



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 23, 2026

Licensee

The Caring Sisters Home Care
2852 Yosemite Avenue South
Saint Louis Park, MN 55416

RE: Project Number(s) SL23620016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 26, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

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

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEpHV>**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Renee L. Anderson". The signature is written in a cursive, flowing style.

Renee L. Anderson, Supervisor

State Evaluation Team

Email: Renee.L.Anderson@state.mn.us

Telephone: 651-201-5871 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 23620	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/26/2026
NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2852 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416			
(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: SL23620016-0 On August 24, 2026, through August 26, 2026, 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 4 residents, all of whom were receiving services under the provider's Assisted Living Facility license.	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 License Providers. 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 surveyors' 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 pursuant to 144G.31 Subd. 1, 2 and 3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 2 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August 24, 2026, 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			

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0 690	Continued From page 3	0 690			
0 690 SS=F	144G.43 Subdivision 1 Resident record (a) Assisted living facilities must maintain records for each resident for whom it is providing services. Entries in the resident records must be current, legible, permanently recorded, dated, and authenticated with the name and title of the person making the entry. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure entries in resident records were authenticated with the name and title of the person making the entry for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's Service Plan dated July 8, 2026, indicated R2 received services including assistance with reminders for activities of daily living (ADLs), medication administration, and behavioral health services. On August 25, 2026, at 8:00 a.m., the surveyor observed ULP-D assisting R2 with medication administration.	0 690			

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0 690	Continued From page 4 R2's services documentation, titled "Daily Home Health Aide Charting" dated August 2026, included multiple entries of staff initials for services provided during day shift (7:00 a.m. - 3:00 p.m.), evening shift (3:00 p.m. - 11:00 p.m.), and overnight shift (11:00 p.m. - 7:00 a.m.). The documentation included initials that appeared to be those of unlicensed personnel (ULP)-F, on August 2, however lacked authentication including ULP-F's full name and title. The documentation further lacked titles of all staff, to identify the category of staff assisting R2 with cares and services. R2's Medication Administration Record (MAR) dated August 2026, indicated staff assisted R2 with medication administration twice daily. The end of each page of the MAR included a line item for staff to document their Staff Name/Title/Initials. The MAR included staff initials for medication administration that appeared to be those of ULP-F, on August 1, 9, 11, and 14, however lacked authentication including ULP-F's full name and title. The authentication for three additional staff lacked titles to identify the category of staff assisting R2 with medication administration. R3 R3's Service Plan dated May 1, 2025, indicated R3 received services including assistance with ADLs, medication administration, blood glucose (sugar) management, and behavioral health services. On August 24, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R3 with blood glucose monitoring.	0 690			

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0 690	Continued From page 5 R3's services documentation ("Daily Home Health Aide Charting") dated August 2026, included multiple entries of staff initials for services provided during day shift (7:00 a.m. - 3:00 p.m.), evening shift (3:00 p.m. - 11:00 p.m.), and overnight shift (11:00 p.m. - 7:00 a.m.). The documentation included initials that appeared to be those of ULP-D and ULP-F, however lacked authentication with their full names and titles. The documentation further lacked titles of all staff, to identify the category of staff assisting R3 with cares and services. R3's MAR dated August 2026, indicated staff assisted R3 with medication administration five times daily. The end of each page of the MAR included a line item for staff to document their Staff Name/Title/Initials. The documentation lacked titles of all staff to identify the category of staff assisting R3 with medication administration. On August 24, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-B stated it looked like staff had not properly authenticated the records for R2 or R3. CNS-B further stated staff were expected to authenticate resident records, and she was not sure why it had not been done. The licensee's Clinical Records policy dated August 1, 2021, indicated all entries in the clinical record would be authenticated with the name and title of the person making the entry. The licensee's Medication Documentation policy dated August 1, 2021, indicated complete documentation of medication administration included the signature and title of the staff administering the medication. No further information was provided.	0 690			

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0 690	Continued From page 6	0 690			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730			

