

HEALTH REGULATION DIVISION
NOTICE OF REFUSAL TO RENEW

In the Matter of Caring Rose Homes LLC
449 Aurora Ave
St. Paul, MN 55103

MDH HFID # **36815**

IT IS ORDERED that the Minnesota Department of Health ("Department" or "MDH") refuses to renew the assisted living facility license for Caring Rose Home LLC (Caring Rose), license number 422990, under the provisions of Minnesota Statutes Section 144G.20 Subd. 1, as explained below.

Facts and Law:

1. Minn. Stat. Ch. 144G authorizes the Department to regulate assisted living facilities in Minnesota. This authority includes issuing assisted living facility licenses, conducting surveys to determine compliance with the assisted living laws, and conducting complaint investigations of alleged violations of the assisted living facility laws. The Commissioner of Health is also authorized to refuse to renew an assisted living facility license pursuant to Minn. Stat. § 144G.20, Subd. 1 if certain conditions occur.
2. On August 1, 2021, MDH issued an assisted living facility license to Caring Rose. The most recent renewal of the license was effective September 1, 2025, and expires on August 31, 2026.
3. On June 29, 2026, to July 7, 2026, Department surveyors from the Health Regulation Division entered the Caring Rose facility, HFID 36815, to conduct a survey under Minn. Stat. § 144G.30. The survey findings resulted in forty-one (41) total correction orders (deficiencies); there were five (5) Level 3 violations and one (1) Level 4 violation. The current average number of correction orders for assisted living facilities is ten (10).
 - a. A Level 3 citation is 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
 - b. A Level 4 citation is a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury or death
4. As a result of the survey MDH initiated on June 29, 2026, MDH determined the facility violated the following laws:
 - a. Minn. Stat. § **144G.10, Subd. 1**, no assisted living facility may operate in Minnesota unless it is licensed under Chapter 144G, when the licensee was operating an assisted living facility in an unlicensed building.

- i. Caring Rose completed license relocation requirements on November 17, 2025, which allowed them to move to the 449 Aurora Ave. location in St. Paul. The license effective date was updated to reflect December 3, 2025.
- ii. During the survey initiated on June 29, 2026, while speaking with staff at the facility at 8:30 a.m., the surveyor learned of an emergency evacuation due to flooding at the licensed facility in December 2025, to an address registered as a vacation rental home; 970 Western Avenue North in St. Paul.
- iii. The undated emergency preparedness plan for Caring Rose, located at 1043 Hague Ave. in St. Paul (the facility's pre-relocation address) indicated, "If family has not agreed to be responsible party during an emergency, our agency will continue services or reach out to another home care agency, nursing home or assisted living who may be able to care for them." In the case of an evacuation, the plan directed staff to bring residents to the host site: Holiday Inn, 175 7th St. W. in St. Paul; three miles from the facility.
- iv. The undated emergency preparedness plan also indicated the facility would keep the Office of Ombudsman for Long-Term Care abreast of evacuations and status. On Friday, June 26, 2026, per routine preparation for a survey, the surveyor reached out to the regional ombudsman (RO) and asked if any relocation notices were received by them; the RO responded none had been received.
- v. The flooding occurred on December 19, 2025, and water clean-up was initiated on December 22, 2025. There was one resident residing at the facility during this time; he moved to the upper level on approximately January 1, 2026. The licensee moved the resident and business operations to the (unlicensed) Western Avenue North location on February 24, 2026, and remained there at the time of the survey.
- vi. Per Minn. Stat. § 144G.45, Subd. 6 (a), any construction required as of August 1, 2021, architectural and engineering plans and specifications for new construction must be prepared and signed by architects and engineers who are registered in Minnesota. No plans were submitted for review. Cosmetic fixes, such as painting, do not require a plan review. In addition, the licensee did not notify the City of St. Paul as to the extent of the damage. There were no obvious repairs observed in the licensed facility during the survey.
- vii. On June 29, 2026, at 10:41 a.m., the (engineer) surveyor saw an active plumbing leak in the basement of the (licensed) 449 Aurora Ave. building. There was water dripping from the ceiling in the basement living-room area with a bucket on the ground catching the water dripping from the ceiling. The surveyor asked unlicensed personnel (ULP)-A if she was aware of the leak and if it was being addressed. ULP-A stated that there was no leak and that a previous plumbing leak in the first-floor bathroom had already been repaired. When the surveyor pointed out the water actively dripping from the ceiling and dropping into a bucket on the floor,

ULP-A stated she thought the dripping water could be caused by the air conditioner.

- b. Minn. Stat. § **144G.10, Subd. 1a**, each assisted living facility must employ an assisted living director licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS), when the licensee did not employ a Licensed Assisted Living Director (LALD) since November 1, 2025. An Assisted Living Director (ALD) is the person who administers, manages, supervises, or is in general administrative charge of a Minnesota licensed assisted living facility.
 - i. On June 28, 2026, at 8:36 a.m., ULP-A stated, via phone, she had a temporary ALD permit and was in the process of completing her training to become an LALD. At 10:20 a.m., she also stated the previous LALD was the director of record for the licensee from September 10, 2025, through October 31, 2025. ULP-A stated the licensee has been searching for a new LALD since October 2025 and has been unable to fill the position.
 - ii. On June 29, 2026, at 12:55 p.m., Director of Assisted Living and Education for Minnesota BELTSS, indicated, via email, "She (ULP-A) applied on June 16, 2026, and we sent her paperwork needing to be completed, however have had no response from her. She has 30 days to obtain her permit from the date she began in the role. We have no known association with this facility for her. The last (Director of Record) DOR was [LALD-E] through 10/31/25."
 - iii. As of July 1, 2026, at 8:46 a.m., the BELTSS website depicted the licensee had no current licensed or permitted LALD of record.
- c. Minn. Stat. § **144G.41, Subd. 1 (13)**, all assisted living facilities shall provide staff access to an on-call registered nurse 24 hours per day, seven days per week, when the licensee did not have a Registered Nurse (RN) employed for approximately two months and then hired one to only provide medication set-up for the two residents.
 - i. On June 29, 2026, at 1:24 p.m., the facility's prior RN stated via phone call with the survey supervisor that she had not worked for the licensee since January 2026.
 - ii. On June 29, 2026, at 11:30 a.m., ULP-A stated, RN-B was hired as the licensee's registered nurse on March 26, 2026.
 - iii. According to Minn. Stat. § 144G.62, Subd. 1, all assisted living facilities must have an RN available for consultation by staff performing delegated nursing tasks. Unlicensed staff were observed during the survey performing delegated nursing tasks, such as medication administration.
 - iv. On June 29, 2026, at approximately 11:30 a.m., RN-B stated she currently worked full time as Director of Nursing (DON) at a skilled nursing facility; approximately a one and one-half hour drive from the licensee's assisted living facility. On June 30, 2026, at 1:02 p.m., RN-B stated, via phone, the licensee hired her to assist with weekly medication set up for the two residents and that ULP-A told her the owner/ULP (O/ULP)-C was the DON

- for the facility. There is no one listed on the Minnesota Board of Nursing with a license under the same name as O/ULP-C. RN-B was told her only role was to complete medication set ups for the licensee's two residents.
- v. On June 30, 2026, at 1:02 p.m., RN-B further stated after she was hired, she asked about nursing assessments that needed to be completed for the two residents, and ULP-A then agreed to give RN-B access to the licensee's online medical record to also complete resident assessments. RN-B stated she was not hired to provide on-call 24 hours a day, seven days per week nursing coverage for the licensee. RN-B also stated she never received a job-description, any orientation, nor training prior to beginning her employment. She was shocked during the survey when ULP-A told the surveyor RN-B was the licensee's clinical nurse supervisor (CNS) on-call 24 hours a day, seven days per week. RN-B terminated her employment with the licensee, effective at the week's end (July 3, 2026).
- d. Minn. Stat. § **144G.45, Subd. 2 (b-f)**, each assisted living facility shall develop and maintain fire safety and evacuation plans, when the facility did not have a current, up-to-date fire safety and evacuation plan.
- i. The fire safety and evacuation plan (FSEP) was written for the address 1043 Hague Ave in St. Paul which was a previous facility location that they are no longer operating at. The document also indicated the licensee has an Assisted Living with Dementia Care license, which is inaccurate; and the "first person in charge" and the "alternate contact person" to contact for emergencies are no longer employed by the facility.
 - ii. The FSEP did not provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout (both licensed and unlicensed locations) and environmental risks. The FSEP provided by the facility was from an (outdated) third-party provider and had not been updated to the specific location(s).
 - iii. On June 30, 2026, at 11:19 a.m. ULP-A stated that they did not have a written policy that discussed resident actions to take in the event of a fire or similar emergency. ULP-A stated that they do not have any records of residents receiving training on the FSEP. No training records for residents were provided during the survey.
 - iv. On June 30, 2026, at 11:20 a.m. ULP-A stated that staff received training on the facility's FSEP quarterly. ULP-A also stated that they did not have any written record of staff receiving training on the FSEP available on site. No staff training records were provided for review during the survey. ULP-A stated that they do not have a written record of evacuation drills. No drill records were provided during the survey.
- e. Minn. Stat. § **144G.71, Subd. 8**, documentation of administration of medications, when the licensee did not ensure medications were administered as prescribed.
- i. A resident (R2) who was admitted on June 25, 2024, had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality

disorder, polysubstance use, and mild intellectual disability. R2's unsigned service plan, dated June 16, 2026, indicated R2 received medication administration five times daily. R2's most recent assessment dated June 26, 2026, indicated R2 was unable to self-administer his own medications. R2 was also under a Jarvis order (a civil commitment that requires persons with mental illness to take neuroleptic/antipsychotic medications).

- ii. On June 30, 2026, at 8:33 a.m., ULP-A assisted R2 with medication administration. Some of the medications were set up in a daily dose box; ULP-A knew others were in prescription bottles. ULP-A stated she knew one medication was not included in the pack and retrieved a prescription bottle from the locked box for Celebrex (for inflammation and pain). ULP-A then asked R2 what "as needed" (PRN) medications he wanted to take that morning. ULP-A retrieved two additional medications, a muscle relaxant and a medication for anxiety, adding them all to a med cup. ULP-A did not follow the "rights" of medication administration and verify the medications against R2's medication administration record (MAR), before she observed R2 swallow the medications from the paper med cup.
 1. ULP-A documented medications administered from the daily dose box on a paper MAR. She did not document the muscle relaxant administration because it was not included on either R2's electronic or paper MAR for June 2026.
 2. ULP-A's employee file reflected that she received training on how to properly administer medication.
- iii. A hospital Psychiatry Department Admission document dated June 14, 2026, indicated, on June 13, 2026, R2 was "admitted for agitation and psychosis from assisted living facility in the context of chronic medical conditions, chronic psychiatric conditions, non-adherence to both psychiatric and medical treatment, conflict with caseworker, and poor insight. The patient is being admitted on a 72-hour hold."
- iv. R2's hospital discharge orders dated June 26, 2026, included new orders for Aripiprazole (used to treat bipolar disorder), take one tablet daily for 13 days; melatonin (used for insomnia), take three tablets at bedtime as needed for sleep; and to continue taking hydroxyzine (used to treat anxiety), take one capsule by mouth twice daily as needed.
- v. R2's *electronic version* MAR dated June 1 to July 2, 2026, depicted the following:
 1. aripiprazole 20 mg, one tablet by mouth "one time a day in the morning starts 6/26 01:51 PM"
 2. the medication (aripiprazole) was not given on June 27, 28, 29, and 30, 2026
 3. no end date to identify when the 13 doses (of aripiprazole) were expected to be complete
 4. hydroxyzine 25 mg (daily) give 1-2 tablets (25-50 mg) by mouth every four hours as needed for anxiety or itching

5. an entry on June 28, 2026, documented as "1". The entry did not match the prescription order; no dosage or time indicated; no initials indicating who administered the medication; and no documentation of follow-up for effectiveness of the PRN medication
- vi. R2's *paper version* MAR dated June 1 to July 2, 2026, depicted the following:
 1. aripiprazole 20 mg tab, "give one 20 mg by mouth one time in the morning". It was documented as administered June 27-30, at 7:00 a.m., and July 1-2 at 7:00 a.m.
 2. "ariprazole [sic] 20 mg tablet, take one tablet once daily". It was documented as administered June 27-30, at 9:00 a.m. July 1 at 9:00 a.m., and 9:00 p.m., and on July 2 at 9:00 a.m.
- vii. The duplication of medication transcription indicated aripiprazole was administered twice daily in June rather than once daily; three times on July 1; and twice on July 2, rather than once daily.
- viii. Neither R2's electronic nor paper MARs included the melatonin order.
- ix. R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including medication administration four times daily.
- x. R3's record included a provider office visit summary dated June 2, 2026, indicating R3 was seen by her provider for a possible urinary tract infection (UTI). The visit note indicated the provider ordered Macrobid (nitrofurantoin-an antibiotic) 100 mg, oral capsule; take one capsule by mouth twice daily for five days.
- xi. R3's MAR did not include any transcription of the medication order (antibiotic), nor administration of it.
 1. On July 6, 2026, at 6:28 a.m., ULP-A stated she did not recall Macrobid being prescribed at R3's office visit on June 2, 2026.
 2. On July 6, 2026, at 6:39 a.m., RN-B stated she was not aware R3 had an office visit on June 2, 2026. RN-B said she was not updated by the licensee about this provider visit or any new orders as a result of this appointment.
- xii. On June 30, 2026, at 8:44 a.m., ULP-A assisted R3 with medication administration. Again, ULP-A did not follow the "rights" of medication administration and verify the medications against R3's MAR, before administering the medications. After administering the medications, ULP-A documented the medications in R3's *paper* MAR.

- xiii. In addition to a paper MAR, R3 also had an *electronic* MAR which depicted the following discrepancies:
 - 1. metformin 500 mg, "take 2 tablets by mouth (1000 mg), twice every day (Starts: 06/15 03:00 PM)". Documentation indicated administration at "AM" on June 16-18, 20, 22, 26-30, 2026
 - 2. metformin 500 mg, "give 2 - 500 mg tabs (1000 mg) by mouth, two times day [sic], Starts 06/15 03:16 PM". Documentation indicated administration at "AM" on June 16-18, 20, 22, 26-30, 2026, and at "PM" on June 18, 22, 24, and 26-30, 2026. The documentation indicated the medication was administered three times rather than twice daily on June 18, 22, and 26-30, 2026
 - 3. no documentation to indicate why metformin (used to treat diabetes) was not administered as ordered June 19-21 and 23-25, 2026
 - 4. hydroxyzine (daily), give one 25 mg tablet up to 3 dose [sic] in a 24-hour period by mouth (Starts: 06/15 03:55 PM); the MAR did not indicate any doses were administered in June 2026.
 - xiv. On June 30, 2026, at 8:33 a.m., ULP-A stated the licensee's electronic MAR was not functioning well at times, so the licensee used a paper MAR for resident medication administration documentation. She further stated she did not check the electronic or paper MAR before administering R2 and R3's medications; she does the medications for these residents every day and "knows the medications the residents receive".
 - xv. On July 6, 2026, at 6:19 a.m., ULP-A stated, she created R2 and R3's paper MARs on her computer. ULP-A verbalized she was the person who updated the paper MARs by copying the information from the residents' electronic medical record.
 - xvi. After observation, interview and record review related to medication administration for R2 and R3, due to the multitude of noncompliance, the surveyor was unable to determine what medications were administered, if the medications administered were administered according to provider orders, and if unlicensed staff were administering as-needed medications appropriately.
- f. Minn. Stat. § **144G.72, Subd.5**, documentation of administration of treatments and therapies, when the licensee did not ensure treatments were administered as ordered.
- i. A resident (R3) who was admitted on June 1, 2026, and had diagnoses including type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received

medication administration four times daily and to record weight two days per week.

- ii. On June 3, 2026, R3 was seen by a medical provider. The visit summary from the appointment indicated R3 had a urinary tract infection and R3 would use a continuous glucose monitor (CGM) to be replaced every 14 days because "[R3] requires regular glucose monitoring, and self-monitoring blood glucose is currently inadequate. To improve optimal blood sugar control CGM is medically necessary for this patient." The summary indicated R3 would have a visit to follow up on blood glucose levels on July 28, 2026.
 - a) The Centers for Disease Control and Prevention guidance, Your Immune System and Diabetes, dated May 15, 2024, indicated, High blood sugar can ...damage your internal organs over time...it's harder to fight off infections. Research shows that people with diabetes can have more frequent illnesses like... urinary tract infections (UTIs).
- iii. R3's record included an Individualized Treatment and Therapy Plan last updated June 18, 2026. The plan indicated blood pressure monitoring, to be provided daily by unlicensed personnel, but did not include information related to blood glucose monitoring. The plan further indicated, "RN - Review the previous weeks blood sugar and blood pressure values".
- iv. On June 30, 2026, at 8:55 a.m., ULP-A stated R3 refused to allow the nurse to place her (R3) CGM to monitor her blood glucose levels since she moved into the facility (June 1, 2026).
- v. R3's record did not include regular (ordered) blood glucose results, nor daily blood pressure readings. Only two notes were found in R3's record addressing the blood glucose noncompliance. On June 18, 2026, "Nurse Note, Reviewed medications and visited with resident. She does not want [sic] to take her blood glucose levels. MD notified". On June 30, 2026, "Record - Blood Glucose REFUSED." There was no further contact made with the prescribing medical provider, nor any follow-up measures provided to meet the needs of R3.
- vi. The electronic record, Service Recap Summary for June 2026, indicated the licensee assisted R3 with blood glucose and blood pressure monitoring on June 26-29, 2026. The documentation lacked documentation of regular blood glucose monitoring or daily blood pressure monitoring on any other days in June, or documentation of refusal and follow-up actions.
- vii. The paper record, "Mental Health/Health Related/ADL Record" for June 2026, indicated the licensee assisted R3 with checking "vital signs" weekly on the following dates: June 5, 12, 19, and 26. The paper record did not include documentation of regular blood glucose monitoring nor daily

- blood pressure monitoring on any other days in June; no documentation of refusal and follow-up actions were completed.
- viii. R3 was seen on June 27, 2026, by a medical provider for pelvic pain and was diagnosed with a yeast infection.

[These violations are elaborated in the attached state form, enclosure 1.]

5. On July 12, 2026, MDH received an application to renew the assisted living facility license for Caring Rose Homes LLC (HFID 36815). The license has not been renewed as of the date of this notice.
6. In conclusion, MDH determines that these violations support a refusal to renew.
 - a. The overall lack of leadership with the failure to employ a Licensed Assisted Living Director to oversee, supervise and be in general administrative charge of the facility, placed the residents at imminent risk of harm.
 - b. The facility failed to provide the required level of registered nurse (RN) availability to staff, and additionally a Clinical Nurse Supervisor as required by Minn Stat. 144G.41 Subd. 4. An RN must be readily available to staff when they are performing nurse delegated tasks. Without this required clinical oversight, it poses an imminent risk to the residents' health, safety, and well-being.
 - c. The licensee was operating out of an unlicensed facility that had not undergone proper MDH engineering plan review and approval. As a result, there were several physical environment items of concern including an egress window in R2's bedroom that was too high for safe egress in case of a fire, and smoke alarms that were not interconnected as required. This poses an imminent risk to the safety of the residents, staff and visitors.
 - d. The licensee did not allow the RN access to the residents' complete records and initially only allowed the RN 20 minutes per week to set up medications for the residents. Two weeks prior to the survey, the RN demanded the licensee allow her to complete (resident) assessments so that she can properly manage the medications. This was granted, however that was the only oversight the RN had for the facility and the residents. As a result, the treatment plans and medication management were critically compromised and caused imminent risk of harm to the health of the residents.
7. The foregoing violations constitute grounds to refuse to renew a license under Minn. Stat. § 144G.20, Subd. 1(a)(1), (3), (5), (13), and (14).

Current Status and Requirement for Transition Plan

This letter notifies you that MDH is refusing to renew assisted living facility license number 422990 (HFID 36815).

1. Pursuant to Minn. Stat. § 144G.20, Subd. 12, within five business days of receipt of this notice, you are required to provide to MDH, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities the names

of residents and the names and addresses of the residents' designated representatives and legal representatives, and family or other contacts listed in the assisted living contract. The controlling individual or designees of the facility must provide updated information each month until the proceeding is concluded. If the controlling individual or designee of the facility fails to provide the information within this time, the facility is subject to the issuance of a correction order; a \$500 fine the first day of noncompliance; and an increase in the \$500 fine by \$100 increments for each day the noncompliance continues.

2. You may appeal this decision.

1. Minn. Stat. § 144G.20, Subd. 13, states you are entitled to a contested case hearing under Minn. Stat. § 14.57 to 14.69.
2. Minn. Stat. § 144G.20, Subd. 18, states to appeal “an action against a license under this section, a licensee must request a hearing no later than 15 business days after the licensee receives notice of the action.”

3. The appeal must be made in writing by mail or delivered to MDH, per Minn. Stat. § 144G.20, Subd. 14, and must contain “a brief and plain statement describing every matter or issue contested” and “a brief and plain statement of any new matter that the applicant or assisted living facility believes constitutes a defense or mitigating factor.” The appeal can be sent to the following address:

Reconsideration Unit, Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
625 Robert Street North
Saint Paul, MN 55155

4. Minn. Stat. § 144G.20, Subd. 16 states “Within 15 business days of receipt of the licensee's timely appeal of a sanction under this section, other than for a temporary suspension, the commissioner shall request assignment of an administrative law judge. The commissioner's request must include a proposed date, time, and place of hearing. A hearing must be conducted by an administrative law judge pursuant to Minnesota Rules, parts 1400.8505 to 1400.8612, within 90 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause or for purposes of discussing settlement. In no case shall one or more extensions be granted for a total of more than 90 calendar days unless there is a criminal action pending against the licensee.”
5. **If you do not request a hearing** within 15 business days of your receipt of this notice, or if an appeal of the refusal to renew is withdrawn or dismissed, this Notice will become the Commissioner’s order of refusal to renew. You must provide MDH, county adult protection and case managers, the ombudsman for long-term care, and the Office of Ombudsman for Mental Health and Developmental Disabilities, the information described in Minn. Stat. § 144G.20, Subd. 15. MDH will then monitor your transfer plan.

You are permitted to continue operating while residents are being transferred to other service providers. Your license will be closed upon completion of the transfer plan.

6. **Impact on issuance of other licenses:** Minn. Stat. § 144G.20, Subd. 5 states that” the owners and managerial officials of a facility whose Minnesota license has not been renewed or whose license in this state or any other state has been revoked because of noncompliance with applicable laws or rules,” then the owner and managerial officials of that assisted living facility “shall not be eligible to apply for nor will be granted an assisted living facility license under this chapter or a home care provider license under chapter 144A, or be given status as an enrolled personal care assistance provider agency or personal care assistant by the Department of Human Services under section 256B.0659, for five years following the effective date of the nonrenewal or revocation. If the owners or managerial officials already have enrollment status, the Department of Human Services shall terminate that enrollment.”

Further, Minn. Stat. § 144G.20, subd. 5 (c) indicates “the commissioner shall not renew, or shall suspend or revoke, the license of a facility that includes any individual as an owner or managerial official who was an owner or managerial official of a facility whose license in this state, or any other state was not renewed or was revoked as described in paragraph (a) for five years following the effective date of the nonrenewal or revocation.”

Issuance of Survey Results / No Limited Authority:

MDH will continue to conduct any surveys or investigations already initiated and may issue correction orders to Caring Rose Homes LLC as well as maltreatment determinations under Minn. Stat. § 626.557. Based on the results of those findings, or on the results of any additional complaint investigations which may be initiated, or on the results of any other inspection conducted by MDH or another agency with appropriate jurisdiction, MDH may employ any of the enforcement tools listed in Minn. Stat. § 144G.20. This Order does not in any way or manner limit or affect the authority of MDH to proceed against the facility or any employee of the facility, based on any act, conduct or admission that justifies that action, whether it occurred before or after the date of this Order.

Carol Backstrom
Assistant Commissioner

**MINNESOTA DEPARTMENT OF HEALTH
HEALTH SYSTEMS BUREAU**



Carol Backstrom

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
(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: SL36815016-0 On June 29, 2026, through July 7, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were two residents; two receiving services under the Assisted Living Facility license. Immediate correction orders were identified on July 1, 2026, issued for SL36815016-0, tag identification 0495 and 0110. An immediate correction order was identified on July 6, 2026, issued for SL36815016-0, tag identification 1760.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 100 SS=I	144G.10 Subdivision 1 License required (a)(1) Beginning August 1, 2021, no assisted	0 100			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103			
(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
0 100	Continued From page 1 living facility may operate in Minnesota unless it is licensed under this chapter. (2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e). (b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law. (c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type. (d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided. (e) Upon approving an application for an assisted	0 100			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 100	Continued From page 2 living facility license, the commissioner may: (1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or (2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to operate at an address location licensed by the Minnesota Department of Health (MDH) and provided assisted living services to two of two residents (R2, R3). 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: On June 29, 2026, at 8:36 a.m., via phone, unlicensed personnel (ULP)-A stated the licensed location at 449 Aurora Avenue (Ave) had a flood in December 2025. ULP-A stated they had to relocate and currently had two residents residing at a temporary location, 970 Western Ave, Saint	0 100			

Minnesota Department of Health

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0 100	Continued From page 3 Paul. The licensee's undated emergency preparedness plan, had not been updated with the current address of the facility (449 Aurora Ave), and indicated, "If family has not agreed to be responsible party during an emergency, our agency will continue services or reach out to another home care agency, nursing home or assisted living who may be able to care for them." In the case of an evacuation, the plan directed staff to bring residents to the host site: Holiday Inn, 175 7th St. W. in St. Paul; three miles from the facility. On June 26, 2026, at 12:30 p.m., the regional ombudsman from the Office of Ombudsman for Long-term Care (OOLTC) indicated via email, "I've done a thorough search through our notices data base and we have not received any emergency relocation notices from this facility." R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. R3 was admitted on June 1, 2026, (to the unlicensed facility) and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure).	0 100			

Minnesota Department of Health

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0 100	Continued From page 4 R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. On June 29, 2026, at 10:12 a.m., during the entrance conference, ULP-A stated the licensed facility at 449 Aurora Ave had a flood in the basement on December 19, 2025. ULP-A further stated R2 had been living in the basement, and moved to the upstairs of the facility on approximately January 1, 2026. R2 later moved to the temporary location at 970 Western Ave. ULP-A stated R3 was admitted to the temporary facility location at 970 Western Ave on June 1, 2026. On June 29, 2026, at 10:35 a.m., the nursing and engineering surveyors toured the licensed facility at 449 Aurora Ave. The walls of the basement appeared intact. The ceiling appeared water damaged, and there was an active leak from the ceiling that had a pail positioned to catch the dripping water. The engineering surveyor asked ULP-A if they were aware of the leak and if it was being addressed. ULP-A stated that there was no leak and that a previous plumbing leak in the first floor bathroom had already been repaired. When the surveyor pointed out the water actively dripping from the ceiling and dropping into a bucket on the floor ULP-A stated that they thought the dripping water could be caused by the air conditioner. ULP-A further stated clean-up with water mitigation began on December 22, 2025, and a construction company began making repairs to the basement on June 11, 2026. On June 29, 2026, at 10:46 a.m., ULP-A stated the licensee's emergency preparedness plan did	0 100			

Minnesota Department of Health

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0 100	Continued From page 5 not indicate they would relocate residents to 970 Western Ave if they needed to evacuate the licensed facility at 449 Aurora Avenue. On June 30, 2026, at approximately 8:33 a.m., the surveyor observed ULP-A assist R2 and R3 with medication administration. The service was provided at the unlicensed location, 970 Western Ave. in St. Paul. In the Physical Environment Inspection Report dated July 2, 2026, the engineering surveyor documented the following physical environment correction orders issued for the unlicensed facility at 970 Western Ave from the survey ending July 7, 2026: 0775: -"In the 970 Western building the windowsill for the egress window in the room occupied by resident 2 (R2) was 50 inches above the finished floor." -In the 970 Western building in the second floor common hallway there was an old nonfunctioning smoke alarm that was missing the battery and cover. There was an operable smoke alarm in the same area. Unlicensed personnel (ULP)-A stated that the landlord had left it that way." 0780: -"When the surveyor requested that ULP-A test the smoke alarms in the 970 Western building it was discovered that none of the smoke alarms were interconnected and all smoke alarms only sounded locally." 0790: -"The fire extinguishers in the 970 Western building were installed too high above the finished floor. Both fire extinguishers were installed 65 inches above the finished floor." (Fire extinguishers shall be installed so that the top of the fire extinguisher is no higher than 60 inches	0 100			

Minnesota Department of Health

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0 100	Continued From page 6 above the finished floor.) -"In the 970 Western building, both fire extinguishers were 1-A:10-B:C rated fire extinguishers." (Portable fire extinguishers must have a minimum 2-A:10-B:C rating). 0810: -Lack of evidence of Fire Safety and Evacuation Plan training for employees and residents. Minnesota Department of Health (MDH) records indicated a facility repair plan was not submitted to the department, as of June 29, 2026. TIME PERIOD OF CORRECTION: Two (2) Days	0 100			
0 110 SS=I	144G.10 Subdivision 1a Assisted living director license required Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employment of an assisted living director (ALD) who was licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS) and affiliated as the director of record with the board. This had the potential to affect all current residents receiving assisted living services. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	0 110	The immediate order was identified July 1, 2026. The licensee provided a plan of correction, and took steps to mitigate the immediate risk to the residents, effective July 4, 2026.		

Minnesota Department of Health

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0 110	Continued From page 7 or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 28, 2026, at 8:36 a.m., unlicensed personnel (ULP)-A stated, via phone, she had a temporary ALD permit and was in the process of completing her training to become a licensed assisted living director (LALD). On June 28, 2026, at 10:20 a.m., ULP-A stated the previous LALD was the director of record for the licensee from September 10, 2025, through October 31, 2025. ULP-A stated she had submitted the ALD permit application to BELTSS, was currently training for the LALD license and had a mentor identified to assist her. On June 29, 2026, at 12:55 p.m., director of assisted living and education for Minnesota BELTSS, stated, via email, "She applied on 6/16 and we sent her paperwork needing to be completed however have had no response from her. She has 30 days to obtain her permit from the date she began in the role. We have no known association with this facility for her. The last DOR was [LALD-E] through 10/31/25." On June 30, 2026, at 7:42 a.m., ULP-A stated, the previous LALD ended employment with licensee in October 2025. ULP-A verbalized she began the process of becoming the temporary LALD in June 2026. ULP-A stated the licensee had been searching for a new LALD since October 2025 and had been unsuccessful to fill	0 110			

Minnesota Department of Health

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0 110	Continued From page 8 the position. On June 30, 2026, at 9:36 a.m., director of assisted living and education for Minnesota BELTSS was asked, via email, if ULP-A had identified a mentor, and if she would be considered to be the director of the facility. The BELTSS director replied, "No, we have nothing from her to date. I did send her the information again yesterday." The BELTSS website dated July 1, 2026, at 8:46 a.m., indicated the licensee had no current licensed or permitted ALD of record. The licensee's 4.01 Assisted Living Director policy dated June 2021, indicated, "[Licensee], is required to have an Assisted Living Director licensed or permitted by the Board of Executives for Long Term Services and Supports (BELTSS)." In addition, included, "1. The licensed or permitted Assisted Living Director will maintain a current and active license or permit with BELTSS. 2. The Assisted Living Director on record is responsible for the licensed Assisted Living and all operations within the setting. 3. The license or permit of the Assisted Living Director will be hung in the facility. 4. Any relevant documentation will also be kept in the Directors employment file. 5. [Licensee] expects the licensed or permitted Director to comply with all requirements set forth by BELTSS as a licensed professional to remain in good standing (i.e., notifications, education requirements, renewal, etc.)." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	0 110			

Minnesota Department of Health

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0 340	Continued From page 9	0 340			
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to record actions taken to comply with all correction orders from a survey completed March 6, 2024. The lack of action to ensure compliance with regulations 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	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 340	Continued From page 10 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: The findings from the licensee's previous survey, concluded on March 6, 2024, was sent to the licensee via email on April 4, 2024. The longest time period for correction (the time frame in which the licensee must document and correct orders) was 21 days from the date the licensee received their survey results, or April 25, 2024. In addition, an amended survey notice dated June 27, 2024, was sent to the licensee via email, correction order 0100, 144G.10 Subdivision 1. (a-e) License required, was amended to reflect accurate description of dwelling. On June 29, 2026, at 11:30 a.m., during the entrance conference, unlicensed personnel (ULP)-A stated she would need to check with owner/ULP-C to see if the licensee had any documented plans of correction from the previous survey. The licensee lacked documented corrective actions for the following previously cited orders: -0660, 144G.42 Subd. 9. Tuberculosis prevention and control; -0780, 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; -0790, 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment;	0 340			

