Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 27, 2026

Licensee
Aurora Carefree Living by Oxford Living
304 East 3rd Avenue South
Aurora, MN 55705

RE: Project Number(s) SL31407016

Dear Licensee:

On December 16, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on October 15, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the October 15, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on October 15, 2025, found not corrected at the time of the December 16, 2025, follow-up survey and/or subject to penalty assessment are as follows:

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

The details of the violations noted at the time of this follow-up survey completed on December 16, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

IMPOSITION OF FINES

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

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

REQUESTING A HEARING

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

We urge you to review these orders carefully. If you have questions, please contact Stephanie Jones de Palma at 651-201-4320.

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

Sincerely,

Stephanie Jones de Palma, Supervisor
State Engineering Services Section
Email: stephanie.jones.de.palma@state.mn.us
Telephone: 651-201-4320 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31407	A. BUILDING: _____ B. WING _____	R 12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA CAREFREE LIVING BY OXFORD LIVI	304 EAST 3RD AVENUE SOUTH AURORA, MN 55705

(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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS: SL31407016-1 On December 15, 2025, through December 22, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on October 15, 2025. As a result of the follow-up survey, the following order was reissued.	{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.	
{0 480} SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	{0 480}		

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

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{0 480}	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by:	{0 480}	Not reviewed during this survey.	
{0 510} SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 510}	Not reviewed during this survey.	

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{0 775}	Continued From page 3	{0 775}		
{0 775} SS=E	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, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On December 15, 2025, the surveyor emailed the licensee and requested follow-up survey documentation and a plan of correction for physical environment violations identified on October 13, 2025. On December 16, 2025, the licensee responded with a plan of correction and indicated the dementia care courtyard gate lock was removed. On December 19, 2025, the surveyor emailed the licensee and requested a photo of the courtyard gate. On December 22, 2025, the licensee provided a	{0 775}		

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{0 775}	Continued From page 4 gate photo. - The photo indicated the gate lock had been removed but the gate opening hardware was installed on the non-exit side (outside the fence) and not accessible to the building occupants. - The licensee responded they thought the gate was in compliance after the gate lock and cable were removed. Record review of the available documentation indicated the gate opening hardware was still not compliant on the day of the follow up. Previous survey findings: On October 13, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance coordinator (MC)-G. During the facility tour, the surveyor observed the following: In the secure dementia care unit, an illuminated exit sign was installed above the door leading to an exterior courtyard enclosed by a fence. The exterior exit gate that was part of the required marked exit path leading to the public way (parking lot/ street) had a lock installed requiring a code to unlock. Additionally, the gate opening hardware was installed on the non-exit side (outside the fence) and was not accessible to the building occupants. The chain lock was removed by MC-G while the surveyor was onsite.	{0 775}		
{0 790} SS=D	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	{0 790}		

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{0 790}	Continued From page 5 fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by:	{0 790}	Not reviewed during this survey.	
{0 810} SS=D	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.	{0 810}		

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{0 810}	Continued From page 6 (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:	{0 810}	Not reviewed during this survey.	
{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 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	{01500}		

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{01500}	Continued From page 7 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}	Not reviewed during this survey.	
{01530} SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-	{01530}		

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{01530}	Continued From page 8 (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 topics related to mental illness and de-escalation for each 12 months of employment thereafter;	{01530}		

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{01530}	Continued From page 9 This MN Requirement is not met as evidenced by:	{01530}	Not reviewed during this survey.	
{01910} SS=D	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. This MN Requirement is not met as evidenced by:	{01910}	Not reviewed during this survey.	
{02040} SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and	{02040}		

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{02040}	Continued From page 10 the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by:	{02040}	Not reviewed during this survey.	

Electronically Delivered

November 3, 2025

Licensee
Aurora Carefree Living by Oxford Living
304 East 3rd Avenue South
Aurora, MN 55705

RE: Project Number(s) SL31407016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 15, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

IMPOSITION OF FINES
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Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

pursuant to this survey:

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze, Supervisor
State Evaluation Team
Email: Jessie.Chenze@state.mn.us
Telephone: 218-332-5175 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	31407	A. BUILDING: _____ B. WING _____	10/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AURORA CAREFREE LIVING BY OXFORD LIVI	304 EAST 3RD AVENUE SOUTH AURORA, MN 55705

(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 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: SL31407016-0 On October 13, 2025, through October 15, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 51 residents; 51 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living 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.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated October 13, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24	0 480		

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0 480	Continued From page 3 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) 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 ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for two of two employees (unlicensed personnel (ULP)-F, ULP-L). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	0 510		

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0 510	Continued From page 4 a large portion or all of the residents). The findings include: R6's diagnosis included dementia. R6's Service Plan dated January 10, 2025, indicated R6 received assistance with dressing, grooming, bathing, toileting, bed mobility, transferring, eating and medication administration. On October 15, 2025, at 9:22 a.m., the surveyor observed ULP-F and ULP-L grab a pair of gloves and enter R6's room. ULP-F and ULP-L put on gloves and removed R6's urine soiled disposable brief. ULP-L removed R6's Tegaderm dressing from R6's coccyx and provided perineal cares, wearing the same pair of gloves, ULP-L applied a new Tegaderm (adhesive waterproof) dressing and ULP-F and ULP-L assisted R6 transfer into the geri chair (supportive recliner chair with wheels). ULP-H removed gloves and made R6's bed. ULP-L removed gloves, escorted R6 to the breakfast table and ULP-H and ULP-L washed hands in the dining room. On October 15, 2025, at 12:21 p.m., clinical nurse supervisor (CNS)-B stated ULPs were expected to complete hand hygiene before and after providing services to a resident. CNS-B further stated hand hygiene was expected to be conducted before putting on gloves and after removing gloves. CNS-B stated the licensee provided infection control training upon hire and an a minimum annually. On October 15, 2025, at 2:28 p.m., ULP-L stated ULP-L usually brought gloves into the resident	0 510		

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0 510	Continued From page 5 room because residents did not have gloves in each room; however, gloves should be available in each shared resident bathrooms. ULP-L stated gloves should have been changed after providing resident personal cares. The licensee's Hand Washing policy dated November 15, 2021, indicated hands should be washed: -before and after contact with a resident; -if moving from a contaminated-body site to a clean-body site during client care; and -after removal of gloves. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. This had the potential to directly affect all building occupants. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and	0 775		

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0 775	Continued From page 6 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: On October 13, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance coordinator (MC)-G. During the facility tour, the surveyor observed the following: CARBON MONOXIDE ALARMS/DETECTION -Carbon monoxide alarms were not installed within ten feet of all resident sleeping rooms. On October 13, 2025, MC-G provided a copy of the fire alarm inspection report dated March 6, 2025. Record review of the available documentation indicated carbon monoxide detectors were not tied into the building fire alarm system to sound an alarm notifying building occupants of the presence of carbon monoxide. During an interview on October 13, 2025, at 2:15 p.m., MC-G verified the above listed carbon monoxide observations and documentation. When carbon monoxide alarms are not tied into the building fire alarm system, carbon monoxide alarms are required to be installed within ten feet of all sleeping rooms. LOCKING - Electromagnetic locks were installed on the emergency exit doors in the secure dementia care unit and in the transitional assisted living area of the building where rooms 28-37 were located. Keypads were installed at these doors and required entry of a code into the keypad to	0 775		