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0 730	Continued From page 7 professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's Service Plan dated July 8, 2026, indicated R2 received services including assistance with activities of daily living (ADLs) reminders, medication administration, and behavioral health services.	0 730			

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0 730	Continued From page 8 On August 25, 2026, at 8:00 a.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with medication administration. R2's Daily Home Health Aide Charting for August 2026, was identified by clinical nurse supervisor (CNS)-B as their documentation of services the licensee provided for R2. The Daily Home Health Aide Charting document included a line item for each service to be provided by the licensee and a box for every date and time of day where the staff member who completed the service would place a check mark and place their initial in the "staff initials" box. R2's Daily Home Health Aide Charting from August 1-24, 2026, lacked documentation the scheduled services were provided as agreed upon in the Service Plan, or whether the services were declined/refused on the following dates: -8 of 9 scheduled services on August 1-3, 24; -2 of 9 scheduled services on August 4; -3 of 9 scheduled services on August 5-6; -5 of 9 scheduled services on August 9-10; -6 of 9 scheduled services on August 1-13, 15, 18-19, 21-22, -9 of 9 scheduled services on August 14, 17, 23; and -1 of 9 scheduled services on August 16. R3 R3's Service Plan signed May 5, 2026, indicated R2 received services including meal assistance, blood glucose monitoring, vital signs check, bed making, dressing, grooming, laundry, behavior management, and medication assistance. On July 21, 2026, at 8:10 a.m., the surveyor observed ULP-C assisting R2 with medication administration.	0 730			

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0 730	Continued From page 9 R3's documentation of services, "Daily Home Health Aide Charting" for August 1-23, 2026, lacked documentation the scheduled services were provided as agreed upon in the Service Plan, or whether the services were declined/refused on the following dates: -8 of 9 scheduled services on August 1-3, 17; -3 of 9 scheduled services on August 4-6, 9; -7 of 9 scheduled services on August 7, 13, 15-16; -2 of 9 scheduled services on August 8, -5 of 9 scheduled services on August 10, -6 of 9 scheduled services on August 11, 18-23; and -9 of 9 scheduled services on August 12, 14. On August 24, 2026, at 1:50 p.m., CNS-B stated staff were not documenting properly on the Daily Home Health Aide Charting form, and they should have documented when services were done. CNS-B stated they believed it was an oversight by staff. The licensee's Clinical Record policy dated August 1, 2021, indicated all services provided would be documented in the resident's record. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:	0 775			

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0 775	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
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;	0 780			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2852 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416			
(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 11 (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	0 780			

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0 780	Continued From page 12 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) 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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 790			

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0 790	Continued From page 13 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 800			

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0 800	Continued From page 14 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans	0 810			

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0 810	Continued From page 15 upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related	0 810			

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0 810	Continued From page 16 the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan 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. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part	01620			

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01620	Continued From page 17 of the resident's reassessment. (e) 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. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment, including a reassessment 14 calendar days from the initiation of services for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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:	01620			

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01620	Continued From page 18 R2 was admitted March 1, 2025. R2's Service Plan dated July 8, 2026, indicated R2 received services including assistance with activities of daily living (ADLs) reminders, medication administration, and behavioral health services. On August 25, 2026, at 8:00 a.m., the surveyor observed ULP-D assisting R2 with medication administration. R2's record included an initial comprehensive nursing assessment, dated March 1, 2025, and a subsequent RN reassessment on April 25, 2025 (55 days from the initiation of services). R2's record lacked reassessment and monitoring conducted by a registered nurse no more than 14 calendar days after initiation of services. On August 25, 2026, at 12:30 p.m., clinical nurse supervisor (CNS)-B stated R2's 14-day assessment was completed late because it was missed. The licensee's Assessment and Reassessment policy dated August 1, 2021, indicated "the RN will provide a reassessment visit to update the evaluation of the resident and services no more than 14 days after the initiation of services." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01760 SS=F	144G.71 Subd. 8 Documentation of administration of medication	01760			

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01760	Continued From page 19 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff document the reason why medication administration was not completed as prescribed, for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R2 R2's Service Plan dated July 8, 2026, indicated R2 received services including assistance with activities of daily living (ADLs) reminders,	01760			