Minnesota Department of Health

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0 340	Continued From page 11 -0800, 144G.45 Subd. 2 (a) (4) Fire protection and physical environment; and -0810, 144G.45 Subd. 2 (b-f) Fire protection and physical environment. The licensee remained out of compliance with the above-listed statutes, and correction orders were reissued as a result of the current survey, ending July 7, 2026. On June 30, 2026, at 9:23 a.m., ULP-A stated, the licensee had another assisted living director employed at the time the last survey was completed in 2024, and the licensee was not able to find any plans of correction completed or documented in their files from the last survey. The Minnesota Department of Health (MDH) Correction Order Documentation Guidelines, dated January 3, 2023, indicated, correction order documentation should include the following: -identify how each order was corrected related to each individual client(s)/employee(s) identified in the order; -identify how each order was corrected for all the provider's clients/employees identified in the order; and -identify what changes to the provider's systems and practices were made to ensure compliance with the specific statute. Include information about how the provider will maintain compliance in the future. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 460	Continued From page 12	0 460			
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to provide a means for residents to request assistance for health and safety needs 24 hours a day, seven days a week. This had the ability to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 460			

Minnesota Department of Health

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0 460	Continued From page 13 The findings include: On June 29, 2026, at 11:30 a.m., during the entrance conference, unlicensed personnel (ULP)-A stated the licensee did not use a system for the residents at the temporary facility location at 970 Western Avenue North, St. Paul, where R2 and R3 currently resided due to water damage which occurred in the lower level of the licensed facility. ULP-A stated they had not moved the resident notification system from the licensed facility at 449 Aurora Avenue, St. Paul, to the temporary facility. R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's unsigned service plan, effective June 16, 2026, indicated R2 received services including assistance with housekeeping, bathing, incontinence care, vital signs, garbage removal, wheelchair use, managing behavior, CPAP treatment, and medication administration. R2's service plan had not been updated to indicate he no longer used a CPAP device. On June 30, 2026, at 8:33 a.m., the surveyor observed ULP-A assist R2 with medication administration. On June 30, 2026, at 8:10 a.m., R2 stated he did not have a way to summon care staff other than to yell out to the licensee. ULP-A stated the resident would yell out and the care staff would attend to him right away. The licensee's 2.01 24-Hour Emergency	0 460			

Minnesota Department of Health

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0 460	Continued From page 14 Response policy dated June 2021, indicated, "Residents living at [Licensee] have access to 24-hour emergency response by staff." In addition, included, "PROCEDURE: 1. All residents are given instructions on the use of emergency response system upon move in and ongoing, as need. 2. Pressing the button on the emergency response button or pulling an emergency response cord will activate the response system which will notify a designated staff person. 3. An emergency cell phone will be carried at all times by a designated staff person. All emergency cell phones will be answered immediately. 4. The system will be tested on a regular basis, and no less than annually by the management staff of [Licensee]." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 470	Continued From page 15 situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to develop and implement a staffing plan for determining its staffing level and to failed ensure the daily staffing schedule was posted, at the beginning of each work shift, in a central location, accessible to staff, residents, volunteers, and the public, as required, potentially affecting all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 June 29, 2026, at 10:49 a.m., the surveyor	0 470			

Minnesota Department of Health

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0 470	Continued From page 16 observed the licensee's postings at 449 Aurora Avenue, St. Paul, in all areas of the facility with unlicensed personnel (ULP)-A. On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated the licensee had not yet completed or documented a review of a facility staffing plan. ULP-A stated she and owner/ULP (O/ULP)-C were the only unlicensed personnel working currently, and each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. On June 29, 2026, at 12:58 p.m., the surveyor observed the temporary home location at 970 Western Avenue North, St. Paul, with ULP-A. The licensee lacked a posted daily staffing schedule including: -direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked; -identify the direct-care staff members' resident assignments or work location; and -be posted, after redacting direct-care staff member's resident assignments, at the beginning of each work shift in a central location in each building. On June 29, 2026, at 10:56 a.m., ULP-A stated, they took the postings down at 449 Aurora Avenue, St. Paul, due to water damage that occurred in the lower level of the facility on December 19, 2025. ULP-A verbalized R2 and R3 currently resided at the temporary location. ULP-A further stated, they could not put up any postings at the temporary address due to the home being a vacation rental they were using temporarily until the water damage was repaired	0 470			

Minnesota Department of Health

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0 470	Continued From page 17 at the licensed assisted living facility. The licensee's 4.06 Staffing & Scheduling policy dated June 2021 indicated, "1. The clinical nurse supervisor will develop and implement a written staffing plan that provides an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. 2. The clinical nurse supervisor must ensure that staffing levels are adequate to address the following: a. Each resident's needs, as identified in the resident's service plan and assisted living contract b. Each resident's acuity level, as determined by the most recent assessment or individualized review c. The ability of staff to timely meet the residents' scheduled and reasonably foreseeable unscheduled needs given the physical layout of the facility premises d. Whether the facility has a secured dementia care unit, and e. Staff experience, training, and competency. 3. The clinical nurse supervisor will develop a 24-hour daily staffing schedule that will identify: a. direct-care staff work schedules for each direct-care staff member showing all work shifts, including days and hours worked, and b. the direct-care staff member's resident assignments or work location. 4. The daily work schedule must be posted, after redacting direct-care staff members' resident assignments, at the beginning of each work shift in a central location in each building of a facility or campus, accessible to staff, residents, volunteers, and the public. The facility shall not disclose any information that is protected by law from public disclosure."	0 470			

Minnesota Department of Health

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0 470	Continued From page 18 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a menu a week in advance and inform residents in advance of menu changes. This practice resulted in a level one violation (a violation that will cause only minimal impact on the residents and does not affect health or safety) and was issued at a widespread scope (when	0 485			

Minnesota Department of Health

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0 485	Continued From page 19 problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 29, 2026, at 10:49 a.m., the surveyor observed the licensee's postings at 449 Aurora Avenue, St. Paul, in all areas of the facility with unlicensed personnel (ULP)-A. On June 29, 2026, at 12:58 p.m., the surveyor observed all areas of the facility of the temporary home located at 970 Western Avenue North, St. Paul, with ULP-A. The licensee lacked a menu prepared at least one week in advance and made available to all residents. On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated, they had not provided a copy of the menu to any of their residents. ULP-A verbalized, both R2 and R3 prepared their own meals with supervision at the facility. Also, ULP-A stated both R2 and R3 would provide input on the groceries the licensee purchased, and they typically went grocery shopping one time per week with the licensee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or	0 490			

Minnesota Department of Health

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0 490	Continued From page 20 make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs, that create opportunities for active participation in the community at large. This had the potential to affect all residents of the facility. 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	0 490			

Minnesota Department of Health

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0 490	Continued From page 21 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 June 29, 2026, at 10:49 a.m., the surveyor observed the licensee's postings at 449 Aurora Avenue, St. Paul, in all areas of the facility with unlicensed personnel (ULP)-A. On June 29, 2026, at 12:58 p.m., the surveyor observed all areas of the facility of the temporary home located at 970 Western Avenue North, St. Paul, with ULP-A. The licensee lacked evidence of a daily program of social and recreational activities that were based upon individual and group interests, physical, mental, and psychosocial needs, and that created opportunities for active participation in the community at large. On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated staff tried to offer activities to the residents, but they did not have a schedule or necessarily offer social and recreational activities every day, because both residents typically decline or they wanted independent activities. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490			

Minnesota Department of Health

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0 495	Continued From page 22	0 495			
0 495 SS=I	144G.41 Subdivision. 1 (13) Minimum Requirements (13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure that a registered nurse (RN) was available on-call 24 hours a day, seven days per week. This had the potential to affect all residents and staff of the facility. 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: According to Minnesota Statute § 144G.62, Subd. 1, all assisted living facilities must have a registered nurse available for consultation by staff performing delegated nursing tasks; this includes medication administration. The licensee's assisted living license was effective December 3, 2025, after a relocation. A resident roster provided June 29, 2026, listed two residents: -R2: admit date listed as January 1, 2026; diagnoses included schizoaffective with bipolar disorder; and -R3: admit date listed as June 1, 2026; diagnoses	0 495	The immediate order was identified July 1, 2026. The licensee provided a plan of correction, but did not demonstrate actions taken to mitigate the immediate risk to residents, as of the survey exit on July 7, 2026.		

Minnesota Department of Health

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0 495	Continued From page 23 included schizophrenia. During entrance conference, on June 29, 2026, at 11:30 a.m., unlicensed personnel (ULP)-A stated, registered nurse(RN)-B was hired as the licensee's registered nurse on March 26, 2026. RN-B stated the licensee provided medication administration for both R2 and R3. RN-B stated she currently worked full time as Director of Nursing at a skilled nursing facility approximately one and one half-hour drive from the licensee's assisted living facility. On June 29, 2026, at 1:24 p.m., RN-D stated via phone call with the survey supervisor that she previously worked for the licensee, but no longer worked for the licensee and had not worked for them since January 2026, "about five months ago". RN-B was hired March 26, 2026, to provide medication set-up services to the residents in the facility. On June 30,2026, at 8:33 a.m., the surveyor observed ULP-A assist R2 with medication administration. On June 30,2026, at 8:44 a.m., the surveyor observed ULP-A assist R3 with medication administration. R2's assessment dated June 26, 2026, indicated self-administration of medications was not applicable, and R2 needed assistance with medication management. R3's assessment dated June 9, 2026, indicated self-administration of medications was not applicable, and R3 needed assistance with	0 495			

Minnesota Department of Health

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0 495	Continued From page 24 medication management. On June 30, 2026, at 1:02 p.m., RN-B stated, via phone, the licensee hired her to assist with weekly medication set up for R2 and R3, and that ULP-A had told her the owner/ULP (O/ULP)-C was the director of nursing for the licensee. RN-B stated ULP-A told her her role was only to complete medication set ups for the licensee's two residents, R2 and R3. RN-B further stated after she was hired, she asked about nursing assessments that needed to be completed for R2 and R3, and ULP-A then agreed to give RN-B access to the licensee's online medical record to also complete resident assessments. RN-B stated she was not provided a job description, and received no orientation or training prior to starting to work for the licensee. RN-B stated she was not hired to provide on call 24 hours a day seven days per week nursing coverage for the licensee. RN-B added she was shocked when during the entrance conference of the survey, ULP-A told the surveyor RN-B was the licensee's clinical nurse supervisor on call 24 hours a day seven days per week. Finally, RN-B informed the surveyor she gave her notice to resign her position with the licensee as of the end of the week. According to Minnesota Rule 4659.0140 Subpart 1. Admissions: A. The assisted living director, in cooperation with the clinical nurse supervisor, is responsible for admitting residents to the facility according to the facility's admission policies. B. Unless otherwise provided by law, an assisted living facility must not admit or retain a resident unless it can provide sufficient care and supervision to meet the resident's needs, based on the resident's known physical, mental,	0 495			

Minnesota Department of Health

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0 495	Continued From page 25 cognitive, or behavioral condition. The licensee's undated 6.12 Availability of an RN for Staff policy, indicated, "[Licensee] have a registered nurse available for consultation by staff performing delegated nursing tasks and must have an appropriate licensed health professional available if performing other delegated services such as therapies. The RN must be readily available either in person, by telephone, or by other means to the staff at times when the staff is providing services." No further information was provided. TIME PERIOD FOR CORRECTION: Immediate On July 1, 2026, at 11:04 a.m., the surveyor attempted a phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 1, 2026, at 12:26 p.m., RN-B had not responded to the previous contact. The surveyor placed a second call. RN-B's voicemail box was full, but the surveyor was able to send a short message service (SMS) text message with the telephone number, requesting a return call. On July 2, 2026, at 9:11 a.m., RN-B had not responded to previous attempts to contact her. The surveyor emailed RN-B requesting a response to a list of questions provided in the email. On July 2, 2026, at 9:40 a.m., RN-B had not responded to previous attempts to contact her. The surveyor placed a third call to RN-B. No answer; SMS text sent with number to return call.	0 495			

Minnesota Department of Health

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0 495	Continued From page 26 As of July 6, 2026, at 6:00 a.m., no response had been received from RN-B by email, text, or phone. On July 6, 2026, at 6:10 a.m., ULP-A stated the licensee met with RN-B and she agreed to being the licensee's clinical nurse supervisor including 24-hours, seven days a week on-call coverage for the facility. ULP-A stated she planned to get an updated job description to RN-B that day. On July 6, 2026, at 6:39 a.m., the surveyor called RN-B and she answered. RN-B stated she came to the facility on Friday July 3, 2026, and spoke to ULP-A. RN-B verbalized she agreed to continue employment with the licensee and act in the role of clinical nurse supervisor including 24-hour seven days per week on call coverage. RN-B stated, the licensee planned to provide her a new job description today. On July 6, 2026, at 11:48 a.m., ULP-A stated, via phone, she had not received a call back from RN-B yet after she called her a couple of hours ago. On July 6, 2026, at 2:05 p.m., the surveyor again attempted a phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:25 a.m., the surveyor placed another phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:30 a.m., ULP-A stated she tried to call RN-B approximately an hour prior, and had not heard back from RN-B yet.	0 495			

Minnesota Department of Health

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0 495	Continued From page 27 On July 7, 2026, at 8:44 a.m., the surveyor placed a text message to RN-B which read, "Hi [RN-B]. This is [surveyor] from Minnesota Department of Health (MDH). Have you received my messages yesterday and today? Please call me back a {sic} soon as you are able. Thank you." On July 7, 2026, at 11:16 a.m., RN-B responded to the text message with a text indicating, "Yes I have. Sorry I have been really busy. I will be responding to the emails once I get home later today." As of July 8, 2026, at 1:30 p.m., RN-B had not responded by email, text, or phone.	0 495			
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by:	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 550	Continued From page 28 Based on observation and interview, the licensee failed to support protection and safety by not posting the licensee's grievance procedure, with the current name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all residents, staff, and visitors of the facility. 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 June 29, 2026, at 10:56 a.m., the surveyor toured the licensed assisted living facility location, 449 Aurora Avenue, with unlicensed personnel (ULP)-A. The licensee lacked a posting of the licensee's grievance form and contact information including the name, email, and phone number for the contact person for the individual responsible for handling resident grievances. ULP-A stated they took the postings down at the licensed facility due to the water damage that occurred in the lower level of the facility in December 2025. ULP-A further stated they were unable to post any required postings at the temporary location where the residents resided, at 970 Western Avenue North, due to the home being a vacation rental home the licensee currently rented until the water damage was repaired. On June 29, 2026, at 12:58 p.m., the surveyor	0 550			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 550	Continued From page 29 toured the licensee's temporary location, where residents were living, at 970 Western Avenue North. The surveyor observed there was no grievance form posted. The licensee's 2.10 Complaint / Grievance Posting policy dated June 2021, indicated, "[Licensee] will post, in a conspicuous place, information about our complaint/ grievance procedure, and the name, telephone number, and email contact information for the individual(s) who are responsible for handling resident complaint/grievances." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550			
0 570 SS=C	144G.42 Subdivision 1 Display of license The original current license must be displayed at the main entrance of each assisted living facility. The facility must provide a copy of the license to any person who requests it. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to display the original current license at the main entrance of the assisted living facility as required. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level one violation (a violation that will cause only 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	0 570			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 570	Continued From page 30 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living license effective December 3, 2025, through August 31, 2026. On June 29, 2026, at 10:56 a.m., the surveyor toured the licensed facility at 449 Aurora Avenue, with unlicensed personnel (ULP)-A. The licensee lacked a posting of the licensee's assisted living license. ULP-A stated they took the postings down at the licensed facility location due to water damage that occurred in the lower level of the facility in December 2025. ULP-A further stated they could not post any required postings at the temporary facility location where the residents resided, at 970 Western Avenue North, due to the home being a vacation rental home the licensee was temporarily renting until the water damage at the licensed facility was repaired. The licensee's 2.04 Assisted Living License and Posting policy dated July 2021, indicated, "[Licensee] will maintain a current Assisted Living License issued by the Minnesota Department of Health. The issued license will be posted at the main entrance of the facility." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 570			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management	0 580			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 580	Continued From page 31 appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in and maintain documentation of quality management activity appropriate to the size of the facility and relevant to the type of services provided. This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: The licensee lacked documentation on quality management activities to evaluate quality of care. On June 29, 2026, during an entrance conference at 11:30 a.m., unlicensed personnel (ULP)-A	0 580			

Minnesota Department of Health

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0 580	Continued From page 32 stated they had not completed or documented any management discussions or meetings about quality improvement. The licensee's 2.31 Quality Management Project policy, dated June 2021, indicated, "[Licensee] will have at least one documented quality management project in place at all times, and retain records of such projects for at least two years." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 580			
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of two residents (R2).	0 630			

Minnesota Department of Health

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0 630	Continued From page 33 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 June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. R2's record included an Individual Abuse Prevention Plan (IAPP) dated June 26, 2026. The document lacked the following required content: -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 30, 2026, at 1:02 p.m., registered nurse (RN)-B stated, via phone, she was not aware of all the requirements for the IAPP and was not aware R2's IAPP was missing an assessment of his risk of abuse to other vulnerable adults and specific interventions for staff. RN-B verbalized she planned to follow up with the licensee's electronic medical record provider to see if this additional assessment question could be added.	0 630			

Minnesota Department of Health

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0 630	Continued From page 34 The licensee's 2.44 Vulnerable Adult Maltreatment - Prevention & Reporting policy dated June 2021, indicated, "Consistent with the Minnesota Vulnerable Adults Act and Assisted Living licensure regulations, [Licensee] prohibits the maltreatment of residents. To support this prohibition, [Licensee] educates clients, family members, and staff (mandated reporters) about how to report suspected maltreatment internally and to the Minnesota Adult Abuse Reporting Center (MAARC). [Licensee] also develops individualized vulnerable adult abuse prevention plans to identify vulnerability risks and develop measures to minimize maltreatment based on identified information." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 650	Continued From page 35 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview, and record review, the licensee failed to ensure the employee record contained the required content for three of three employees (unlicensed personnel (ULP)-A, registered nurse (RN)-B, and owner/ULP(O/ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she and owner/ULP (O/ULP)-C were the only unlicensed personnel working currently, and each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. ULP-A	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 650	Continued From page 36 ULP-A was hired August 19, 2023, and provided direct care and services to residents. ULP-A's employee records lacked documentation of an annual performance review that identified areas of improvement needed and training needs. RN-B RN-B was hired March 26, 2026, and provided direct nursing care and services to residents. RN-B's employee record lacked documentation of a current job description, including qualifications, responsibilities, and identification of staff persons providing supervision On June 30, 2026, at 1:02 p.m., RN-B stated she was hired by the licensee to complete weekly medication set up for the residents. RN-B stated she was not given a job description, and she had asked the licensee for a job description several times and had not received it yet from the licensee. O/ULP-C O/ULP-C was hired December 2, 2020, and provided direct care and services to residents. O/ULP-C's employee records lacked documentation of an annual performance review that identified areas of improvement needed and training needs. On July 1, 2026, at 10:35 a.m., ULP-A stated they did not have an annual performance review completed yet for ULP-A and O/ULP-C. On July 6, 2026, at approximately 6:00 a.m., ULP-A stated the plan was to go over a new job	0 650			

Minnesota Department of Health

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0 650	Continued From page 37 description for RN-B over the phone and then have her sign it when she is back at the facility again. On July 6, 2026, at 6:39 a.m., RN-B stated, via phone, she expected to get her job description from the licensee that day, during the survey. The licensee's 4.05 Employee Records policy, dated June 2021, indicated, "1. Employee records for each person will include: -Evidence of current professional licensure, registration or certificate, if required -Records of all training and in-service education required and/or provided including record of competency testing as required -Current signed job description, which includes qualifications, responsibilities, and identification of supervisors, if any -Documentation of annual performance reviews that identify areas of improvement needed and training needs -For individuals providing Assisted Living services, verification that required health screenings for Tuberculosis (TB) have taken place and the dates of those screenings. (recommended to keep medical information in a separate employee medical file) -Documentation of a completed criminal background study -Evidence that a reference check has been completed -Verification of completed orientation and annual training and competency testing as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 660	Continued From page 38	0 660			
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 observation, interview, and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), to include an annual TB Facility Risk Assessment, and screening for active TB including history and symptom screening for one of three employees (owner/unlicensed personnel (O/ULP)-C), and baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA) TB blood test) for two of three employees (ULP)-A, registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 660	Continued From page 39 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 June 29, 2026, at 11:30 a.m., during the entrance conference, the surveyor requested a copy of the most current TB facility risk assessment. On June 29, 2026, at 12:03 p.m., ULP-A provided a TB Facility Risk Assessment dated January 15, 2023, and noted "Name of facility: [Licensee]" and included an address not currently associated with the licensee. ULP-A stated the licensee did not have a more current TB Facility Risk Assessment completed. The licensee lacked a completed annual TB Facility Risk Assessment. On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she and O/ULP-C each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. ULP-A ULP-A was hired August 19, 2023, and provided direct care and services to residents. On June 30, 2026, from 8:33 a.m. to 8:51 a.m., the surveyor observed ULP-A assist R2 and R3 with medication administration.	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 660	Continued From page 40 ULP-A's employee record included a TB history and symptom screening completed upon hire, August 19, 2023, but lacked: -baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA- TB blood test). RN-B RN-B was hired March 26, 2026, and provided direct nursing care and services to residents. RN-B's employee record included a TB history and symptom screening completed upon hire, March 26, 2026, but lacked: -baseline testing (either by a two-step tuberculin skin test (TST) or a single interferon gamma release assay (IGRA-TB blood test). O/ULP-C O/ULP-C was hired December 1, 2020, and provided direct care and services to residents. O/ULP-C's employee record included baseline testing by a QuantiFERON blood test dated October 2, 2020, and an incomplete TB history and symptom screening template form. The employee record lacked: -a completed TB history and symptom screening form. On July 1, 2026, at 10:35 a.m., ULP-A stated, via phone, the missing TB documents from ULP-A, RN-B, and O/ULP-C employee records could not be located and were missing. ULP-A verbalized they may either be in the garage or were destroyed with water damage that occurred at the facility in December 2025. The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 660	Continued From page 41 in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and Health Care Worker (HCW) education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST-tuberculin skin test (first step) dated within 90 days before hire. The second TST may be performed after the HCW starts working with patients. Baseline TB screening should be documented in the employees' record. The licensee's 8.16 Tuberculosis Screening policy, dated June 2021, indicated, "Staff whose essential job functions require work within the same air space of home care clients will be screened and tested for tuberculosis prior to the staff being exposed to clients. Baseline (upon hire) screening will be completed, but serial (annual) screening will only be required with increased occupational risk or exposure. Screening will be conducted as follows: 1. New staff will be screened for active signs of TB using the Baseline TB Screening Tool for HCWs. 2. New staff will have an IGRA blood test or a two-step Mantoux conducted with results documented on the Baseline TB Screening Tool for HCWs. 3. No staff will be permitted to begin work where the work involves sharing the air space with residents until the negative results of the first Mantoux are read and documented or a negative IGRA blood test result is received and documented.	0 660			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
(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
0 660	Continued From page 42 4. Staff TB screening results will be kept in each employee medical file. 5. Staff should be screened for signs and symptoms on an annual basis." No further information was provided. TIME PERIOD FOR CORRECTION: 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.	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 680	Continued From page 43 This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to have a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents receiving services under the assisted living license. 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 June 29, 2026, at 10:40 a.m., the facility EPP binder was provided by unlicensed personnel (ULP)-A to the surveyor for review. The EPP binder indicated incorrectly under the introduction section, "[Licensee] is licensed as an Assisted Living facility with Dementia Care." Also, on number 1 of the first page incorrectly noted, "Licensee Name: [Licensee], Address: 1043 Hague Ave, St Paul, MN 55104." The licensee's undated EPP binder lacked annual review, and current information for the facility. The EPP further lacked evidence of the following required content: -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	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 680	Continued From page 44 emergency; -post an emergency disaster plan prominently; -provide building emergency exit diagrams to all residents; -post emergency exit diagrams on each floor; -review of the missing resident policy quarterly; -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. On June 29, 2026, at 10:54 a.m., ULP-A stated the licensee had not updated the EPP for the facility since relocating the assisted living facility location to 449 Aurora Avenue, St. Paul. ULP-A verbalized the licensee had not had the opportunity yet to update the EPP binder to include the required items. In addition, ULP-A stated the EPP was not updated with the temporary evacuation of the residents from 449 Aurora Avenue, St. Paul, to the temporary facility location at 970 Western Avenue North, St. Paul, due to water damage that occurred in December 2025. ULP-A stated she was not aware of the required documentation of review of the missing resident policy or annual review of the EPP. The licensee's 9.01 Emergency Preparedness Plan -Appendix Z Compliance policy dated June 2021 indicated, "It is the intent that [Licensee] has in place an effective and compliant Emergency Preparedness Plan. The intent is the plan will be aligned with the Centers for Medicare and Medicaid Services State Operation Manual Appendix Z: "State Operations Manual Appendix Z - Emergency Preparedness for All Provides and	0 680			

Minnesota Department of Health

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0 680	Continued From page 45 Certified Supplier Types: Interpretive Guidance." In addition, the plan included, "PROCEDURE: [Licensee] emergency preparedness plan will include all required elements of appendix Z. The plan will be in writing and reviewed annually. The plan is based on our assisted living-based and community-based risk assessments, utilizing an all-hazards approach. Key elements of the plan include four primary components: 1. Risk assessment and planning 2. Policies and procedures 3. A communication plan 4. Staff training and exercises/drills." The licensee's 2.28 Missing Resident policy dated June 2021, indicated, "12. [Licensee] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
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,	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 730	Continued From page 46 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 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 interview and record review the licensee failed to ensure the resident records contained all required contents for two of two	0 730			

Minnesota Department of Health

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0 730	Continued From page 47 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 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: R2 R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. On June 30, 2026, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R3 R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 730	Continued From page 48 assistance with weight supervision and medication administration. On June 30, 2026, at 8:44 a.m., the surveyor observed ULP-A assist R3 with medication administration. On December 3, 2025, at 12:16 p.m., an email was sent to the licensee granting a relocation of the Assisted Living facility from the previous address at 1043 Hague Avenue, St. Paul, Minnesota (MN), to the relocated address of 449 Aurora Avenue, St. Paul, MN effective December 3, 2025. R2 and R3's service plans dated June 16, 2026, both indicated the address of the facility was 1043 Hague Ave, which was no longer the licensee's address as of December 3, 2025. R2 and R3's paper and electronic medical records included the previous Hague Avenue address, and were not updated with the new address at Aurora Avenue. The records lacked the following: -identifying information, including the resident's current address and telephone number. On July 1, 2026, at 1035 a.m., ULP-A stated the licensee had not been able to update the electronic or paper medical records yet to include the relocated or temporary facility address in either R2 or R3's records. ULP-A stated she planned to get this information updated in R2 and R3's medical records. The licensee's Resident Record - Information and Content policy dated June 2021, indicated, "Resident Records must include: 1. Identifying information, including resident's	0 730			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 730	Continued From page 49 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 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 15. Other documentation required under this chapter and relevant to the resident's services or	0 730			

Minnesota Department of Health

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0 730	Continued From page 50 status." A policy was requested and not provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
0 775 SS=D	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: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated July 2, 2026, for the specific violations related the	0 775			

Minnesota Department of Health

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0 775	Continued From page 51 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; (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	0 780			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 780	Continued From page 52 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 July 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 780			
0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire	0 790			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 790	Continued From page 53 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 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 July 2, 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,	0 800			

Minnesota Department of Health

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0 800	Continued From page 54 systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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 July 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 810	Continued From page 55	0 810			
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 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 810	Continued From page 56 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 July 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810			
0 910 SS=C	144G.50 Subd. 2 (a-b) Contract information (a) The contract must include in a conspicuous place and manner on the contract the legal name and the health facility identification of the facility. (b) The contract must include the name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the facility and contracted service provider when applicable; (2) the licensee of the facility; (3) the managing agent of the facility, if applicable; and	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 910	Continued From page 57 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract included all required content for the licensee's two residents (R2, R3). This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: R2 R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. R2's Rental Agreement (contract) signed January 20, 2025, lacked the following: -the health facility identification (HFID) number of the facility; and -the telephone number and current physical mailing address of the facility. R3 R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. R3's Rental Agreement signed May 30, 2026, lacked the following:	0 910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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0 910	Continued From page 58 -the health facility identification (HFID) number of the facility; and -the telephone number of the facility. On July 2, 2026, at 9:12 a.m., unlicensed personnel (ULP)-A stated she was not aware the assisted living contract was missing the required content as identified above. ULP-A verbalized she planned to follow up on the missing required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 910			
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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01060	Continued From page 59 (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 after an emergency relocation, 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:	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01060	Continued From page 60 R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. A Regions Hospital Psychiatry Department Admission document dated June 14, 2026, indicated, on June 13, 2026, R2 was "admitted for agitation and psychosis from assisted living facility in the context of chronic medical conditions, chronic psychiatric conditions, non-adherence to both psychiatric and medical treatment, conflict with case worker, and poor insight. The patient is being admitted on a 72 hour hold." R3 was discharged back to the temporary facility location at 970 Western Avenue North, St. Paul, on June 26, 2026. R2's record lacked evidence of a written notice provided to the resident, the resident's legal representative, and designated representative on the previously listed dates, that contained at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01060	Continued From page 61 that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On June 29, 2026, at 11:50 a.m., unlicensed personnel (ULP)-A stated she was not aware of the requirement to provide an emergency relocation notice for residents who were admitted to the hospital, or to notify the OOLTC if a resident remained in the hospital for more than four days. ULP-A stated an emergency relocation notice, and notifications were not completed for R2's hospitalization. Education was provided to ULP-A. The licensee's Discharge and Transfer of Residents policy effective August 1, 2021, indicated in section labeled Emergency Relocation, "25. In the event of an emergency relocation, the facility will, as soon as possible, provide written notice of Emergency Relocation to the following: a) The resident b) The resident's legal representative c) The resident's designated representative d) If the resident receives home and community-based services, the resident's case manager e) If the resident has been relocated and not returned to [Licensee] within four {4} days, the Office of Ombudsman for Long-Term Care f) Notice of the right to appeal the decision under 144G.54." Also, included, "26. The written notice shall include the following: a) The reason for the relocation b) Name and contact information for the location	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01060	Continued From page 62 to which the resident has been located and any new service provider c) Contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities d) If known, the approximate date range within which the resident is expected to return to the facility or a statement that the date is not currently known e) A statement that, if the facility refuses to provide housing or services after a relocation, the resident has a right to appeal the decision and contact information for the person to whom the resident should submit the appeal." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060			
01370 SS=F	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01370	Continued From page 63 (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse completed training and competency testing, in all skill areas, required for all unlicensed personnel, for two of two employees (unlicensed personnel (ULP)-A, owner/ULP (O/ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01370	Continued From page 64 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 June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she and O/ULP-C were the only unlicensed personnel working currently, and each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. ULP-A ULP-A was hired August 19, 2023, and provided direct care assistance to residents. On June 30, 2026, from 8:33 a.m. to 8:51 a.m., the surveyor observed ULP-A assist R2 and R3 with medication administration. ULP-A's employee record lacked documentation of training and competency testing in the following areas: -awareness of commonly used health technology equipment and assistive devices. O/ULP-C O/ULP-C was hired December 1, 2020, and provided direct care assistance to residents. On July 6, 2026, at 8:00 a.m., the surveyor observed O/ULP-C at the temporary home facility at 970 Western Avenue North, St. Paul. O/ULP-C left the home shortly after the surveyor arrived. O/ULP-C's employee record lacked documentation of training and competency testing in the following areas:	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01370	Continued From page 65 -standby assistance techniques and how to perform them; and -awareness of commonly used health technology equipment and assistive devices. On July 1, 2026, at 12:19 p.m., ULP-A stated, via phone, the licensee no longer had access to the online training program the licensee previously used. ULP-A verbalized they must have missed completing some of the initial required training for ULP-A and O/ULP-C. The licensee's 5.02 Competency Training Evaluations policy dated June 2021, indicated, "5. Training and competency evaluations for all ULP's will include: a) Documentation requirements for all services provided b) Reports of changes in the resident's condition to the supervisor designated by the facility c) Basic infection control, including blood-borne pathogens d) Maintenance of a clean and safe environment e) Appropriate and safe techniques in personal hygiene and grooming, including: i. hair care and bathing ii. care of teeth, gums, and oral prosthetic devices iii. care and use of hearing aids iv. dressing and assisting with toileting f) Training on the prevention of falls g) Standby assistance techniques and how to perform them h) Medication, exercise, and treatment reminders i) Basic nutrition, meal preparation, food safety, and assistance with eating j) Preparation of modified diets as ordered by a licensed health professional k) Communication skills that include preserving the dignity of the resident and showing respect for	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01370	Continued From page 66 the resident and the resident's preferences, cultural background, and family l) awareness of confidentiality and privacy m) Understanding appropriate boundaries between staff and residents and the resident's family n) Procedures to use in handling various emergency situations o) Awareness of commonly used health technology equipment and assistive devices." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370			
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by:	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01380	Continued From page 67 Based on observation, interview, and record review, the licensee failed to ensure competency evaluations required for unlicensed personnel (ULP) providing assisted living services were completed for one of two employees (owner/ULP (O/ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: O/ULP-C was hired December 1, 2020, and provided direct care assistance to residents. On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she and O/ULP-C were the only unlicensed personnel working currently, and each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. On July 6, 2026, at 8:00 a.m., the surveyor observed O/ULP-C at the temporary home located at 970 Western Avenue North, St. Paul, and she left the home shortly after the surveyor arrived. O/ULP-C's employee file lacked documentation of training for the following topics required for ULP's providing Assisted Living services: -safe transfer techniques and ambulation; and	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01380	Continued From page 68 -range of motioning and positioning. On July 1, 2026, at 12:19 p.m., ULP-A stated, via phone, the licensee no longer had access to the online training program the licensee previously used. ULP-A verbalized some of the initial training and competencies required for O/ULP-C must have been missed being completed. The licensee's Competency Training Evaluations policy, dated June 2021, indicated, "6. In addition to the above training and competency evaluation for unlicensed personnel providing assisted living services must include: a. Observing, reporting, and documenting resident status b. Basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel c. Reading and recording temperature, pulse, and respirations of the resident d. Recognizing physical, emotional, cognitive, and developmental needs of the resident e. Safe transfer techniques and ambulation f. Range of motioning and positioning g. Administering medications or treatments as required." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01440	Continued From page 69 appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a registered nurse (RN) conducted direct supervision of staff performing a delegated task within 30 days of providing services for two of two employees (unlicensed personnel (ULP)-A, owner/ULP (O/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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(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
01440	Continued From page 70 portion or all of the residents). The findings include: On June 29, 2026, at 11:30 a.m., during the entrance conference On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. ULP-A stated the licensee provided medication administration to both current residents. ULP-A verbalized both she and O/ULP-C had been trained by the previous registered nurse (RN) to administer medications. ULP-A ULP-A was hired on August 19, 2023, and provided direct care services for the licensee's assisted living residents. On June 30, 2026, from 8:33 a.m. to 8:51 a.m., the surveyor observed ULP-A assist R2 and R3 with medication administration. O/ULP-C O/ULP-C was hired on December 1, 2020, and provided direct care services for the licensee's assisted living residents. On July 6, 2026, at 8:00 a.m., the surveyor observed O/ULP-C at the temporary facility located at 970 Western Avenue North, St. Paul, and she left the home shortly after the surveyor arrived. ULP-A and O/ULP-C's record lacked documentation the RN conducted direct supervision of the ULP performing a delegated task within 30 days of performing the task.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01440	Continued From page 71 On June 30, 2026, at 1:02 p.m., registered nurse (RN)-B stated she had not yet had the opportunity to complete an observation of ULP-A or O/ULP-C's medication administration skills. On July 6, 2026, at 7:00 a.m., ULP-A stated, she had not been able to find a 30-day supervision for ULP-A or O/ULP-C. The licensee's 6.17 Supervision of Staff - Delegated Services policy dated June 2021, indicated, "1. Direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [Licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);	01470			

Minnesota Department of Health

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01470	Continued From page 72 (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual	01470			

Minnesota Department of Health

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01470	Continued From page 73 and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living facility licensing requirements and regulations prior to providing assisted living services to residents for one of three employees (registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-B was hired March 26, 2026, and provided direct nursing care services for the licensee's assisted living residents. On June 29, 2026, at 12:58 p.m., the surveyor observed RN-B at the temporary facility located at 970 Western Avenue North, St. Paul, covering part of a care shift while owner/unlicensed personnel (O/ULP)-C took R2 to an appointment. RN-B's employee record lacked documentation the following orientation topics were completed	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01470	Continued From page 74 prior to providing assisted living services: -an overview of the Assisted Living statutes 144G and rules; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. On June 30, 2026, at 1:02 p.m., RN-B stated, via phone, she had not received any training from the licensee since she was hired. The licensee's 5.01 Orientation of Staff and Supervisors & Content policy, dated June 2021,	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01470	Continued From page 75 indicated, 1. All [Licensee] employees must complete the orientation to assisted living facility requirements before providing assisted living services to residents. 2. The materials and/or type of training (i.e. video, lecture, reading, etc.) will be documented for compliance. 3. The orientation must contain the following topics: -An overview of the appropriate Assisted Living statutes and rules -An introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person -Handling of emergencies and use of emergency services -Compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC) -The assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights -Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person -Handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints -Consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services -A review of the types of assisted living services the employee will be providing and the facility's category of licensure -The staff person's job description upon hire and	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01470	Continued From page 76 whenever there is a change to the job description that changes the nature of the job or how the job is to be performed -The facility's organization chart and the roles of staff within the facility, and the services offered by the facility as identified in the uniform checklist disclosure of services -The identification of incidents of maltreatment as defined under Minnesota Statutes, section 626.5572, subdivision 15, including abuse, financial exploitation, and neglect, and an explanation that any act that constitutes maltreatment is prohibited." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470			
01500 SS=F	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such	01500			

Minnesota Department of Health

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01500	Continued From page 77 as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01500	Continued From page 78 Based on observation, interview, and record review, the licensee failed to ensure employees received at least eight hours of annual training for each 12 months of employment for two of two employees for whom annual training was required (unlicensed personnel (ULP)-A, and owner/ULP (O/ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she and O/ULP-C each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00 a.m., every day. ULP-A ULP-A was hired on August 19, 2023, and provided direct care services for the licensee's assisted living residents. On June 30, 2026, from 8:33 a.m. to 8:51 a.m., the surveyor observed ULP-A assist R2 and R3 with medication administration. ULP-A's employee record lacked documentation of eight hours of annual training completed within the last 12 months, including the following required topics: -training on reporting of maltreatment of	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01500	Continued From page 79 vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. O/ULP-C O/ULP-C was hired one December 1, 2020, and provided direct care services for the licensee's assisted living residents. On July 6, 2026, at 8:00 a.m., the surveyor observed O/ULP-C at the temporary facility located at 970 Western Avenue North, St. Paul, and left the home shortly after the surveyor arrived. O/ULP-C's employee record lacked documentation of eight hours of annual training	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01500	Continued From page 80 completed within the last 12 months, including the following required topics: -training on reporting of maltreatment of vulnerable adults under section 626.557; -review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; -effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. On July 1, 2026, at 12:19 p.m., ULP-A stated, via phone, the licensee no longer had access to the online training program the licensee previously used. ULP-A verbalized annual training had not been completed for ULP-A and O/ULP-C in 2024, 2025, or 2026. The licensee's 5.06 Annual Required Staff Training policy dated June 2021 indicated, "All staff that perform direct care services at	01500			

Minnesota Department of Health

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01500	Continued From page 81 [Licensee] will complete at least eight (8) hours of annual training for each 12 months of employment." In addition, included, "The following training elements MUST be included every 12 months to all staff who performs direct care services: 1. Training on reporting of maltreatment of vulnerable adults under section 626.557 2. Review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights 3. Review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases 4. Effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders 5. Review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures 6. Principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01530	Continued From page 82	01530			
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01530	Continued From page 83 topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure employees completed dementia care training (at least eight hours within 120 working hours of the employment start date), and two hours of initial training on mental illness and de-escalation topics for three of three employees (unlicensed personnel (ULP)-A, registered nurse (RN)-B, and owner/ULP (O/ULP)-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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: ULP-A, RN-B and O/ULP-C had hire dates of August 19, 2023, March 26, 2026, and December 1, 2020, respectively, and provided direct care services to the assisted living residents. On June 29, 2026, at 11:30 a.m., during the entrance conference, ULP-A stated she and owner/ULP (O/ULP)-C were the only unlicensed personnel working currently, and each worked 12-hour shifts: ULP-A worked 8:00 a.m. to 8:00 p.m., and O/ULP-C worked 8:00 p.m. to 8:00	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
(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
01530	Continued From page 84 a.m., every day. RN-B's employee record lacked documentation of the completed required training for the following: -initial eight hours of training related to dementia care, within 120 working hours of employment start date; and -two hours of initial training on mental illness and de-escalation topics. ULP-A and O/ULP-C's employee record lacked documentation of the completed required training for the following: -initial eight hours of training related to dementia care, within 160 working hours of employment start date; -two hours of initial training on mental illness and de-escalation topics; and -two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter. On July 1, 2026, at 12:19 p.m., ULP-A stated, via phone, the licensee no longer had access to the online training program the licensee previously used. ULP-A verbalized the licensee did not have the required documented hours of initial dementia, annual dementia, and mental health and de-escalation training for ULP-A, RN-B, and O/ULP-C. The licensee's 3.06 Module - 6 Mental Illness & De-escalation policy dated June 2025, indicated, "This training program is designed to comply with MN Statutes 144G.64 and 144G.63, ensuring all staff in assisted living facilities are equipped to recognize and respond appropriately to residents with mental health needs. Mental health refers to a person's emotional, psychological, and social	01530			

Minnesota Department of Health

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01530	Continued From page 85 well-being, affecting how they think, feel, and behave in daily life. Training topics include mental illness recognition, de-escalation techniques, and crisis resolution strategies." The licensee's 5.03 Dementia Training policy dated June 2021, indicated, "Assisted Living licensed facilities: 1. Supervisors of direct care staff will complete eight (8) hours of initial training within 120 hours of the employment start date. 2. Direct care employees will complete eight (8) hours of initial training within 160 hours of the employment start date. 3. Employees may not provide direct care until the training is complete unless another employee who has completed the initial training is present to provide assistance. 4. A qualified trainer or supervisor must be available for consultation with new employees until training is complete. 5. Non-direct care staff will complete four (4) hours of initial training within 160 hours of the employment start date. 6. All staff will complete two (2) hours of additional training for each 12 months of work thereafter." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			
01620 SS=F	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.	01620			

Minnesota Department of Health

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01620	Continued From page 86 (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 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	01620			

Minnesota Department of Health

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01620	Continued From page 87 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 a registered nurse (RN) conducted resident monitoring and reassessment including a reassessment completed within 14 days after the initiation of services 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 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 June 29, 2026, at 11:30 a.m., during the entrance conference, registered nurse (RN)-B stated the licensee completed nursing assessments upon admission, within 14 days of admission, every 90 days, and with a change in condition. R2 R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability.	01620			

Minnesota Department of Health

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01620	Continued From page 88 On June 29, 2026, at 11:30 a.m., during the entrance conference, unlicensed personnel (ULP)-A stated the licensee was currently not providing any treatment for the residents. ULP-A stated R2 used to have continuous positive airway pressure (CPAP) he used every night, but it had been more than a year since R2 used the CPAP device. R2's record included assessments completed June 24, 2024, July 13, 2024, April 7, 2026, and June 26, 2026. All assessments indicated R2 "independently uses CPAP". The assessments had not accurately identified R2 no longer used a CPAP device. On June 29, 2026, at 12:58 p.m., the surveyor observed the temporary home location at 970 Western Avenue North, St. Paul, with ULP-A. R2's bedroom was observed and there was no evidence of a CPAP machine. ULP-A stated R2 no longer used a CPAP device. On July 2, 2026, at 9:12 a.m., ULP-A stated, she had not realized R2's service plan still included the CPAP, and this should have been updated. R3 R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and	01620			

Minnesota Department of Health

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01620	Continued From page 89 medication administration. On June 30, 2026, at 8:44 a.m., the surveyor observed ULP-A assisting R3 with medication administration. R3's medical record included an initial assessment dated June 9, 2026, eight days after admission to the facility, and lacked a subsequent 14-day reassessment completed within 14 days after start of services. R3's record included a visit summary from a visit with her health care provider dated June 3, 2026. The summary indicated R3 had symptoms including vomiting, abdominal pain and diarrhea, and was diagnosed with a urinary tract infection. The summary indicated R3 would use a continuous glucose monitor (CGM) to be replaced every 14 days. The summary further indicated, "[R3] requires regular glucose monitoring, and self monitoring blood glucose is currently inadequate. To improve optimal blood sugar control CGM is medically necessary for this patient." R3's record lacked a nursing assessment to evaluate a change of condition after the provider visit. On July 6, 2026, at 2:05 p.m., the surveyor attempted a phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:25 a.m., the surveyor placed another phone call to RN-B. There was no answer. The surveyor left a message to return the call.	01620			

Minnesota Department of Health

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01620	Continued From page 90 On July 7, 2026, at 8:44 a.m., the surveyor placed a text message to RN-B which stated, "Hi [RN-B]. This is [surveyor] from Minnesota Department of Health (MDH). Have you received my messages yesterday and today? Please call me back a {sic} soon as you are able. Thank you." On July 7, 2026, at 11:16 a.m., RN-B responded to the text message indicating, "Yes I have. Sorry I have been really busy. I will be responding to the emails once I get home later today." As of July 8, 2026, at 1:30 p.m., no response to the surveyor had been received from RN-B by email, text, or phone. The licensee's 6.01 Assessments, Reviews & Monitoring policy dated June 2021, indicated, "3. 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." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the	01640			

Minnesota Department of Health

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01640	Continued From page 91 facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a current written service plan was revised and included a signature or other authentication by the resident, or their representative, documenting agreement on the services to be 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 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:	01640			

Minnesota Department of Health

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01640	Continued From page 92 On June 29, 2026, at 11:30 a.m., during the entrance conference, unlicensed personnel (ULP)-A and registered nurse (RN)-B stated the licensee had a current service plan for both residents and the residents would authenticate the service plan and revisions as needed. Also, ULP-A stated the licensee was currently not providing any treatment for the residents. ULP-A stated R2 used to have continuous positive airway pressure (CPAP) he used every night, but it had been more than a year since R2 used the CPAP device. R2 R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. On June 29, 2026, at 12:58 p.m., the surveyor observed the temporary home location at 970 Western Avenue North, St. Paul, with ULP-A. R2's bedroom was observed and there was no evidence of a CPAP machine. ULP-A stated R2 no longer used a CPAP device. On June 30, 2026, at 8:33 a.m., the surveyor observed ULP-A assist R2 with medication administration. R2's unsigned service plan, effective June 16, 2026, indicated R2 received services including assistance with housekeeping, bathing, incontinence care, vital signs, garbage removal, wheelchair use, managing behavior, CPAP treatment, and medication administration. R2's service plan had not been updated to indicate he no longer used a CPAP device. R2's record lacked:	01640			

Minnesota Department of Health

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01640	Continued From page 93 -a revised service plan to reflect the current services being provided, daily assistance with CPAP treatments at bedtime were no longer being provided; and -a service plan including a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. R3 R3 was admitted on June 1, 2026, and had diagnoses including anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). On June 30, 2026, at 8:44 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including medication administration four times daily and record weight two days per week. R3's service plan lacked a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. R3's record included documentation of services provided both on a paper form and in an electronic health record. -The electronic Service Recap Summary for June 2026, lacked documentation of monitoring weights two days per week, or documentation of refusal and follow-up actions. -The paper documentation, "Mental Health/Health Related/ADL Record" for June 2026, indiated the licensee assisted R3 with checking "vital signs" and weight weekly on the following dates: June 5,	01640			

Minnesota Department of Health

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01640	Continued From page 94 12, 19, and 26. The paper documentation lacked documentation of monitoring weights two days per week, or documentation of refusal and follow-up actions. The record lacked documentation services were provided as indicated on the service agreement. On July 1, 2026, at 11:04 a.m., the surveyor attempted a phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 1, 2026, at 12:26 p.m., RN-B had not responded to the previous contact. The surveyor placed a second call. RN-B's voicemail box was full, but the surveyor was able to send a short message service (SMS) text message with the telephone number, requesting a return call. On July 2, 2026, at 9:11 a.m., RN-B had not responded to previous attempts to contact her. The surveyor emailed RN-B requesting a response to questions provided in the email. On July 2, 2026, at 9:12 a.m., ULP-A stated, she had not realized R2's service plan still included the CPAP, and this should have been updated as well as authenticated. Also, ULP-A verbalized she was not sure why R3's service plan had not been authenticated. On July 2, 2026, at 9:40 a.m., RN-B had not responded to previous attempts to contact her. The surveyor placed a third call to RN-B. No answer, SMS text sent with number to return call. As of July 6, 2026, at 6:00 a.m., no response had been received from RN-B by email, text, or phone.	01640			

Minnesota Department of Health

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01640	Continued From page 95 The licensee's 6.08 Service Plan policy dated June 2021, indicated, "1. Within 14 days after the date that services are first provided to a resident, [Licensee] will finalize a written service plan. 2. The service plan and any revisions shall include a signature or other authentication by [Licensee] and by the resident, or resident's representative, documenting agreement on the services to be provided. 3. Services plans shall be revised, if needed, based on resident reassessments and monitoring. 4. Services plans shall include fees for the services indicated in the service plan. 5. [Licensee] shall provide information to the residents about any changes to the facility's fees for assisted living services, included with a change in fees is information how to contact the Office of Ombudsman for Long Term Care. 6. [Licensee] will implement and provide all services indicated in the service plan. 7. Services plans and any revisions or updates shall be entered into the resident's record, including notice of change in fees when applicable. 8. Staff providing services indicated in the service plan shall be informed of the current written service plan." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01650 SS=F	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided,	01650			

Minnesota Department of Health

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01650	Continued From page 96 the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the resident service plan included the required content 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 is issued at a widespread scope (when problems	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01650	Continued From page 97 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 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. The service plan did not include the licensee's current address. On June 30, 2026, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. R3 R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). On June 30, 2026, at 8:44 a.m., the surveyor observed ULP-A assist R3 with medication administration. R3's record included a Service Recap Summary for June 2026, documenting services provided. The documentation indicated the licensee assisted R3 with blood glucose monitoring June 26-29, 2026.	01650			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01650	Continued From page 98 R3's record included a visit summary from a visit with her health care provider dated June 3, 2026. The summary indicated R3 was to use a continuous glucose monitor (CGM) to be replaced every 14 days. The summary further indicated, "[R3] requires regular glucose monitoring, and self monitoring blood glucose is currently inadequate. To improve optimal blood sugar control CGM is medically necessary for this patient." R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. The service plan lacked any information related to blood glucose monitoring for R3, and did not include the licensee's current address. R2 and R3's service plans lacked the following: -a contingency plan that includes: -the action to be taken if the scheduled service cannot be provided; -information and a method to contact the facility. On July 2, 2026, at 9:12 a.m., ULP-A stated, she had not realized the licensee's service plan did not have a current address or telephone number for the facility and she would need to get this updated in the licensee's electronic medical record system. The licensee's 6.08 Service Plan policy revised June 2021, indicated, "9. A service plan will include: a. A description of the services that are to be provided based on the most recent assessment and resident preferences	01650			

Minnesota Department of Health

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01650	Continued From page 99 b. Fees for services to be provided c. The frequency of each service to be provided based on the most recent assessment and resident preferences d. An identification of staff or categories of staff who will be providing services (RN, LPN, unlicensed personnel, etc.) e. A schedule and method for the next planned assessment or monitoring f. A schedule and method for the next planned monitoring of staff providing services g. A contingency plan that includes: i. Actions [Licensee] will take if scheduled services cannot be provided ii. Information regarding how the resident can contact [Licensee]." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650			
01760 SS=L	144G.71 Subd. 8 Documentation of administration of medication 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.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 100 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were documented properly and administered as prescribed for two of two residents (R2, R3). This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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: R2 R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. R2's assessment dated June 26, 2026, indicated under the category, Medication Administration, "Specific resident instructions relating to the administration, monitoring, and documentation of medications, specify: RN will follow up with the resident and direct care staff administering all his scheduled medication, and treatment per provider order." The assessment further indicated, "Med Self-Admin [self-administration] is not applicable."	01760	The immediate order was identified July 6, 2026. The licensee provided a plan of correction on July 9, 2026, after survey exit.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 101 On June 30, 2026, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. ULP-A retrieved R2's locked medication box. R2's medications had been previously set up into a medi-set (a daily dosing medication box). ULP-A placed the contents of the medi-set section labeled Tuesday morning into a small paper cup. ULP-A stated she knew one medication was not included in the pharmacy pill pack, and retrieved a prescription bottle from the locked box: -Celebrex (celecoxib-for inflammation and pain) 100 mg: Take 1 capsule (100 mg) by mouth two times a day with meals. ULP-A asked R2 what "as needed" (PRN) medications he wanted to take that morning, and also retrieved the following PRN medication bottles: -hydroxyzine (for anxiety) 50 mg: one Capsule (50 mg) by mouth two times daily as needed, and -Flexeril (cyclobenzaprine-a muscle relaxant) 10 milligrams (mg): one tablet ULP-A added the additional medications to the paper cup. ULP-A did not follow the "rights" of medication administration, and verify the medications against R2's medication administration record (MAR), before she observed R2 swallow the medications from the paper cup. ULP-A documented medications administered from the medi-set on a paper MAR. ULP-A did not document the Flexeril administration; it was not included on R2's electronic or paper MAR for June 2026. ULP-A's record included medication administration training documentation dated August 19, 2023. The training was signed by a previous RN, and also by ULP-A. The training included the following:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 102 -Before, during, and after medication administration, check the six rights of medication administration by speaking the following out loud: Right Resident, Right Medication, Right Date, Right Time, Right Route, Right Dose. -If the medication is a non-scheduled or PRN (as needed) administration, document the effectiveness of the medication within 30 minutes of administration. Fundamentals of Nursing, 12th edition, 2025, on page 643 - Standards, indicated, "To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights: 1. The right medication 2. The right dose 3. The right patient 4. The right route 5. The right time 6. The right documentation 7. The right indication." A Regions Hospital Psychiatry Department Admission document dated June 14, 2026, indicated, on June 13, 2026, R2 was "admitted for agitation and psychosis from assisted living facility in the context of chronic medical conditions, chronic psychiatric conditions, non-adherence to both psychiatric and medical treatment, conflict with case worker, and poor insight. The patient is being admitted on a 72 hour hold." R2's hospital discharge medication orders dated June 26, 2026, included an illegible marking at the bottom of the page. ULP-A indicated this was the provider's signature. The marking was	01760			

Minnesota Department of Health

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01760	Continued From page 103 illegible and undated. The document indicated, "START taking these medications" which included: -aripiprazole (antipsychotic for schizophrenia and bipolar disorder) 20 mg tablet, "take one tablet (20 mg) by mouth daily for 13 doses"; -melatonin (for insomnia) 3 mg, "Take 3 tablets (9 mg) by mouth at bedtime as needed for Sleep". The document further indicated, "CONTINUE taking these medications" which included: -hydroxyzine 50 mg, "Take one Capsule (50 mg) by mouth two times daily as needed". R2's electronic MAR dated June 1-30, and July 1-2, 2026, indicated R2 was administered medication as follows: -aripiprazole 20 mg, one tablet by mouth "one time a day in the morning starts 6/26 01:51 PM"; the MAR lacked documentation the medication was administered on June 27-30, and lacked an end date for the medication to indicate when R2 would complete 13 doses, as ordered. -hydroxyzine 25 mg (daily) give 1-2 tablets (25-50 mg) by mouth every four hours as needed for anxiety or itching. oral: documented as "1" on June 28 only. The entry did not match the prescription order. There was no dosage or time indicated, no initials indicating who administered the medication, and no documentation of follow-up for effectiveness of the PRN medication. R2's paper MAR dated June 1-30, and July 1-2, 2026, indicated R2 was administered medication as follows: -aripiprazole 20 mg tab, "give one 20 mg by mouth one time in the morning": documented as administered June 27-30, at 7:00 a.m., and July 1-2 at 7:00 a.m. -"ariprazole {sic} 20 mg tablet. take one tablet	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 104 once daily": documented as administered June 27-30, at 9:00 a.m. July 1 at 9:00 a.m., and 9:00 p.m., and on July 2 at 9:00 a.m. The paper MAR indicated aripiprazole was administered twice daily in June rather than once daily, three times on July 1, and twice on July 2, rather than once daily. There was no end date noted on July MAR to indicate when R2 would have completed 13 doses, as ordered. -hydroxyzine 25 mg, "give 1-2 tablets (20-50 mg {sic}) by mouth every four hours as needed for anxiety or itching, oral": documented as administered by ULP-A on June 1, 3-6, 12-13, 16, 19-20, 22, 26, 28, 30, and July 1-2. The medication entry did not match the prescription order. There was no record of administration times, no indication of the actual dosage administered, and no documentation of follow-up for effectiveness of the PRN medication. R2's electronic and paper MARs both did not include melatonin as was ordered to be started on June 26, 2026. R3 R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. R3's assessment dated June 9, 2026, indicated under category Medication Administration, "twice	01760			

Minnesota Department of Health

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01760	Continued From page 105 a day and the ULP reminds her to take." The assessment further indicated, "Med Self-Admin is not applicable." R3's record included a provider office visit summary dated June 2, 2026, indicating R3 was seen by their provider for a possible urinary tract infection (UTI). The visit note indicated the provider ordered Macrobid (nitrofurantoin-an antibiotic) 100 mg, oral capsule; take one capsule by mouth twice daily for five days. R3's record lacked any documentation R3 was administered the antibiotic, as ordered above, to treat the UTI. R3's record also included a Regions Hospital Emergency Department After Visit Summary (AVS) dated June 28, 2026, where R3 was seen for pelvic pain. The instructions included, "We treated you for vaginal yeast infection as well as prophylactically for chlamydia and gonorrhea." No new medications were added subsequent to the emergency visit. On July 6, 2026, at 6:28 a.m., ULP-A stated she did not recall Macrobid being prescribed at R3's office visit dated June 2, 2026. ULP-A verbalized she was not sure why the prescription was not sent to R3's pharmacy. Also, ULP-A stated she was not sure why the nurse had not placed this information into R3's medical record. On July 6, 2026, at 6:39 a.m., registered nurse (RN)-B stated, via phone call, she was not aware R3 had an office visit on June 2, 2026. RN-B verbalized she was not updated by the licensee about this provider visit or any new orders as a result of this appointment.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 106 Guidance from Mayo Clinic on urinary tract infections (UTIs) dated September 26, 2025, indicated common symptoms of urinary tract infection can include pelvic pain that occurs mostly in the center of the pelvis and around the area of the pubic bone, and if left untreated, UTIs can cause serious health issues including the following: -Lasting kidney damage. Without treatment, UTIs can spread to the kidneys and damage them. The damage doesn't go away. -Sepsis. This complication of urinary tract infection can be life-threatening. The risk of sepsis is higher if the infection travels up the urinary tract to the kidneys. On June 30, 2026, at 8:44 a.m., the surveyor observed ULP-A assist R3 with medication administration. ULP-A took a pharmacy-provided medication packet labeled with R3's name and "Jun.30/26, Tue Morning," from the locked medication storage box and emptied the medications into a small paper cup. ULP-A did not perform the "rights" of medication administration and did not compare the medications to R3's MAR. After administering the medications, ULP-A documented the medications in R3's paper MAR. The medications included in the pharmacy medication pill pack included the following: -amlodipine (for high blood pressure) 2.5 mg tablet; -escitalopram (for depression) 10 mg tablet; -escitalopram 20 mg tablet; -famotidine (to decrease stomach acids) 20 mg tablet; -levothyroxin {sic} (replaces thyroid hormones) 75 micrograms (mcg) tablet; -metformin (to stabilize blood sugar) 500 mg extended release (ER), two tablets;	01760			

Minnesota Department of Health

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01760	Continued From page 107 -pantoprazole (for heartburn) 40 mg tablet; and -pregabalin (for nerve pain) 75 mg capsule. R3's electronic MAR dated June 2026, indicated R3 was administered medications as follows: -metformin 500 mg, "take 2 tablets by mouth (1000 mg), twice every day (Starts: 06/15 03:00 PM)"; documented as administered "AM" on June 16-18, 20, 22, 26-30. -metformin 500 mg, "give 2 - 500 mg tabs (1000 mg) by mouth, two times day{sic} Starts 06/15 03:16 PM"; documented as administered "AM" on June 16-18, 20, 22, 26-30, and "PM" on June 18, 22, 24, and 26-30. The documentation indicated the medication was administered three times rather than twice daily on June 18, 22, and 26-30. The record lacked documentation of the time administered, and documentation as to why metformin was not administered as ordered June 19-21 and 23-25. -hydroxyzine (daily) give one 25 mg. tab up to 3 dose {sic} in a 24 hour period by mouth (Starts: 06/15 03:55 PM); not documented as administered in June 2026. The electronic MAR did not include documentation of the following medications that were included in the pharmacy pill pack: -famotidine 20 mg tablet; -pantoprazole 40 mg tablet; and -pregabalin 75 mg capsule. R3's record also included a paper MAR with hand-written documentation. The initials on the MAR for June 1-30, 2026, were all entered identically in blue ink, in straight lines across the paper, with the initials for ULP-A appearing in every a.m. space and the initials for ULP-C appearing in every p.m. entry space, with no other deviations in who administered the	01760			

Minnesota Department of Health

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01760	Continued From page 108 medications, handwriting, and no documented refusals or missed doses. The paper MAR indicated R3 was administered medications including the following: -metformin 500 mg, "give 2 tablets by mouth, twice daily"; documented as administered twice daily at 9:00 a.m. and 9:00 p.m.; -hydroxyzine, "25 mg tablet. Take 1 tablet by mouth every six hours as needed for anxiety."; documented as administered by ULP-A on June 1, 5, 15-18, 23-24, and 27. There was no documentation of the time administered and no documentation of follow-up for effectiveness of the PRN medication. The paper MAR did not include the following medications that were included in the pharmacy pill pack: -famotidine 20 mg tablet; -pantoprazole 40 mg tablet; and -pregabalin 75 mg capsule. The medication administration information documented on R3's electronic MAR differed from the information documented on the paper MAR. R3's medication record lacked evidence of provider orders for all scheduled and PRN medications. On June 30, 2026, at 8:33 a.m., ULP-A stated the licensee's electronic MAR was not functioning well at times, so the licensee used a paper MAR for resident medication administration documentation. On June 30, 2026, at 8:55 a.m., ULP-A stated she did not check the electronic or paper MAR before administering R2 and R3's medications. ULP-A verbalized she does the medications for these residents every day and knows the medications the residents receive.	01760			

Minnesota Department of Health

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01760	Continued From page 109 On June 30, 2026, from 1:02 p.m. to 1:52 p.m., registered nurse (RN)-B stated, via phone call, the licensee hired her initially to only complete weekly medication set ups for the residents. RN-B stated the licensee would only allow her to take 20 minutes to complete medication set ups and she stated ULP-A always wanted to make sure she was present when RN-B was at the facility to complete medication set ups. RN-B stated the employees were to call her if a PRN medication was needed for one of the residents, and indicated she had not yet been notified of any PRNs needing to be given, to date. RN-B verbalized she had not completed supervision of medication administration for ULP-A or owner/ULP-C. RN-B verbalized she would be available for any questions as the surveyor began review of the resident medical records. On July 1, 2026, at 11:04 a.m., the surveyor attempted a phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 1, 2026, at 12:26 p.m., RN-B had not responded to the previous contact. The surveyor placed a second call. RN-B's voicemail box was full, but the surveyor was able to send a short message service (SMS) text message with the telephone number, requesting a return call. On July 2, 2026, at 9:11 a.m., RN-B had not responded to previous attempts to contact her. The surveyor emailed RN-B requesting a response to questions provided in the email. On July 2, 2026, at 9:40 a.m., RN-B had not responded to previous attempts to contact her. The surveyor placed a third call to RN-B. No	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 110 answer, SMS text sent with number to return call. As of July 6, 2026, at 6:00 a.m., no response had been received from RN-B by email, text, or phone. On July 6, 2026, at 6:19 a.m., ULP-A stated, she created R2 and R3's paper MARs on her computer. ULP-A verbalized she was the person who updated the paper MARs by copying the information from the residents' electronic medical record. After observation, interview and record review related to medication administration for R2 and R3, the surveyor was unable to determine what medications were administered, if the medications administered were administered according to provider orders, and if unlicensed staff were administering as-needed medications appropriately. The licensee's 7.00 Medication Management Services Required policy, dated June 2021, indicated, "An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines." The licensee's 7.15 Medication & Treatment - Administration & Delegation policy dated June 2021, indicated, "When administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [Licensee] will ensure that the registered nurse has:	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 111 1. Instructed the unlicensed personnel (ULP) in the proper methods with respect to each resident to administer the medications or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures 2. Specified, in writing, specific instructions for each resident and documented those instructions in the resident's records 3. Communicated with the unlicensed personnel about the individual needs of the resident." The licensee's 7.16 Medication & Treatment Orders - Implementing policy dated June 2021, indicated, "Medication and treatment/therapy orders received by [Licensee] must be implemented within 24 hours of receipt." The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy dated June 2021, indicated, "1) The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy 2) If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided." No further information was provided.	01760			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01760	Continued From page 112	01760			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup by the registered nurse (RN) included all the 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 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: R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01770	Continued From page 113 assistance with managing behavior and medication administration. On June 29, 2026, at 11:30 a.m., during the entrance conference, registered nurse (RN)-B stated the licensee provided medication management services for R2, which included weekly medication setup into a medi-set (a daily dosing medication box) by the RN. R2's assessment dated June 26, 2026, indicated under the category, Medication Administration, "Specific resident instructions relating to the administration, monitoring, and documentation of medications, specify: RN will follow up with the resident and direct care staff administering all his scheduled medication, and treatment per provider order." The assessment further indicated, "Med Self-Admin [self-administration] is not applicable." On June 30, 2026, at 8:33 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R2 with medication administration. ULP-A retrieved R2's locked medication box. R2's medications had been previously set up into a medi-set. ULP-A placed the contents of the medi-set section labeled Tuesday morning into a small paper cup, and administered the medications to R2. R2's record included a document titled "Resident Notes" with nurse notes documented from April 7, 2026, to June 9, 2026, indicating RN-B completed a medication set up on April 7, 14; May 12, 19, 26; and June 9, 2026. The document lacked any evidence medication setup was completed for R2 between April 14 - May 12, and June 9 - June 30. R2's medication setup documentation lacked the following:	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01770	Continued From page 114 - name of medication; - quantity of dose; - times to be administered; and - route of administration. On June 30, 2026, at 1:02 p.m., RN-B stated, via phone, she completed R2's medication set up into his daily dose mediset once per week. RN-B verbalized she completed a weekly medication review progress note but was not aware of the required medication information to be included. The licensee's 7.08 Medication Management - Administration & Setup policy dated June 2021, indicated, "The nursing staff and unlicensed personnel trained to provide medication administration at [Licensee] will document any medication administration provided accurately in each resident record. A licensed nurse will correctly and accurately document any medication setup provided." In addition, included, "6. The licensed nurse who sets up the medications in the dosage box will observe and monitor the past week's medication administration documentation and compliance and will initial that this has been done. The medication regimen will also be updated and reviewed at the same time of medication set up. 7. The licensed nurse who sets up the medications will also be observant of any problems regarding storage of medications. 8. A licensed nurse will set up medications in dosage boxes for the resident, usually on a weekly basis, and will make or direct changes between set ups when necessary. ULP will verify medications are set up correctly in the dosage box before administration to the resident by use of the medication profile. If any question of medication accuracy in the dosage box arises, the unlicensed staff will contact the licensed nurse	01770			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01770	Continued From page 115 and receive direct instructions on handling any necessary changes at that time, while in direct contact with the nurse." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
01820 SS=F	144G.71 Subd. 13 Prescriptions There must be a current written or electronically recorded prescription as defined in section 151.01, subdivision 16a, for all prescribed medications that the assisted living facility is managing for the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure there were current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a, for all prescribed medications that the assisted living facility was managing 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 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:	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 116 R2 R2 was admitted on June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026, indicated R2 received services including assistance with managing behavior and medication administration. R2's record included both an electronic medication administration record (MAR) and a second, paper MAR. R2's paper MAR for June 2026, indicated R2 was scheduled to take the following medications: -ammonium lactate (for dry skin) 12 percent (%), "Apply topically to the affected area twice daily;" -aripiprazole (an antipsychotic) 20 milligrams (mg), "Tab Give one 20 mg by mouth one time in the morning;" -aripiprazole 20 mg tablet, "Take 1 tablet once daily;" -aspirin (for pain/blood thinner) 81 mg, "Take 1 Tablet by Mouth Daily;" -celecoxib (for inflammation/pain) 100 mg, "Take 1 capsule (100 mg) by mouth two times daily with meal;" -eplerenone (for high blood pressure) 25 mg, "Take 1 tablet by mouth once daily;" -folic acid (a supplement) 1 mg, "Give 1mg tablet one time every day by mouth;" -lisinopril (for high blood pressure) 30 mg, "Give one 30 mg table (sic) by mouth one time daily;" -metoprolol (for high blood pressure) 50 mg, "Give 1 tablet (50 mg) by mouth once daily. Oral;" -multivitamin/multimineral (a supplement), "Take one tab by mouth one time a day every day;" -rosuvastatin (for high cholesterol), "Give 1 tablet	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 117 20 mg by mouth every evening-oral;" -tamsulosin (for enlarged prostate) 0.4 mg, "Capsule Give 1 once daily capsule after a meal. Oral;" and -thiamine (a supplement) 100 mg, "Give one 100 mg tablet by mouth everyday in the morning." The paper MAR also included the following as needed (PRN) medications: -hydroxyzine (for anxiety) 25 mg "Give 1-2 tablets (20-50 mg) by mouth every 4 hours as needed for anxiety or itching. oral;" -loperamide (anti-diarrheal) 2 mg capsule, "Give 1 capsule by mouth 4 times daily as needed for diarrhea;" -nicotine lozenge mint 2 mg, "Place 1 lozenge (2 mg) inside cheek every hour as needed for smoking cessation;" -Nitro-Bid (nitroglycerin) 0.4 mg, "Every 0.08 hours. Give one tab under the tongue every 15 min. as needed for chest pain. Repeat every 15 min until help arrives;" -nystatin 10000 international units (iu) 3 times per day, "Apply a small amount of powder to groin up to 3 times every day;" -pain reliever regular strength 325 mg tablet, "Give 2 tablet (650 mg) by mouth every 4 hours as needed for mild pain;" -terbinafine hydrochloride (anti-fungal), "Apply a small amount of cream to groin PRN itching up to two times a day." R2's electronic MAR for June 2026, indicated R2 included the above listed medications, and also included: -olmesartan medoxomil (for high blood pressure) 20 mg, "TAKE 1 TABLET (20MG) BY MOUTH ONCE DAILY." R2's hospital discharge medication orders dated	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 118 June 26, 2026, included an illegible marking at the bottom of each page. ULP-A indicated this was the provider's signature. The marking was illegible and undated. The document indicated, "START taking these medications" and indicated: -aripiprazole (antipsychotic for schizophrenia and bipolar disorder) 20 mg tablet, "take one tablet (20 mg) by mouth daily for 13 doses;" -aripiprazole extended-release injection 400 mg, "Inject 400 mg intramuscularly every 4 weeks." ULP-A stated R2 received these injections at the providers clinic; -lisinopril 30 mg, "Take 1 Tablet (30 mg) by mouth daily;" -melatonin (for insomnia) 3 mg, "Take 3 tablets (9 mg) by mouth at bedtime as needed for Sleep;" -multivitamin with minerals, "Take 1 Tablet by mouth daily;" -nystatin (an antifungal) 100000 units/gram powder, "Apply topically three times a day as needed for rash;" -terbinafine 1% cream, "Apply topically to affected area(s) two times a day;" and -thiamine 100 mg, "Take 1 Tablet (100 mg) by mouth daily." The document further indicated, "CONTINUE taking these medications," and indicated: -acetaminophen (for pain) 325 mg, "Take 1-2 Tablets (325-650 mg) by mouth every 6 hours as needed for Pain;" -ammonium lactate 12% lotion, "Apply 1 Application topically two times a day;" -aspirin 81 mg, "Take 1 Tablet (81 mg) by mouth daily;" -celecoxib 100 mg, "Take 1 Capsule (100 mg) by mouth two times a day with meals;" -eplerenone 25 mg, "Take 1 Tablet (25 mg) by mouth daily;"	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 119 -folic acid 1 mg, "Take 1 Tablet (1 mg) by mouth daily;" -hydroxyzine pamoate (for anxiety) 50 mg, "Take one Capsule (50 mg) by mouth two times daily as needed;" -loperamide 2 mg capsule, "Take 2 capsules by mouth 4 times daily as needed for Diarrhea;" -metoprolol succinate 50 mg 24 hour release tablet, "Take 1 Tablet (50 mg) by mouth daily;" -nitroglycerin 0.4 mg, "Place 1 tablet under tongue every 5 min. as needed for chest pain;" -rosuvastatin 20 mg, "Take 1 Tablet (20 mg) by mouth daily at bedtime;" -nicotine 2 mg lozenge, and -tamsulosin 0.4 mg, "Take 1 Capsule (0.4 mg) by mouth." The discharge medication list did not include olmesartan medoxomil , as was listed on R2's electronic MAR. R2's record lacked current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a, for all medications the licensee managed for R2. R3 R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. R3's record included both an electronic MAR and	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 120 a paper MAR. R3's paper MAR for June 2026, indicated R3 was scheduled to take the following medications: -amlodipine (for high blood pressure) 2.5 milligrams (mg), "Take 1 TABLET BY MOUTH DAILY AT MORNING;" -BenzePrO (reduces acne bacteria) 5 percent (%), "Apply topically evenings;" -clotrimazole and betamethasone dipropionate (an antifungal) 1-0.05%, topical. "Apply small amount to areas of rash two times every day on top of skin.;" -escitalopram (for depression) 10 mg, "Give 3 tab by mouth daily;" -haloperidol (an antipsychotic) 10 mg, "Give 1 tablet by mouth daily at BEDTIME.;" -haloperidol 5 mg, "Give 1 tablet by mouth daily at BEDTIME;" -trazodone (for insomnia) 50 mg. Take 1 tablet by mouth daily at bedtime.;" -metformin (stabilize blood sugars) extended release (ER) 500 mg, "Give 2 tablets by mouth twice daily;" -Pepcid (for indigestion) 20 mg, "Give 1 tablet by mouth daily;" -Singulair (for asthma) 10 mg, "Take 1 tablet by mouth daily at BEDTIME;" -Skin Conditioner (for dry skin), "Apply Topically 4 times daily after toileting;" and -Symbicort {sic} (for asthma) 160-4.5 mg, "Take 2 puffs by mouth 2x daily." R3's electronic MAR for June 2026, indicated R3 was scheduled to take the above-listed medications, and additionally included: -levothyroxine (replaces thyroid hormone), "Give before morning meal. 75 micrograms (mcg) (sic) by mouth one time a day."	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 121 R3's record lacked current written or electronically recorded prescriptions as defined in section 151.01, subdivision 16 a, for all medications the licensee managed for R3. On June 30, 2026, at 1:02 p.m., registered nurse (RN)-B stated, via phone, she was not aware the After Visit Summaries (AVS) documents did not contain a legal prescription. Education provided. Also, RN-B stated unlicensed personnel (ULP)-A would not regularly provide the provider documents or office visit summaries for R2 or R3. Finally, RN-B verbalized she was only allowed approximately twenty minutes to complete the weekly medication set ups for R2 and R3. The Office of the Revisor of Statutes defined 151.01 Subd. 16 a., "Prescription. "Prescription" means a prescription drug order that is written or printed on paper, an oral order reduced to writing by a pharmacist, or an electronic order. To be valid, a prescription must be issued for an individual patient by a practitioner within the scope and usual course of the practitioner's practice, and must contain the date of issue, name and address of the patient, name and quantity of the drug prescribed, directions for use, the name and address of the practitioner, and a telephone number at which the practitioner can be reached. A prescription written or printed on paper that is given to the patient or an agent of the patient or that is transmitted by fax must contain the practitioner's manual signature. An electronic prescription must contain the practitioner's electronic signature." The licensee's 7.20 Medication & Treatment Orders policy dated June 2021, indicated, "PROCEDURE: 1) The RN is responsible for assuring that:	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 122 a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff. 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance."	01820			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01820	Continued From page 123 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01820			
01880 SS=D	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: Based on observation, interview, and record review, the licensee failed to ensure medications were stored securely for one of two residents (R2) with medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 June 25, 2024, and had diagnoses including schizoaffective disorder, bipolar disorder, antisocial personality disorder, polysubstance use, and mild intellectual disability. R2's service plan, effective June 16, 2026,	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
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01880	Continued From page 124 indicated R2 received services including assistance with managing behavior and medication administration. On June 29, 2026, at 12:58 p.m., the surveyor toured the temporary residence located at 970 Western Avenue North, St. Paul, with unlicensed personnel (ULP)-A. During the tour, the surveyor observed a prescription bottle of nitroglycerin 0.4 milligrams (mg) (for chest pain) in the hallway of the lower-level of the facility where R2's bedroom was located. ULP-A stated R2 wanted to have this medication with him in case he needed it so R2 would not let the licensee secure this medication. R2's assessment dated June 26, 2026, indicated direct care staff administered all R2's scheduled medication, and treatment per provider order. The assessment further indicated, "Med Self-Admin [self-administration] is not applicable." The assessment also included under Medication Management: -Secure storage of controlled medications, specify: "All controlled substances are double-locked in the medication cabinet. Staff are responsible for counting every shift and when administered"; -Secure storage of all other medications, specify: "Locked in the medication cabinet. keys with staff are (sic) all times"; and -Interventions in place to prevent the diversion of medications by the resident or others who may have access to the medications, specify: "Medications are secured in the medication cabinet. A resident has no access to the medicines (sic) for diversion. Staff count medications at the shift change." R2's hospital discharge medication orders dated	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01880	Continued From page 125 June 26, 2026, included an illegible marking at the bottom of the page. ULP-A indicated this was the provider's signature. The marking was illegible and undated. The document indicated, "CONTINUE taking these medications" which included: -nitroglycerin 0.4 mg, sublingual tablet, place one tablet under tongue every five minutes as needed. R2's paper and electronic medication administration record (MAR) dated May 2026 to July 2026, indicated the licensee had not documented any administration of nitroglycerin for R2 during this time. On June 30, 2026, at 1:02 p.m., registered nurse (RN)-B stated she was not aware there was a bottle of R2's nitroglycerin unsecured in the lower level hallway area near his bedroom. RN-B stated R2 could not safely perform self-administration of medication independently and all his medications should be secured. The licensee's 7.11 Medication Storage policy, dated June 2021, indicated, "When medications are managed and stored by [Licensee], medications will be kept securely locked and stored per manufacturer's directions. Only authorized staff will have access to stored medications." In addition, included, "PROCEDURE: -Medications will be stored consistent with each residents' medication management plan and service plan. -Medications managed by [Licensee] will be stored to prevent diversion of medications by residents or others who may have access to the medications. Diversion means the misuse, theft, or illegal or improper dispositions of medications.	01880			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01880	Continued From page 126 -Medications managed outside of a resident's private "living space" must be in securely locked and substantially constructed compartments and permit only authorized personnel to have access. This may be a medication room, medication cart, or similar setup. -Medications will be stored consistent with manufacturer's recommendations (refrigerated, room temperature, or frozen)." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition.	01910			

Minnesota Department of Health

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01910	Continued From page 127 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide documentation in the resident's record regarding the disposition of medication to include medication name, quantity and names of staff and other individuals involved in the disposition of medications for one of one discharged resident (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: R1's record included a discharge summary printed June 30, 2026. The summary indicated R1 was admitted to the licensee on February 12, 2025, and discharged on May 3, 2025. The discharge reason was listed as, "Nursing Home Transfer". The summary lacked any information related to the disposition or transfer of medications for R1. R1's record included a Medication list printed July 1, 2026. The list indicated the nurse set up medications for R1, and the following medications were started February 18, 2025: -benztropine (for Parkinson's) 1 milligram (mg); -haloperidol (for agitation) 2 mg; -omeprazole (for indigestion) 40 mg; -polyethylene glycol powder (for constipation); -vitamin D (a supplement) 50,000 units (u);	01910			

Minnesota Department of Health

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01910	Continued From page 128 -cyclobenzaprine hydrochloride 5 mg as needed (PRN); -ibuprofen 600 mg PRN; -lorazepam 0.5 mg PRN; -naproxen 500 mg PRN; -famotidine 20 mg PRN; and -senna concentrate/docusate sodium 8.6 mg - 50 mg PRN. R1's record lacked documentation of R1's disposition of medications upon termination of the service plan, with the following requirements: -the name of the medication; -strength; -prescription number if applicable; -quantity; -to whom the medications were given; -date of disposition; and -the names of the staff and other individuals involved in the disposition. On July 1, 2026, at 10:49 a.m., unlicensed personnel (ULP)-A stated they did not have a disposition record for R1. ULP-A later stated R1's medication disposition documentation was either accidentally disposed of or damaged because of the water damage that occurred in the lower level of the facility. The licensee's 7.23 Medication Disposal policy, dated June 2021, section titled Unused Prescription Drugs indicated, "Current unused medications managed by [Licensee] will be returned to the pharmacy for credit, or given to the resident or the resident's representative, when the resident's medications are no longer managed by the facility or the medication has been discontinued by the prescriber. Upon disposition, the facility must document in the resident's record the disposition of the medication	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01910	Continued From page 129 including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
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 (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and	01940			

Minnesota Department of Health

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01940	Continued From page 130 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 (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 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: R3 was admitted on June 1, 2026, and had diagnoses including paranoid schizophrenia, bipolar disorder, post-traumatic stress disorder (PTSD), organic personality syndrome, antisocial personality disorder, anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. R3's assessment dated June 9, 2026, indicated	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01940	Continued From page 131 on page four, "PHYSICAL, Endocrine Diabetic, specify: NIDDM (Non-Insulin Dependent Diabetes Mellitus)." R3's record included a Service Recap Summary for June 2026, documenting services provided. The documentation indicated the licensee assisted R3 with blood glucose monitoring June 26-29, 2026. R3's record included a visit summary from a visit with her health care provider dated June 3, 2026. The summary indicated R3 was to use a continuous glucose monitor (CGM) to be replaced every 14 days. The summary further indicated, "[R3] requires regular glucose monitoring, and self monitoring blood glucose is currently inadequate. To improve optimal blood sugar control CGM is medically necessary for this patient." R3's record included an Individualized Treatment and Therapy Plan last updated June 18, 2026. The plan indicated blood pressure monitoring, to be provided daily by unlicensed personnel, but lacked information related to blood glucose monitoring. The plan further indicated, "RN - Review the previous weeks blood sugar and blood pressure values". The Treatment Management Plan lacked the following: -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to unlicensed personnel; -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and -any resident-specific requirements relating to	01940			

Minnesota Department of Health

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01940	Continued From page 132 documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On June 30, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3 with medication administration. ULP-A verbalized that R3 had been refusing since she moved into the facility to have the nurse place her blood glucose monitor to monitor her blood glucose levels. On July 6, 2026, at 2:05 p.m., the surveyor attempted a phone call to registered nurse (RN)-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:25 a.m., the surveyor placed another phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:44 a.m., the surveyor placed a text message to RN-B which stated, "Hi [RN-B]. This is [surveyor] from Minnesota Department of Health (MDH). Have you received my messages yesterday and today? Please call me back a {sic} soon as you are able. Thank you." On July 7, 2026, at 11:16 a.m., RN-B responded to the text message indicating, "Yes I have. Sorry I have been really busy. I will be responding to the emails once I get home later today." As of July 8, 2026, at 1:30 p.m., no response to the surveyor had been received from RN-B by email, text, or phone.	01940			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01940	Continued From page 133 The licensee's 7.05 Treatment and Therapy Management Plan policy, dated June 2021, indicated, "1. [Licensee] will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: a. A statement of the type of services that will be provided b. Documentation of specific resident instructions relating to the treatments or therapy administration c. Identification of treatment or therapy tasks that will be delegated to unlicensed personnel d. Procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services e. Any resident-specific requirements relating to documentation of treatment and therapy received f. Verification that all treatment and therapy was administered as prescribed g. Monitoring of treatment or therapy to prevent possible complications or adverse reactions." Also, included, "2. The treatment or therapy management record must be current and updated when there are any changes." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940			
01960 SS=G	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01960	Continued From page 134 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document treatment administration, or indication why the treatment was not administered as ordered, for one of two residents (R3). 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 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: R3 was admitted on June 1, 2026, and had diagnoses including anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including medication administration four times daily and record weight two days per week. R3's record included a visit summary from a visit with her health care provider dated June 3, 2026. The summary indicated R3 had symptoms	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01960	Continued From page 135 including vomiting, abdominal pain and diarrhea, and was diagnosed with a urinary tract infection. The summary indicated R3 would use a continuous glucose monitor (CGM) to be replaced every 14 days. The summary further indicated, "[R3] requires regular glucose monitoring, and self monitoring blood glucose is currently inadequate. To improve optimal blood sugar control CGM is medically necessary for this patient." The summary indicated R3 would have a visit to follow up on blood glucose levels on July 28, 2026. R3's record included an Individualized Treatment and Therapy Plan last updated June 18, 2026. The plan indicated blood pressure monitoring, to be provided daily by unlicensed personnel, but lacked information related to blood glucose monitoring. The plan further indicated, "RN - Review the previous weeks blood sugar and blood pressure values". On June 30, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3 with medication administration. ULP-A stated R3 had refused to have the nurse place her continuous blood glucose monitor to monitor her blood glucose levels since she moved into the facility (June 1, 2026). R3's record included Resident Notes from May 1, 2026, to June 30, 2026. The notes indicated the following: -June 18, 2026, "Nurse Note, Reviewed medications and visited with resident. She does not wat {sic} to take her blood glucose levels. MD notified;" and -June 30, 2026, "Record - Blood Glucose REFUSED." No other notes were written related to blood	01960			

Minnesota Department of Health

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01960	Continued From page 136 glucose monitoring, ar any further communication with R3's physician. R3's record included documentation of services provided both on a paper form and in an electronic health record. -The electronic Service Recap Summary for June 2026, indicated the licensee assisted R3 with blood glucose and blood pressure monitoring June 26-29, 2026. The documentation lacked documentation of regular blood glucose monitoring or daily blood pressure monitoring on any other days in June, or documentation of refusal and follow-up actions. -The paper documentation, "Mental Health/Health Related/ADL Record" for June 2026, indiated the licensee assisted R3 with checking "vital signs" weekly on the following dates: June 5, 12, 19, and 26. The paper record lacked documentation of regular blood glucose monitoring or daily blood pressure monitoring on any other days in June, or documentation of refusal and follow-up actions. R3's medical record lacked evidence of the following: -regular blood glucose results and daily blood pressure readings; and -documentation of the reason why the treatment was not completed and any follow-up procedures that were provided to meet the resident's needs. The Centers for Disease Control and Prevention guidance, Your Immune System and Diabetes, dated May 15, 2024, indicated, "High blood sugar can trigger a protective immune response called inflammation, which can damage your internal organs over time. If you have inflammation, your immune system is working harder. When this happens while your immune system may already be weakened, it's harder to fight off infections.	01960			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 36815	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/07/2026
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01960	Continued From page 137 Research shows that people with diabetes can have more frequent illnesses like: -Respiratory tract infections -Influenza (flu) -Pneumonia -Urinary tract infections -Skin infections" R3's record included an After Visit Summary for an emergency department visit on June 27, 2026. The summary indicated R3 was seen for pelvic pain, and was diagnosed with a yeast infection and tested for gonorrhea and chlamydia. R3 was treated with azithromycin (an antibiotic used to treat bacterial infections and commonly used to treat sexually transmitted diseases) and a ceftriaxone injection (an antibiotic used to treat bacterial infections, and commonly used to treat urinary tract infections). On July 6, 2026, at 2:05 p.m., the surveyor attempted a phone call to registered nurse (RN)-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:25 a.m., the surveyor placed another phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:44 a.m., the surveyor placed a text message to RN-B which stated, "Hi [RN-B]. This is [surveyor] from Minnesota Department of Health (MDH). Have you received my messages yesterday and today? Please call me back a {sic} soon as you are able. Thank you." On July 7, 2026, at 11:16 a.m., RN-B responded to the text message indicating, "Yes I have. Sorry I have been really busy. I will be responding to the	01960			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER CARING ROSE HOMES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 449 AURORA AVE SAINT PAUL, MN 55103		
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01960	Continued From page 138 emails once I get home later today." As of July 8, 2026, at 1:30 p.m., no response to the surveyor had been received from RN-B by email, text, or phone. The licensee's 7.22 Medication & Treatment Record - Documentation & Refusal policy, dated June 2021, indicated, "PROCEDURE: 1)The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: a. The date, b. The time, c. The quantity of dosage, d. The method of administration of all prescribed legend and over-the-counter medications and or treatments/therapy e. Signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy 2) If medication and or treatment/therapy assistance and/or administration were not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided." No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01960			
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a	01970			

Minnesota Department of Health

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01970	Continued From page 139 description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain prescriber orders for all treatments and therapies, including the frequency, duration and other information needed to administer the treatment or therapy for one of two residents (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 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: R3 was admitted on June 1, 2026, and had diagnoses including anxiety, depression, sleep apnea, type two diabetes, and hypertension (high blood pressure). R3's unsigned service plan, dated June 16, 2026, indicated R3 received services including assistance with weight supervision and medication administration. R3's assessment dated June 9, 2026, indicated on page four, "PHYSICAL, Endocrine Diabetic, specify: NIDDM (Non-Insulin Dependent Diabetes	01970			

Minnesota Department of Health

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01970	Continued From page 140 Mellitus)." R3's record included a Service Recap Summary for June 2026, documenting services provided. The documentation indicated the licensee assisted R3 with blood glucose monitoring June 26-29, 2026. R3's record included a visit summary from a visit with her health care provider dated June 3, 2026. The summary indicated R3 was to use a continuous glucose monitor (CGM) to be replaced every 14 days. The summary further indicated, "[R3] requires regular glucose monitoring, and self monitoring blood glucose is currently inadequate. To improve optimal blood sugar control CGM is medically necessary for this patient." R3's record included Resident Notes from May 1, 2026, to June 30, 2026. The notes indicated the following: -June 18, 2026, "Nurse Note, Reviewed medications and visited with resident. She does not want {sic} to take her blood glucose levels. MD notified; and -June 30, 2026, "Record - Blood Glucose REFUSED." On June 30, 2026, at 8:55 a.m., the surveyor observed unlicensed personnel (ULP)-A assist R3 with medication administration. ULP-A verbalized that R3 had been refusing since she moved into the facility to have the nurse place her blood glucose monitor to monitor her blood glucose levels. R3's medical record lacked a signed prescriber order for R3's blood glucose testing.	01970			

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01970	Continued From page 141 On July 6, 2026, at 2:05 p.m., the surveyor attempted a phone call to registered nurse (RN)-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:25 a.m., the surveyor placed another phone call to RN-B. There was no answer. The surveyor left a message to return the call. On July 7, 2026, at 8:44 a.m., the surveyor placed a text message to RN-B which stated, "Hi [RN-B]. This is [surveyor] from Minnesota Department of Health (MDH). Have you received my messages yesterday and today? Please call me back a {sic} soon as you are able. Thank you." On July 7, 2026, at 11:16 a.m., RN-B responded to the text message indicating, "Yes I have. Sorry I have been really busy. I will be responding to the emails once I get home later today." As of July 8, 2026, at 1:30 p.m., no response to the surveyor had been received from RN-B by email, text, or phone. The licensee's 7.20 Medication & Treatment Orders policy dated June 2021, indicated, "PROCEDURE: 1) The RN is responsible for assuring that: a. current, authorized prescriber orders for medications or treatments administered by the staff are kept on file in the residents' records b. communicated to the resident or responsible party c. educate resident or responsible party on all medication and treatment orders, and d. changes in orders are addressed in the resident's service plan and are communicated to the other staff.	01970			

Minnesota Department of Health

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01970	Continued From page 142 2) An order for medication or treatment must contain the name of the resident, a description of the medication, treatment or therapy to be provided and the frequency, duration, and other information needed to carry out the order. 3) An order for medication or treatment must be dated, signed by the prescriber and must be current and consistent with the resident's nursing assessment. 4) Upon receiving verbal orders or unsigned electronic orders, a licensed nurse will record and sign the order and forward the written order to the prescriber for a signature after receipt of the verbal or electronic order. The licensed nurse will continue to follow-up with the prescriber's office until the signature is received. 5) The licensed nurse will communicate with the prescriber to assure that the prescriber renews a medication or treatment/therapy order at least every 12 months, or more frequently as needed. 6) The licensed nurse will review all medication and treatment orders for progress, effectiveness and necessity on a regular basis and with resident change of condition. 7) The license nurse will also monitor and evaluate medication and treatment/therapy orders and services for effectiveness on a regular basis. 8) A residents MAR and TAR will be audited regularly by licensed nurse or designee for documentation compliance." No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970			
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility	03090			

Minnesota Department of Health

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03090	Continued From page 143 entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entry way of the facility, including statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors to the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On June 29, 2026, at 10:49 a.m., the surveyor observed the licensee's postings at 449 Aurora Avenue, St. Paul, in all areas of the facility with unlicensed personnel (ULP)-A. On June 29, 2026, at 12:58 p.m., the surveyor observed all areas of the facility at the temporary facility location at 970 Western Avenue North, St. Paul, with ULP-A. The licensee lacked an electronic monitoring notice posted with the required statutory language	03090			

Minnesota Department of Health

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03090	Continued From page 144 at either location. On June 29, 2026, at 10:56 a.m., ULP-A stated they took the postings down at 449 Aurora Avenue, St. Paul, due to water damage that occurred in the lower level of the home on December 19, 2025. ULP-A verbalized R2 and R3 currently resided at the temporary facility location. Also, ULP-A stated, they could not put up any postings at the temporary address due to the home being a vacation rental home the licensee was using temporarily until the water damage was repaired at the licensed facility. The licensee's 2.15 Electronic Monitoring policy dated June 2021, indicated., "1. Signs are installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090			



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 Caring Rose Homes LLC 449 AURORA AVE St Paul, MN Ramsey County Parcel: Phone:	License Info License: HFID 36815 Risk: License: Expires on: CFPM: CFPM #: ; Exp:	Inspection Info Report Number: F1039261178 Inspection Type: Full - Single Date: 6/30/2026 Time: 11:00 AM Duration: minutes Announced Inspection: <u>Total Priority 1 Orders: 0</u> <u>Total Priority 2 Orders: 0</u> <u>Total Priority 3 Orders: 0</u> <u>Delivery:</u>
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No orders were issued for this inspection report.

Food & Beverage General Comment

MDH HRD assisted living facility survey conducted by MDH HRD nurse evaluator Dede Hinnendael. Establishment closed at time of inspection due to flooding. No residents are living at the site and no food service is conducted there. No food service inspection of this facility was conducted at this time. Assisted living facility residents are temporarily housed and provided food service at 970 Western Ave N in St Paul.

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 F1039261178 from 6/30/2026

Establishment Representative

Aron Goodner,
Public Health Sanitarian
651-201-4910
aron.goodner@state.mn.us

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL36815016-0	Date: June 28, 2026 - July 2, 2026
Facility Name: Caring Rose Homes LLC	
Facility Address: 449 Aurora Ave, St Paul, MN 55103 (licensed address) 970 Western Ave N, St Paul, MN 55103 (temporary location)	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Isolated

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. Escape window openings shall have a maximum height from the floor to the windowsill opening shall not exceed 48 inches. Escape windows with openings up to 52 inches off of the floor may meet the height requirement for existing buildings by securing a step, platform or bed to the wall directly underneath the window. This step, platform or bed shall be no more than 44 inches below the opening and must be strong enough to support the weight of the person. The minimum acceptable width shall be the same as the window opening. The minimum acceptable depth away from the wall shall be 18 inches. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.26.3, 1104.26.6.1]

Comments: In the 970 Western building the windowsill for the egress window in the room occupied by resident 2 (R2) was 50 inches above the finished floor.

3. Any device that has the physical appearance of life safety or fire protection equipment but that does not perform that life safety or fire protection function shall be prohibited.
- Comments: In the 970 Western building in the second floor common hallway there was an old nonfunctioning smoke alarm that was missing the battery and cover. There was an operable smoke alarm in the same area. Unlicensed personnel (ULP) – A stated that the landlord had left it that way.*

☒ TAG IDENTIFICATION: 0780

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: When the surveyor requested that ULP-A test the smoke alarms in the 970 Western building it was discovered that none of the smoke alarms were interconnected and all smoke alarms only sounded locally.

☒ **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 fire extinguishers in the 449 Aurora building were all installed too high above the finished floor. The fire extinguisher in the first floor living room was installed at 65 inches above the floor, the fire extinguisher in the hallway between the bedrooms was installed at 64 inches above the floor, and the fire extinguisher in the basement was installed at 62 inches above the floor.

The fire extinguishers in the 970 Western building were installed too high above the finished floor. Both fire extinguishers were installed 65 inches above the finished floor.

Fire extinguishers shall be installed so that the top of the fire extinguisher is no higher than 60 inches above the finished floor.

2. Portable fire extinguishers have a minimum 2-A:10-B:C rating within Group R-3 occupancies and travel distance to the nearest fire extinguisher does not exceed 75 feet. [Minn. Stat. 144G.45 subd.2]

Comments: In the 449 Aurora building the fire extinguishers in the first floor living room and in the basement were 1-A:10-B:C rated fire extinguishers.

In the 970 Western building, both fire extinguishers were 1-A:10-B:C rated fire extinguishers.

☒ **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: In the basement of the 449 Aurora building it was discovered that there was an active plumbing leak. There was water dripping from the ceiling in the basement living room area. There was a bucket on the ground that was catching the water that was dripping from the ceiling. The surveyor asked ULP-A if they were aware of the leak and if it was being addressed. ULP-A stated that there was no leak and that a previous plumbing leak in the first floor bathroom had already been repaired. When the surveyor pointed out the water actively dripping from the ceiling and dropping into a bucket on the floor ULP-A stated that they thought the dripping water could be caused by the air conditioner.

☒ **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 (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 provided FSEP was from a third-party provider and had not been updated to the specific facility.

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

Comments: During record review on June 30, 2026, at 11:07 a.m. ULP-A stated that the resident actions were in the binder that the nurse evaluator was looking at. On June 30, 2026, at 11:19 a.m. ULP-A stated that they did not have a written policy that discussed resident actions to take in the event of a fire or similar emergency.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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: No unique or unusual resident need for movement during an evacuation or relocation were provided during the record review.

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

Comments: During record review on June 30, 2026, at 11:20 a.m. ULP-A stated that staff receive training on the facility's FSEP quarterly. On June 30, 2026, at 11:23 a.m. ULP-A stated that they did not have any written record of staff receiving training on the FSEP available on site. No staff training records were provided for review during the survey.

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: ULP-A stated that they do not have any records of residents receiving training on the FSEP. No training records for residents were provided during the survey.

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: ULP-A stated that they do not have a written record of evacuation drills. No drill records were provided during the survey.