
No. of Repeat RF/PHI Categories Out	0	Time In	11:45:00
Legal Authority MN Rules Chapter 4626		Time Out	

The Caring Sisters Home Care	Address: 1375 Oak Grove Circle	City/State: Golden Valley, MN	Zip Code: 55422	Telephone: 9524264690
License/Permit #: 0037762	**Permit Holder**	**Purpose of Inspection:** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

	Compliance Status		COS	R
	Surpervision			
1	IN OUT	PIC knowledgeable; duties & oversight		
2	IN OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	IN OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	IN OUT	Proper use of reporting, restriction & exclusion		
5	IN OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean & properly washed		
9	IN OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	IN OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, & unadulterated		
14	IN OUT N/A N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A N/O	Food separated and protected		
16	IN OUT N/A	Food contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time & temperature		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time & temperature		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking & disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw/undercooked food		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food and Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved & properly used		
28	IN OUT	Toxic substances properly identified, stored, & used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance/specialized process/HACCP		

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" in box if numbered item is **not** in compliance — Mark "X" in appropriate box for COS and/or R — **COS=** corrected on-site during inspection **R=** repeat violation

		Safe Food and Water	COS	R
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

		Proper Use of Utensils	COS	R
43		In-use utensils: properly stored		
44		Utensils, equipment & linens: properly stored, dried, & handled		
45		Single-use/single service articles: properly stored & used		
46		Gloves used properly		
		Utensil Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, & used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55	X	Physical facilities installed, maintained, & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 12/11/23

Inspector (Signature)