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01760	Continued From page 20 medication administration, and behavioral health services. On August 25, 2026, at 8:00 a.m., the surveyor observed ULP-D assisting R2 with medication administration. R2's medication administration record (MAR), from August 1-24, 2026, lacked documentation for the following scheduled medication times: -prevident 5000 (prevent dry mouth) 1.1% sodium fluoride toothpaste at 8:00 p.m., on August 1, 22; -loratadine (relieve allergy symptoms)10 mg at 8:00 p.m., on August 1-3; R3 R3's Service Plan dated May 1, 2025, indicated R3 received services including assistance with ADLs, medication administration, blood glucose (sugar) management, and behavioral health services. On August 24, 2026, at 11:50 a.m., the surveyor observed ULP-C assisting R3 with blood glucose monitoring. R3's MAR, from August 1-24, 2026, lacked documentation for the following scheduled medication times: -insulin glargine 100 units/milliliter (long-acting insulin to manage blood sugar) 25 units at 8:00 a.m., on August 9; -refresh tears (prevent dryness of the eye) 0.5% at 8:00 a.m., on August 15-17, 21- 24. R2 and R3's records lacked documentation all medications were administered as prescribed, or the reason why medication administration was not completed as prescribed and any follow-up procedures that were provided to meet the	01760			

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01760	Continued From page 21 resident's needs when medication was not administered as prescribed. On August 24, 2026, at 1:50 p.m., clinical nurse supervisor (CNS)-B stated staff were not documenting properly on the residents' MAR and they should have documented if the resident refused medication. CNS-B stated they believed it was an oversight by staff. The licensee's Medication Documentation policy dated August 1, 2021, indicated: "2. If the administration of one or more medications was not completed, staff will document the following a. The reason why the medication was not administered b. Follow up procedures to meet the resident's needs in compliance with the Medication Management Plan c. Appropriate notification to RN Supervisor or other persons as instructed regarding missed dosages d. Medication Error report, if appropriate." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	01880			

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01880	Continued From page 22 Based on observation, interview, and record review, the licensee failed to ensure medications were stored according to manufacturer's instructions for one of one resident (R3) with refrigerated medications. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R3's Service Plan dated May 1, 2025, indicated R3 received services including assistance with activities of daily living, medication administration, blood glucose (sugar) management, and behavioral health services. R3's medication administration record (MAR) for August 2026 indicated R3 had the following medications scheduled: -semaglutide (Ozempic, for blood sugar regulation), 8 milligrams (mg)/3 milliliters (ml), inject 2 mg subcutaneously every Friday; and -insulin glargine (long-acting insulin, for diabetes), 100 units (u)/ml, inject 25 u subcutaneously daily. On August 24, 2026, at 12:30 p.m., the surveyor observed the contents of the licensee's medication refrigerator with clinical nurse supervisor (CNS)-B and licensed practical nurse (LPN)-E. The refrigerator contained a box containing 4 syringes filled with Lantus insulin (long-acting insulin used to lower blood sugar),	01880			

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01880	Continued From page 23 one vial of Lantus insulin, and one Ozempic semaglutide injector pen (used to help regulate blood sugar and support weight management). The fridge lacked a thermometer to ensure the medications were stored at the appropriate temperature, according to manufacturer instructions. CNS-B stated they had recently moved the refrigerator to the office upstairs and the thermometer must have been misplaced during the move. The manufacturer's prescribing information for the use of Lantus insulin pens, revised June 2023, indicated unopened medication should be refrigerated at 36-46 degrees Fahrenheit (F). The manufacturer's prescribing information for the use of Ozempic, semaglutide injection, dated June 2026, indicated the medication should be refrigerated at 36-46 degrees Fahrenheit (F) when not in use. The licensee's Storage/Control of Medications policy dated August 1, 2021, indicated medications requiring refrigeration would be clearly labeled and stored in and enclosed container or area separated from food, and the temperature would be maintained at 35-40 degrees. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
02310 SS=F	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted	02310			

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02310	Continued From page 24 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 and interview, the licensee failed to ensure that oxygen cylinders were stored according to accepted health care standards for one of one resident utilizing oxygen (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 the potential to affect a large portion or all of the residents). The findings include: R4's service plan dated May 1, 2026, indicated R4 received services including assistance with medication administration and assistance with oxygen. On August 26, 2026, at 9:10 a.m., the surveyor observed R4's apartment with licensed assisted living director (LALD)-A. The surveyor observed 18 oxygen cylinders stored in R4's room. 12 cylinders were secure in an oxygen storage rack. Six additional cylinders were observed to be free standing next to the storage rack. LALD-A stated R4 recently had oxygen cylinders delivered, and he was not aware there were unsecured cylinders. LALD-A stated he would contact the medical equipment company.	02310			

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NAME OF PROVIDER OR SUPPLIER THE CARING SISTERS HOME CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 2852 YOSEMITE AVENUE SOUTH SAINT LOUIS PARK, MN 55416			
(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 25 The licensee's Oxygen Therapy procedure dated 2020 indicated oxygen cylinders must be placed in a cart or base to avoid dropping or bumping the tank. The Minnesota Department of Health Oxygen Cylinder Storage Requirements, dated April 16, 2020, indicated, "cylinders must be secured (chains or racks) to prevent them from falling over." No further information was provided TIME PERIOD FOR CORRECTION: Seven (7) days	02310			



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

Food & Beverage Inspection Report

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Establishment Info

THE CARING SISTERS HOME CARE
2852 YOSEMITE AVENUE SOUTH
St Louis Park, MN 55416
Hennepin County
Parcel:

Phone:

License Info

License: HFID 23620

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

Inspection Info

Report Number: F1047261206
Inspection Type: Full - Single
Date: 8/24/2026 Time: 12:00 pm
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 2
Total Priority 2 Orders: 3
Total Priority 3 Orders: 0
Delivery:

! New Order: 2-200 Employee Health

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

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

COMMENT: FACILITY DID NOT HAVE AN EMPLOYEE ILLNESS LOG ON SITE. CORRECTED ON SITE- NEW LOG WAS PRINTED OFF.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 2-300 Personal Cleanliness

2-301.15 Priority Level: Priority 2 CFP#: 8

MN Rule 4626.0080 Employees must wash their hands in a handwashing sink. Discontinue using the following sinks for handwashing: sinks used for food preparation or warewashing or a service sink or a curbed cleaning basin used for the disposal of mop water.

COMMENT: NO SIGN LOCATED AT HANDWASHING SINK TO INDICATE WHAT SIDE IS USED FOR HANDWASHING. DESIGNATE ONE SIDE OF THE TWO BASIN SINK AS A HANDWASHING SINK

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

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

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

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

COMMENT: TEMPERATURES OF SEVERAL COLD HOLDING ITEMS WAS WARMER THAN 41F IN THE UPSTAIRS AND DOWNSTAIRS REFRIGERATOR. DOWNSTAIRS FRIDGE TEMPERATURE WAS ADJUSTED SO IT WOULD BE COLDER. UPSTAIRS REFRIGERATOR WAS AT THE COLDEST SETTING. FRIDGE WILL NEED TO BE REPAIRED OR REPLACED IF IT IS NOT MAINTAINING FOOD TEMPERATURES AT OR BELOW 41F.

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities

4-301.12A Priority Level: Priority 2 CFP#: 48

MN Rule 4626.0680A Provide a 3 compartment sink with integrally attached drainboards at each end for manually washing, rinsing and sanitizing equipment and utensils.

COMMENT: FACILITY DOES NOT HAVE A 3 COMP SINK OR A DISHWASHER WITH A SANITIZING FUNCTION. FACILITY IS USING

ADDITIONAL BASINS FOR SANITIZING. FACILITY CAN USE THE BASIN AS A TEMPORARY MEASURE BUT NEEDS PERMANENTLY PLUMBED DISHWASHING EQUIPMENT

Comply By: 2/24/2027 Originally Issued On: 8/24/2026

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

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

COMMENT: NO TEST STRIPS AVAILABLE ON SITE FOR CHLORINE BASED SANITIZER FACILITY USES TO SANITIZE THEIR DISHES

Comply By: 8/24/2026 Originally Issued On: 8/24/2026

Food & Beverage General Comment

The inspection was completed with the operator and reviewed with MDH Nurse Evaluator T. Carlson.

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

A two basin sink is located in the kitchen. One sink basin is designated for hand washing. A residential dish machine is located in the kitchen.

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

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

I acknowledge receipt of the Metro District Office inspection report number F1047261206 from 8/24/2026

Olaleye A. Beckley
Operator



Holly Sievers,
Public Health Sanitarian 3
651-201-5946
holly.sievers@state.mn.us



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

Temperature Observations/Recordings

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Establishment Info

THE CARING SISTERS HOME CARE
St Louis Park
County/Group: Hennepin County

Inspection Info

Report Number: F1047261206
Inspection Type: Full
Date: 8/24/2026
Time: 12:00 pm

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

Location: Downstairs Fridge at 43 Degrees F.

Comment:

Violation Issued?: Yes

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

Location: Upstairs Refrigerator at 45 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upstairs Refrigerator at 46 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL23620016-0	Date: August 25, 2026
Facility Name: THE CARING SISTERS HOME CARE	
Facility Address: 2852 YOSEMITE AVE S, ST. LOUIS PARK, MN 55416	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Occupancy separation shall be provided in Group I and Group R occupancies. Existing wood lath and plaster in good condition or ½ inch gypsum wallboard is acceptable where one hour occupancy separations are required. [Minn. Stat. 144G.45 subd. 2; MSFC 1105.2]

Comments: The facility had a tuck under garage where the protective gypsum drywall on the ceiling was removed/missing. The gypsum drywall is required to protect the living areas above the garage from the spread of fire. Any alteration to a licensed assisted living facility must go through the plan review and approval process with the Minnesota Department of Health (MDH) and the Minnesota Department of Labor and Industry (DLI) or local building authority prior to starting construction or renovation. Any areas of completed construction work may not be permitted to be occupied by assisted living residents until the areas have been cleared for occupancy by the Engineering Services Department at MDH.

3. Multiplug adapters, such as cube adapters, unfused plug strips or any other device not complying with NFPA 70 shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 604.4]

Comments: In the basement laundry room area, there was a multi-plug adapter being used.

☒ TAG IDENTIFICATION: 0780

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Project Number: SL23620016-0

Facility Name: THE CARING SISTERS HOME CARE

Date: August 25, 2026

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

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

Comments: Existing hardwired (receiving power from the building electrical system) smoke alarms in the upper living room and at the bottom of the stairs going to the office are required to be maintained as installed previously and interconnected to additional battery-operated alarms, so activation of one alarm activates all alarms throughout the facility.

2. Smoke Alarm power supply complies with MN State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated. [Minn. Stat. 144G.45 subd.2]

Comments: The existing hardwired smoke alarms in the basement were removed from the facility and replaced with battery powered smoke alarms. Existing hardwired smoke alarms are required to be maintained as installed previously and shall be replaced with smoke alarms having the same type of power supply.

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

Comments: The facility fire extinguisher located in the kitchen had not been serviced in 2 years and there were no monthly inspection records.

☒ **TAG IDENTIFICATION: 0800**

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

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

Comments: On the exterior rear deck, in the smoking area. The facility cable box was hanging off the house with the cover open.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

Comments: The surveyor observed the evacuation plans lacked accurate identification of resident rooms and layout. Exit plan diagrams must be correctly labeled and accurate to the layout of the facility to reduce confusion for emergency responders and potential obstructions for egress in a fire or similar emergency.

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

Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the plan that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The FSEP didn't include standard resident evacuation procedures and failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents.

5. Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. [Minn. Stat. 144G.45 subd.2]

Comments: The licensed assisted living director (LALD)-A lacked documentation that showed training was provided to employees on the facility-specific FSEP upon hire and at least twice per year.

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

Comments: LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan.