



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 30, 2024

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

RE: Project Number(s) SL39960015

Dear Licensee:

This is your **official notice** that you have been **granted your assisted living facility license**. Your license effective and expiration dates remain the same as on your provisional license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 60 days prior to your expiration date, please contact us at (651) 201-5273 or by email at Health.assistedliving@state.mn.us.

The Minnesota Department of Health completed an initial survey on March 25, 2024, for the purpose assessing compliance with state licensing statutes. At the time of the survey, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. The Department of Health documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care 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 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

Per 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 residents/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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state correction order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:

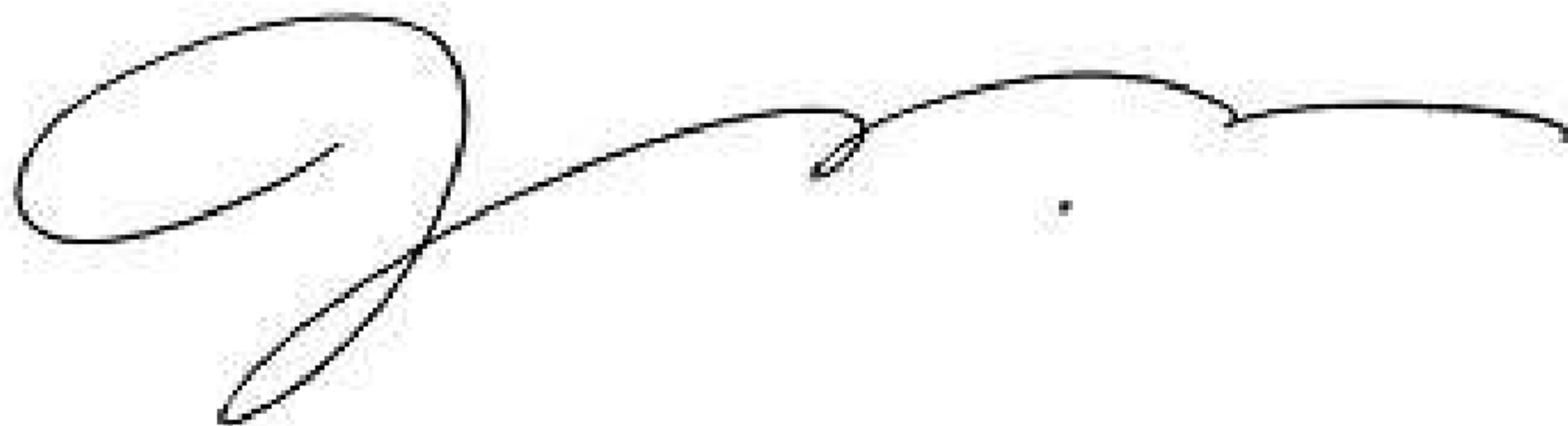
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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,

A handwritten signature in black ink, appearing to read 'Jess Schoenecker', with a stylized, flowing script.

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

PMB

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 03/25/2024
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 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: SL#39960015 On March 18, 2024, through March 25, 2024, 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 no (0) active residents, and no (0) residents receiving services under the Provisional Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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 ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee through the Board of Executives for Long-Term Service and Supports (BELTSS) website. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: LALD/clinical nurse supervisor (CNS)-B was licensed as a LALD on September 13, 2021. On March 18, 2024, at 10:15 a.m. during the entrance conference, agent/registered nurse (A/RN)-A stated they were not aware that LALD/CNS-B was required to identify themselves as the Director of Record on the BELTSS website. A/RN-A stated LALD/CNS-B would log into the BELTSS website to identify themselves as the Director of Record. The BELTSS website accessed on March 13,	0 110			

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0 110	Continued From page 2 2024, at 12:13 p.m., indicated LALD/CNS-B was licensed but was not listed as the Director of Record for any licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) when the licensee failed to complete a facility TB risk assessment.	0 660			

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0 660	Continued From page 3 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On March 18, 2024, at approximately 11:00 a.m. during the entrance conference, agent/registered nurse (A/RN)-A acknowledged the licensee had not completed a facility TB risk assessment. A/RN-A stated the licensee was not aware of the facility TB risk assessment requirement and one was not completed. The licensee's Tuberculosis Screening/Prevention policy dated February 13, 2023, indicated a facility TB risk assessment would be completed annually. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2023, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease and assessing TB history. No further information provided. TIME PERIOD FOR CORRECTION:	0 660			

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0 660	Continued From page 4 Twenty-One (21) days	0 660			
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 and interview, the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all visitors, employees, and residents.	0 680			

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0 680	Continued From page 5 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: On March 18, 2024, at approximately 12:30 p.m., agent/registered nurse (A/RN)-A provided a binder and indicated the contents were the licensee's EPP. The licensee's EPP dated 2023, lacked documentation including all the required elements of: -annual review; -missing resident quarterly review; -description of the population served by licensee; -process for EP cooperation with state and local EP officials/organizations; -development of all policies/procedures (P/P), based on HVA assessment; -development of a communication plan; and -EP training and testing program. On March 18, 2024, at approximately 1:00 p.m., A/RN-A acknowledged the licensee's EPP lacked the above listed required content. A/RN stated the licensee's EPP was a work in progress and was not aware of the requirements of Appendix Z. The licensee's Emergency Preparedness policy dated February 13, 2023, indicated the licensee would have an EPP in place to assure the safety and well-being of residents and staff during	0 680			

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0 680	Continued From page 6 periods of an emergency or disaster that disrupts services and will be reviewed/updated at least annually. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the portable fire extinguishers as required by statute. This deficient condition had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive	0 790			

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0 790	Continued From page 7 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: On March 18, 2024, at 11:40 a.m., survey staff toured the home with registered nurse (RN)-A. During the tour, survey staff observed the back of the tags attached to the portable fire extinguishers were blank. No records for monthly fire extinguisher inspections were provided. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During an interview on March 18, 2024, at 11:40 a.m., RN-A verified monthly inspections had not been completed and stated they were unaware of the monthly fire extinguisher inspection requirement. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790			
0 810 SS=F	144G.45 Subd. 2 (b)-(f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement,	0 810			

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0 810	Continued From page 8 evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to develop a fire safety and evacuation plan with the required content and provide required drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	0 810			

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0 810	Continued From page 9 On March 18, 2024, the licensee provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and employee evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The FSEP included a Fire Safety policy dated February 13, 2023. This policy was a third-party consultant provided plan, and it was not updated to meet the facility-specific layout and environmental risks. The FSEP fire safety policy 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 employee actions for fire were limited to the acronym RACE (Remove, Alarm, Confine, and Extinguish or Evacuate). The FSEP fire safety policy failed to provide specific fire protection procedures for residents evident by limited instructions directing residents to stoop or crawl to avoid smoke. No additional fire protection procedures necessary for residents were included. The FSEP fire safety policy directs employees to evacuate residents from the building but failed to include these procedures. The FSEP failed to include information on where residents should relocate to in the event of a fire. During an interview with survey staff on March 20, 2024, at 9:00 a.m., owner/registered nurse (O/RN)-D verified the FSEP was a template and required more detail. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month as evident by a review of the completed fire drill lacking the required frequency. Two fire drills were recorded in September 2023.	0 810			

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0 810	Continued From page 10 During an interview on March 20, 2024, at 9:00 a.m., O/RN-D verified there were no additional fire drill records and stated the facility has not had any residents since November 2023, the one resident moved out on October 30, 2023. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01620 SS=F	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (c) Resident reassessment and monitoring must be conducted no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment. (d) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (e) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under 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:	01620			

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01620	Continued From page 11 Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing resident monitoring and reassessment no more than 14 days of initiation of services for one resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1 was admitted on August 28, 2023, and discharged on October 30, 2023. R1's Initial Assessment was completed on August 28, 2023, with the next assessment due within 14 days or by September 11, 2023. R1's record did not include any subsequent assessments. On March 18, 2024, at 1:30 p.m., agent/registered nurse (A/RN)-A stated was unsure if R1's 14-day assessment was completed because licensee was transitioning to RTasks electronic charting during that time. The licensee's Assessments and Reassessment policy dated February 13, 2023, indicated licensee would complete resident reassessment no more than 14 days after initiation of services. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			

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 03/25/2024
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	



Minnesota Department Of Health
Food, Pools, and Lodging Services
P.O. Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: 03/20/24
Time: 21:03:53
Report: 1050241058

Food and Beverage Establishment Inspection Report

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Location:

CARING SQUADS LLC
380 YORK AVENUE
St Paul, MN55130
Ramsey County, 62

Establishment Info:

ID #: 0042469
Risk:
Announced Inspection: No

License Categories:

Expires on: 12/31/24

Operator:

Phone #:
ID #:

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

No NEW orders were issued during this inspection.

Total Orders	In This Report	Priority 1	Priority 2	Priority 3
		0	0	0

Inspection was completed with the Nkeira Adoga. Carl Samrock was the lead Health Regulation Division Nurse Evaluator. Facility had zero residents on site at time of inspection. Meals are prepared on site. This establishment has a residential kitchen. The kitchen has wood cabinets with a hollow base and wood flooring and granite countertops. All found to be in new condition.

Frigidaire dish machine was tested using thermal label and had a utensil surface temperature of at least 182F.

Discussed the following:

- Employee illness policy and logging requirements
- Handwashing
- Glove-use and bare hand contact
- Food storage and preventing cross contamination
- Date marking
- Vomit clean up procedures
- Restrictions concerning serving a highly susceptible population

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

I acknowledge receipt of the Minnesota Department Of Health inspection report number 1050241058 of 03/20/24.

Certified Food Protection Manager Nkeira O. Adoga

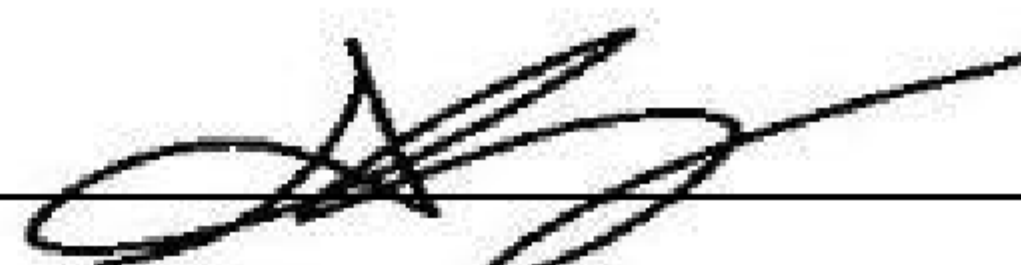
Certification Number: FM116826 Expires: 04/17/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Nkeira O. Adoga
Owner/Operator

Signed: _____


Andrew Spaulding
Public Health Sanitarian 2
FPLS Metro
651-201-5298
andrew.spaulding@state.mn.us