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0 775	Continued From page 7 unlock. To exit the building from the secure dementia care unit, it required passing through two controlled egress doors. The means of egress from any point in the building shall not pass through more than one controlled egress locking system to reach the exterior of the building. - In the secure dementia care unit, an illuminated exit sign was installed above the door leading to an exterior courtyard enclosed by a fence. The exterior exit gate that was part of the required marked exit path leading to the public way (parking lot/ street) had a lock installed requiring a code to unlock. Additionally, the gate opening hardware was installed on the non-exit side (outside the fence) and was not accessible to the building occupants. The chain lock was removed by MC-G while the surveyor was onsite. During the facility tour interview, MC-G verified the above listed locking observations. All paths of egress escape must be maintained as a continuous, unobstructed path to safety. - On October 13, 2025, MC-G provided emergency evacuation plan documents. Record review of the available documentation indicated the plans did not include procedures to operate and unlock the controlled egress door locking system. During an interview on October 13, 2025, at approximately 2:15 p.m., MC-G verified these instructions were not included in the emergency plan. SPACE HEATERS There were portable space heaters in occupied	0 775		

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0 775	Continued From page 8 resident rooms 40 and 45, and in the dementia care shower room. During the facility tour interview, MC-G verified the space heater observations and stated since the geothermal heating system was not working, the licensee had provided the space heaters in room 40 and the shower room as a temporary heat source. MC-G stated they were not aware of the space heater in room 45; this space heater was removed while the surveyor was onsite. FIRE DOOR MAINTENANCE The door closer was broken on the exit door at the end of the corridor near rooms 28-30 and the door closer had been disconnected from the labeled mechanical room fire door. During the facility tour interview, MC-G verified the above listed door observations. Door closing devices shall be maintained as designed, so the doors automatically close and latch. CLOTHES DRYER MAINTENANCE In the assisted living laundry room, the exhaust duct was partially disconnected from the clothes dryer, creating a fire hazard. During the facility tour interview, MC-G verified the clothes dryer observation and corrected the venting while the surveyor was onsite. SMOKE ALARM MAINTENANCE Smoke alarms did not work when tested by MC-G in occupied resident rooms 16 and 28. During the facility tour interview, MC-G verified the smoke alarm observations. The smoke alarms were repaired and then tested as operable while the surveyor was onsite. Smoke alarms shall be maintained. ELECTRICAL	0 775		

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0 775	Continued From page 9 The weatherproof cover was missing from one exterior electrical outlet installed on the side of the building. During the facility tour interview, MC-G verified the electrical observation. Weatherproof covers for electrical outlets are required in outdoor locations to prevent water damage and electrical shocks. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=D	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to maintain four portable fire extinguishers as required by statute. This had the potential to directly affect all building occupants. 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	0 790		

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0 790	Continued From page 10 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: On October 13, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance coordinator (MC)-G. During the facility tour, the surveyor observed the following: - The tags attached to two mechanical room fire extinguishers were dated May 2024, indicating annual maintenance had not been performed by certified service personnel in the past twelve months. - Monthly inspections were not been recorded on the back of the tags attached to the fire extinguishers installed in the kitchen. Fire extinguisher inspections must be conducted every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation. During the facility tour interview on October 13, 2025, MC-G verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	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		

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0 800	Continued From page 11 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 and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety, and well-being of the residents. This had the potential to directly affect all building occupants. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: On October 13, 2025, at 11:00 a.m., the surveyor toured the facility with maintenance coordinator (MC)-G. During the facility tour, the surveyor observed the following: - The geothermal heating system was not working for the dementia care unit. MC-G stated during the facility tour interview, the system broke	0 800		

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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
0 800	Continued From page 12 on Friday, repair parts had already been ordered, and the system would be repaired once these parts arrived. MC-G explained space heaters would be provided by the licensee and used as needed until the system was repaired. - There were several holes in lawn in the dementia care and assisted living courtyards. The was a hole in the carpet in dementia care unit common use living room. These areas create a trip/fall hazard. - Several exterior lights were not securely attached to the side of the building. - One area of floor tiles was in disrepair in the employee dementia care laundry room. During the facility tour interview, MC-G verified the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=D	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	0 810		

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	31407	A. BUILDING: _____ B. WING _____	10/15/2025

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0 810	Continued From page 13 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 record review and interview, the licensee failed to provide the required drill frequency. This had the potential to directly affect all building occupants. 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:	0 810		

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0 810	Continued From page 14 On October 13, 2025, maintenance coordinator (MC)-G provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. DRILLS Record review of the available documentation indicated the licensee failed to conduct evacuation drills for employees at a frequency of every other month evident by fire drill documentation lacking the required frequency. Evacuation fire drills were not completed in July, August, or September 2025. During an interview on October 13, 2025, at 12:15 p.m., MC-G verified the evacuation fire drill frequency was not met and stated they were not aware the statute required drills every other month. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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	01500		

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01500	Continued From page 15 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; 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,	01500		

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01500	Continued From page 16 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: Based on observation, interview, and record review, the licensee failed to ensure employees performing direct services completed the required annual training for two of two employees (unlicensed personnel (ULP)-H, ULP-L). 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 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: ULP-H ULP- H was hired August 12, 2022, to provide direct care services to the residents of the licensee. On October 14, 2025, at 10:25 a.m., the surveyor observed ULP-H assist R2 with catheter cares. ULP-L ULP-L was hired August 31, 2025, to provide direct care services to the residents of the licensee. On October 15, 2025, at 8:35 a.m., the surveyor	01500		

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01500	Continued From page 17 observed ULP-L administering R4's Lantus (long-acting) insulin. ULP-H, and ULP-L's records lacked documentation ULP-H and ULP-I successfully completed annual training in 2024 as required to include: -review of provider's policies and procedures. On October 14, 2025, at 2:41 p.m., clinical nurse supervisor (CNS)-B stated annual training was based on calendar year for completion. CNS-B stated the director of human resources from corporate office was responsible for assigning Educare (web-based training program) training for all employees. CNS-B stated CNS-B had not been documenting the review of policies and procedures with staff throughout the year and did not have a formal process in place to incorporate into annual training. The licensee's Training and Competency of Unlicensed Staff policy dated January 16, 2023, indicated the required annual training included review of the facility's policies and procedures related to provisions of the assisted living services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
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	01530		

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01530	Continued From page 18 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 topics related to mental illness and de-escalation for each 12 months of employment thereafter;	01530		

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01530	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for two of three employees (unlicensed personnel (ULP)-H, ULP-L). This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-H ULP- H was hired August 12, 2022, to provide direct care services to the residents of the licensee. On October 14, 2025, at 10:25 a.m., the surveyor observed ULP-H assist R2 with catheter cares. ULP-L ULP-L was hired August 31, 2025, to provide direct care services to the residents of the licensee. On October 15, 2025, at 7:16 a.m., the surveyor observed ULP-L administering R4's scheduled morning medications.	01530		

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01530	Continued From page 20 ULP-H and ULP-L's records lacked documentation of the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. On October 14, 2025, at 2:41 p.m., clinical nurse supervisor (CNS)-B stated the director of human resources from corporate office was responsible for assigning Educare (web-based training program) training for all employees. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01910 SS=D	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,	01910		

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01910	Continued From page 21 date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident record all of the required content in the disposition of medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included dementia. R1's July 2025, Medication Administration Record indicated R1 was scheduled and received the following medications: -buspirone 15 milligrams (mg) one tablet three times a day for anxiety; -calcium with vitamin D 600 mg/10 micrograms (mcg) one tablet twice a day for supplementation; -divalproex 125 mg two capsules three times a day for mood stabilization; -fluoxetine 20 mg one capsule along with a 40 mg capsule daily for depression/anxiety; -gabapentin 300 milligrams (mg) one capsule three times a day for arthritic pain; -losartan potassium 100 mg one tablet daily for	01910		

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01910	Continued From page 22 high blood pressure; -metoprolol succinate 25 mg one tablet daily for high blood pressure; -one a day womens vitamin one tablet daily for supplementation; and -simvastatin 40 mg one tablet at dinner for high cholesterol. R1's Discharge Summary dated July 7, 2025, indicated R1 services were initiated January 31, 2024, and discharged July 6, 2025. R1's discharge summary indicated R1 received medication management and R1's medications were sent with R1's guardian at the time of discharge. R1's Record of the Inventory and Destruction of Controlled and Uncontrolled Substances record dated July 6, 2025, included documentation for the disposition of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff involved in the disposition; however, lacked documentation of the prescription number, as applicable for the following medications: -buspirone 15 mg; -calcium with vitamin D 600 mg/10 mcg; -divalproex 125 mg; -fluoxetine 20 mg and 40 mg; -gabapentin 300 mg; -losartan 100 mg; -metoprolol 25 mg ; -mirtazapine 7.5 mg; -omeprazole 20 mg; -simvastatin 40 mg; and -Ventolin inhaler 90 mcg. On October 14, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-B stated CNS-B was	01910		

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01910	Continued From page 23 aware of the requirement and did not provide an exploitation why the prescription numbers were not documented. The licensee's Disposition of Medication policy dated January 16, 2023, indicated using the form Record of the Inventory and Destruction of Controlled and Uncontrolled Substances, staff would document in the client's record the disposition of the medication including: the medication's name, strength, prescription number as applicable, quantity, method of disposition/to whom the medications were given, date of disposition, and names of staff and others individuals involved with the disposition. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.	02040		

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02040	Continued From page 24 This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide a safety risk assessment of the physical environment on and around the property with mitigation factors to protect all dementia care residents from harm. 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 pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). Findings include: On October 13, 2025, the surveyor requested a safety risk assessment for the physical environment from licensed assisted living director in residency (LALDIR)-A. A hazard vulnerability assessment was provided by LALDIR-A. Record review of the available documentation indicated the assessment had been completed for emergency preparedness and was not specific to the physical environment to protect dementia care residents from harm. During an interview on October 13, 2025, at approximately 1:50 p.m., LALDIR-A verified a physical environment safety risk assessment inside and outside the secure dementia care unit had not been completed. TIME PERIOD FOR CORRECTION: Twenty-one	02040		

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02040	Continued From page 25 (21) days	02040		

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

AURORA CAREFREE LIVING BY
304 EAST 3RD AVENUE SOUTH
Aurora, MN 55705
St Louis County
Parcel:

Phone:

License Info

License: HFID 31407

Risk:
License:
Expires on:
CFPM: Shawna C. Gibson
CFPM #: 54496; Exp: 11/29/2026

Inspection Info

Report Number: F1006251082
Inspection Type: Full - Single
Date: 10/13/2025 Time: 10:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 2
Total Priority 3 Orders: 1
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: THE QUAT TEST STRIPS EXPIRED IN 2019 AND THE LID WAS OFF SO THEY WERE DAMAGED FROM MOISTURE AND DIDN'T CHANGE APPROPRIATE COLORS WHEN USED. STAFF STATED THEY WOULD ORDER NEW QUAT STRIPS WITH THEIR NEXT ORDER.
Comply By: 10/31/2025 Originally Issued On: 10/13/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT: THE HAND WASHING SINK ON THE MAIN COOK LINE WORKS, BUT THE METAL AREA AROUND THE HOT WATER HANDLE IS CORRODED/DAMAGED. REPAIR FAUCET TO BE IN GOOD CONDITION AND SMOOTH, DURABLE, AND EASILY CLEANABLE.
Comply By: 10/31/2025 Originally Issued On: 10/13/2025

New Order: 5-200A Plumbing: approved materials/design
5-202.12A *Priority Level: Priority 2 CFP#: 10*
MN Rule 4626.1050A Provide a handwashing sink equipped with running water at a temperature to permit handwashing for at least 15 seconds through a mixing valve or combination faucet.
COMMENT: BECAUSE THE HANDLE WAS SWAPPED WITH THE OTHER HAND WASHING SINK THIS HOT WATER HANDLE DOES NOT WORK ON THE HAND WASHING SINK IN THE DISH AREA. ONLY THE COLD WATER HANDLE IS OPERATIONAL. REPAIR HAND WASHING SINK SO BOTH HOT AND COLD WATER WORK.
Comply By: 10/24/2025 Originally Issued On: 10/13/2025

Food & Beverage General Comment

COMMENTS:

KITCHEN IS CLEAN AND ORDERLY.

THE DISH MACHINE TOOK QUITE A FEW RUNS TO GET TO 160F. DISCUSSED WITH STAFF THAT THEY DO DELIME IT REGULARLY. STAFF USUALLY RUN THE FIRST LOAD 3 TIMES TO HELP MAKE SURE IT IS REACHING SANITIZING TEMP, BUT DISCUSSED REALLY MONITORING IT TO MAKE SURE IT IS REACHING 160F INSIDE AT ALL TIMES DURING DISH WASHING. IF IT IS CLOSE, THE BOOSTER HEATER MAY NEED TO BE ADJUSTED.

KITCHEN STAFF WERE UNSURE OF WHAT WAIT STAFF USE TO SANITIZE THE TABLES IN THE DINING ROOM. THERE WERE A FEW DISINFECTANT WIPES UNDER THE COUNTERS, BUT THEY WERE TOO STRONG TO BE USED ON FOOD CONTACT SURFACES. RECOMMEND HAVING WAIT STAFF USE A SANITIZER APPROVED FOR FOOD CONTACT SURFACES IN THE DINING ROOM. EITHER THE QUAT TABLETS OR THE QUAT DISPENSER COULD BE USED THERE.

OBSERVED GOOD HAND WASHING AND GLOVE USE.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY FOODBORNE ILLNESS COMPLAINTS.

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 Duluth District Office inspection report number F1006251082 from 10/13/2025

Callie Harrison

Shawna Gibson

Callie Harrison,
Public Health Sanitarian 3
218-302-6173
callie.harrison@state.mn.us

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Temperature Observations/Recordings

Establishment Info

AURORA CAREFREE LIVING BY
Aurora
County/Group: St Louis County

Inspection Info

Report Number: F1006251082
Inspection Type: Full
Date: 10/13/2025
Time: 10:30 AM

Food Temperature: Product/Item/Unit: TURKEY GRAVY**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED TOMATOES**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: GRAPE JUICE**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLOPPY JOE**; Temperature Process:** Cooling
Location: Ice Bath at 67 Degrees F.
Comment: @~2 HOURS
Violation Issued?: No

Food Temperature: Product/Item/Unit: BEEF STROGANOFF**; Temperature Process:** Cooking
Location: at 172 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: NOODLES**; Temperature Process:** Cooking
Location: at 167 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CARROTS**; Temperature Process:** Cooking
Location: at 185 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ALL FOODS FROZEN**; Temperature Process:**
Location: Walk-in Freezer at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BEEF STROGANOFF**; Temperature Process:** Hot-Holding
Location: Warmer at 160 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: **Product/Item/Unit:** NOODLES**; Temperature Process:** Hot-Holding
Location: WARMER at 150 Degrees F.
Comment:
Violation Issued?: No

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

Sanitizer Observations/Recordings

Establishment Info

AURORA CAREFREE LIVING BY
Aurora
County/Group: St Louis County

Inspection Info

Report Number: F1006251082
Inspection Type: Full
Date: 10/13/2025
Time: 10:30 AM

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 400 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Equal To 400 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: Product: Hot Water**; Sanitizing Process:** Dish Machine
Location: Equal To 160 Degrees F.
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1006251082

Food Establishment Inspection Report

Duluth District Office
Minnesota Department of Health
11 East Superior Street, Suite 290
Duluth, MN 55802

No. of Risk Factor/Intervention/Violations	1	Date: 10/13/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
AURORA CAREFREE LIVING BY	304 EAST 3RD AVENUE SOUTH	Aurora, MN	55705	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 31407		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	OUT	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Person in Charge (signature)

Inspector (signature) [redacted]

Follow-up: Follow-up Date: