



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 12, 2026

Licensee
Caring Squads LLC
380 York Avenue
Saint Paul, MN 55130

RE: Project Number(s) SL39960016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 11, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the facility must take action to correct the state correction orders and document the actions taken to comply in the facility's records. The Department reserves the right to return to the facility at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility.**

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>

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

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

If you have any questions, please contact me.

Sincerely,



Renee Anderson, Supervisor

State Evaluation Team

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

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39960	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER CARING SQUADS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 380 YORK AVENUE SAINT PAUL, MN 55130			
(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: SL39960016-0 On December 8, 2025, through December 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were three residents; three receiving services under the 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

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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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated December 9, 2025, 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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0 680	Continued From page 3	0 680			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a written emergency disaster plan with all required content. This had the potential to affect all three residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 680			

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0 680	Continued From page 4 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: On December 10, 2025, at 12:00 p.m., the surveyor reviewed the licensee's emergency preparedness plan. The licensee's undated plan lacked the following required content: -current, all-hazards approach facility risk assessment; -description of the population served by licensee; -process for emergency preparedness (EP) cooperation with state and local EP officials/organizations; -subsistence needs for staff and residents during emergency situation; -procedure for tracking staff and residents; -development of all policies/procedures, based on assessment; and additional policies for: -potential evacuation; -sheltering in place; -handling medical documents; -handling and use of volunteers; -missing resident policy reviewed quarterly; -documented arrangement with other facilities (including sister facilities); -primary and alternate means for communication; -methods for sharing information; -EP training and testing program; -EP training program for staff (including documentation of training provided); and -annual EP testing requirements. On December 11, 2025, at 10:07 a.m., clinical	0 680			

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0 680	Continued From page 5 nurse supervisor (CNS)-B stated the licensee's administrative staff would complete the EP plan specific to the licensee's surroundings and residents' medical conditions. CNS-B stated they were not aware of all the required content. The licensee's undated Emergency Preparedness Manual indicated "an effective emergency preparedness plan is key for assisted living facilities as part of the community committed to meeting the national goal to prevent, protect against, mitigate, respond to, and recover from the threats and hazards that pose the greatest risk to the care and services of residents and to provide continuity of care and services during an emergency." The "current standards for emergency preparedness planning include the following: an all-hazard approach to identify most likely emergencies in the agency's service area, continuity of operations during the emergency, use of the Incident Command System, patient management strategies, testing and training requirement for staff and patients." No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810			

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0 810	Continued From page 6 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 810			

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0 810	Continued From page 7 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 December 10, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty one (21) days	0 810			
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060			

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01060	Continued From page 8 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, or designated representative and failed to provide the notice to the Office of Ombudsman for Long-Term Care (OOLTC) when the emergency relocation was greater than four (4) days for one of one resident (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	01060			

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01060	Continued From page 9 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: R2 was admitted on August 1, 2025, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD). R2's Nurse Reassessment Visit, dated October 21, 2025, indicated R2 was transported via paramedics to a local hospital, and was hospitalized from October 15, 2025, through October 21, 2025. R2's record lacked documentation R2 or R2's designated representatives were provided a written emergency relocation notice with the following required content: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; -if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. Additionally, R2's record lacked documentation the OOLTC was provided the written notice when	01060			

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01060	Continued From page 10 the resident did not return within four days. On December 11, 2025, at 10:07 a.m., clinical nurse supervisor (CNS)-B stated she was unable to locate documentation of a written notice or ombudsman notification of R2's hospitalization, completed by the previous CNS. CNS-B stated, going forward, the licensee will ensure the notice is completed, as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
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 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	01940			

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01940	Continued From page 11 (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 observation, interview, and record review, the licensee failed to develop an individual treatment and therapy management record with all required content 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: R2 was admitted on August 1, 2025, with diagnoses to include Chronic Obstructive Pulmonary Disease (COPD). R2's Individualized Service Plan Agreement dated August 1, 2025, indicated services include medication administration, transfer assistance, and catheter care. On December 9, 2025, at 8:07 a.m., the surveyor	01940			

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01940	Continued From page 12 observed R2 laying in bed with a catheter drainage bag hanging on the side of the bed. R2 stated the licensee staff empty and change the bag, as needed. R2's Individualized Treatment or Therapy Management Plan, dated December 3, 2025, documented R2's services included blood glucose monitoring, catheter care, and range of motion (ROM). The plan indicated R2 was not independent in the treatment tasks and required staff assistance for safety and accuracy. On December 9, 2025, at 8:07 a.m., clinical nurse supervisor (CNS)-B stated unlicensed personnel (ULP)'s were trained to change R2's catheter bag to a leg bag with morning cares and back to a drainage bag with evening cares. CNS-B stated the bags would be cleaned with vinegar and water with each bag change, although no written instructions were documented for cleaning of the catheter bags. R2's undated Treatment Plan documented "staff" were to empty the catheter bag daily and as needed. The plan lacked instructions regarding catheter bag cleaning and maintenance. R2's individual treatment and therapy record lacked: -documentation of specific resident instructions related to the treatment or therapy administration, and -any resident-specific requirements related to documentation of treatment and therapy received, verification that all treatment and therapy were administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39960	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER CARING SQUADS LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 380 YORK AVENUE SAINT PAUL, MN 55130			
(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 13 The licensee's Individualized Treatment or Therapy Management Plan form, dated December 3, 2025, indicated the treatment plan would include specific requirements relating to documentation and instructions of treatment and therapy services provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
CARING SQUADS LLC 380 York Avenue St Paul, MN 55130 Ramsey County Parcel: Phone:	License: HFID 39960 Risk: License: Expires on: CFPM: Amina Mursam Adan CFPM #: 35901; Exp: 7/7/2026	Report Number: F1013251124 Inspection Type: Full - Single Date: 12/9/2025 Time: 12:30 pm Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 1</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 2</u> <u>Delivery:</u>

- ! 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: SWEET ROLL DOUGH PACKAGES WERE STORED IN THE KITCHEN CABINETS AT ROOM TEMPERATURE. PER MANUFACTURER LABEL THE FOOD MUST BE REFRIGERATED. COMPLY WITH RULE. FOOD WAS DISCARDED.
Comply By: Complied On Site Originally Issued On: 12/9/2025
- New Order: 4-200 Equipment Design and Construction**
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: COOKED PASTA AND MEATBALLS FROM THE PREVIOUS DAY WERE INSIDE THE KITCHEN REFRIGERATOR. PER STAFF THE FOOD WAS PURCHASED FOR A CLIENT AND LEFTOVERS WERE SAVED. COMPLY WITH RULE. DISCUSSED SAME DAY SERVICE AND THE FOOD WAS DISCARDED.
Comply By: Complied On Site Originally Issued On: 12/9/2025
- New Order: 4-500 Equipment Maintenance and Operation**
4-502.13 *Priority Level: Priority 3 CFP#: 45*
MN Rule 4626.0830 Discontinue re-use of any single-service and single-use articles.
COMMENT: HOT SAUCE BOTTLE STORED ON THE KITCHEN COUNTER WAS USED TO STORE VEGETABLE OIL. COMPLY WITH RULE. DISCUSSED USING APPROVED CONTAINERS THAT CAN BE WASHED, RINSED, AND SANITIZED.
Comply By: Complied On Site Originally Issued On: 12/9/2025

Food & Beverage General Comment

Joint inspection with MDH N. Streeter.

The inspection was completed with the operator. The report was provided to the operator and MDH Nurse Evaluator J. Bertelsen.

The establishment has a residential kitchen. The kitchen has laminate cabinets, vinyl plank floor, metal tile walls, granite counter top, and a textured painted ceiling.

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

Residential dish machine is available to wash ware. The dish machine should be run on the sanitize/high temperature cycle.

Discussed hand washing, ware washing, staff illness policy, temperature control, final cook temperatures, cleaning, serving highly susceptible populations, food storage, 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 F1013251124 from 12/9/2025



Amina Mursam Adan
Operator

Jerry Malloy,
Public Health Sanitarian Supervisor
651-201-3998
jerry.malloy@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

CARING SQUADS LLC
St Paul
County/Group: Ramsey County

Inspection Info

Report Number: F1013251124
Inspection Type: Full
Date: 12/9/2025
Time: 12:30 pm

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

Location: Kitchen refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Kitchen refrigerator at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
CARING SQUADS LLC	Report Number: F1013251124
St Paul	Inspection Type: Full
County/Group: Ramsey County	Date: 12/9/2025
	Time: 12:30 pm

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 184 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL39960016-0	Date: December 10, 2025
Facility Name: CARING SQUADS LLC	
Facility Address: 380 YORK AVE, SAINT PAUL, MN, 55130	

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans 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, from a third-party consultant, included standard employee procedures but 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).

2. 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. Facility had resident procedures in a different policy/plan and will add to the FSEP.

3. 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 facility used paper documents for standard resident evacuation procedures. The documentation was blank and failed to show the evacuation status, list special tools or needed equipment and resident room location was not listed.

4. 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: Surveyor requested all staff training on the FSEP from the house manager (HM)-D. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. HM-D stated the facility is using fire drills for staff training, and an electronic based training website. No other staff training documentation was provided.

5. 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: Surveyor requested all resident training documents on the FSEP from the HM-D. The licensee failed to provide evacuation training to residents at least once per year. 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

6. Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. [Minn. Stat. 144G.45 subd.2]

Comments: Surveyor requested all evacuation drill reports from HM-D. The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. Evacuation reports show drills happened every other month at the same time for only one shift and one staff member. No other documentation was provided.