



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 9, 2025

Licensee

Burnsville Carefree Living by Oxford Living
600 East Nicollet Boulevard
Burnsville, MN 55337

RE: Project Number(s) SL20191016

Dear Licensee:

On November 10, 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 September 11, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the September 11, 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 September 11, 2025, found not corrected at the time of the November 10, 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 November 10, 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 Jodi Johnson at 507-344-2730.

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/10/2025
NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING BY OXFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337		
(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 SL20191016-1 On November 10, 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 September 15, 2025. At the time of the survey, there were 57 residents; 57 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders reissued. 0775	{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.		
{0 420} SS=F	144G.40 Subdivision 1 Responsibility for housing and services	{0 420}			

Minnesota Department of Health

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

TITLE

(X6) DATE

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{0 420}	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by:	{0 420}	Not reviewed during this survey		
{0 470} SS=C	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 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;	{0 470}			

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{0 470}	Continued From page 2 (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:	{0 470}	Not reviewed during this survey		
{0 510} SS=D	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}			
{0 650} SS=D	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 infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this	{0 650}			

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{0 650}	Continued From page 3 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; (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:	{0 650}	Not reviewed during this survey		
{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	{0 660}			

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{0 660}	Continued From page 4 compliance with this subdivision. This MN Requirement is not met as evidenced by:	{0 660}	Not reviewed during this survey		
{0 680} SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}			

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{0 700}	Continued From page 5	{0 700}			
{0 700} SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by:	{0 700}			
{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 and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	{0 775}	Not reviewed during this survey		

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{0 775}	Continued From page 6 The findings include: On November 10, 2025, from 12:00 a.m. to 2:00 p.m., the surveyor conducted a facility tour with maintenance worker (MW)-I and licensed assisted living director (LALD)-A for a revisit to follow-up on orders issued pursuant to a survey completed on August 11, 2025. During the tour, the surveyor observed the following: FIRE RATED DOORS: Resident rooms, utility/mech rooms and laundry rooms at the facility had fire rated assemblies and rated fire doors. The doors and rated assemblies all show evidence that the automatic closing mechanism had been removed. Swinging fire doors shall close from the full-open position and latch automatically. SPRINKLER REPORT: The licensee lacked documentation that a current annual sprinkler inspection was completed. There were tags on the sprinkler system indicating that the system had been checked on September 25, 2025, however the inspection report was not available at the time of inspection. SPRINKLER HEADS: Multiple sprinkler heads throughout the facility had accumulated dust and debris. Heads should be kept clear to ensure life safety system performs as intended. CARBON MONOXIDE ALARM: The facility did not have carbon monoxide alarms installed as required, there were two gas water heaters in the facility. Mechanical rooms that have fuel fired appliances will be equipped with a carbon monoxide detector connected to the fire	{0 775}			

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{0 775}	Continued From page 7 alarm panel or each resident living area will have a carbon monoxide alarm in accordance with MN State Fire Code. CONTROLLED EGRESS The door from the memory care unit into the common area had an electromagnetic lock installed with a keypad. The main entrance to the facility was a sliding glass door with a keypad to exit. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The facility's controlled egress doors were not equipped with a separate de-activate button in the fire command center, nurse station, or other approved location in place to unlock the system. Controlled egress doors shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The signal or switch shall directly break power to the lock. The surveyor observed that some corrections to life safety systems were completed. The remaining issues were verified by LALD-A and MW-I accompanying on the tour. LALD-A stated they had not received a copy of the MDH survey finding. They also stated the report was sent to the corporate office and had not been shared with the staff at the facility. MW-I stated they were hired recently and were not aware of the prior survey findings.	{0 775}			
{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}			

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{0 910}	Continued From page 10 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 (4) the authorized agent for the facility. This MN Requirement is not met as evidenced by:	{0 910}	Not reviewed during this survey		
{01060} SS=F	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 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the	{01060}			

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{01060}	Continued From page 11 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:	{01060}	Not reviewed during this survey		
{01620} SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and	{01620}			

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{01620}	Continued From page 12 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 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by:	{01620}			
			Not reviewed during this survey		

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{01620}	Continued From page 13	{01620}			
{01880} SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by:	{01880}			
{01890} SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by:	{01890}	Not reviewed during this survey		
{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	{01910}	Not reviewed during this survey		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

BURNSVILLE CAREFREE LIVING BY OXFORD

600 EAST NICOLLET BOULEVARD

BURNSVILLE, MN 55337

(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

 $\{01910\}$

Continued From page 14

 $\{01910\}$

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:

Not reviewed during this survey

{02040}
SS=F

144G.81 Subdivision 1 Fire protection and physical environment

 $\{02040\}$

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.

This MN Requirement is not met as evidenced by:

Not reviewed during this survey

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/10/2025
NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING BY OXFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337		
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{02170}	Continued From page 15	{02170}			
{02170} SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities.	{02170}			

Minnesota Department of Health

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{02170}	Continued From page 16 This MN Requirement is not met as evidenced by:	{02170}	Not reviewed during this survey		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 21, 2025

Licensee

Burnsville Carefree Living by Oxford Living
600 East Nicollet Boulevard
Burnsville, MN 55337

RE: Project Number(s) SL20191016

Dear Licensee:

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

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 0790 - 144g.45 Subd. 2 (a) (2-3) - Fire Protection And Physical Environment - \$1,000.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,000.00**. 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,

A handwritten signature in black ink, appearing to read "Jodi Johnson", with a stylized flourish at the end.

Jodi Johnson, Supervisor

State Evaluation Team

Email: Jodi.Johnson@state.mn.us

Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING BY OXFORD			STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337		
(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: SL20191016-0 On September 8, 2025, through September 11, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 58 residents; 58 receiving services under the Assisted Living Facility with Dementia Care license. 2310: An immediate correction order was issued on September 10, 2025, at a level 3/Widespread. The licensee took immediate action to mitigate risk; however, the scope and level remains at I.	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.		
0 420 SS=F	144G.40 Subdivision 1 Responsibility for housing and services	0 420			

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: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2025
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0 420	Continued From page 1 The facility is directly responsible to the resident for all housing and service-related matters provided, irrespective of a management contract. Housing and service-related matters include but are not limited to the handling of complaints, the provision of notices, and the initiation of any adverse action against the resident involving housing or services provided by the facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide sufficient management, control, and operation of the housing and services provided by the licensee. 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 had an Assisted Living with Dementia Care license effective April 29, 2025. The licensee's (renewal) "Application for Assisted Living License", section titled "Official Verification of Owner or Authorized Agent", (page four and five of the application), identified an affirmative checkmark next to the statement, "I declare that, as the owner or authorized agent, I attest that I	0 420			

Minnesota Department of Health

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0 420	Continued From page 2 have read Minn. Stat. chapter 144G, and Minnesota Rules, chapter 4659, governing the provision of assisted living facilities, and understand as the licensee I am legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract." Another checkmark was noted at the statement, "I have examined this application and all attachments, and checked the above boxes indicating my review and understanding of Minnesota Statutes, Rules, and requirements related to assisted living licensure. To the best of my knowledge and believe, this information is true, correct and complete. I will notify MDH, in writing, of any changes to this information as required." Page six was electronically signed by the owner/authorized agent on February 18, 2025. As a result of this survey, the following orders were issued under 0470, 0510, 0650, 0660, 0680, 0700, 0775, 0790, 0800, 0810, 0830, 0910, 1060, 1620, 1880, 1890, 1910, 2040, 2170, and 2310 which indicated the licensee's understanding of the Minnesota statutes were limited, or not evident for compliance with Minnesota Statutes, section 144G.01 to 144G.95. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 420			
0 470 SS=C	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2025
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0 470	Continued From page 3 (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 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 ensure the staffing plan was posted in a central location accessible to staff, residents, volunteers and the public, according to MN Rules 4659.0180, Subp.4 (B). This practice resulted in a level one violation (a	0 470			

Minnesota Department of Health

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0 470	Continued From page 4 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 September 9, 2025, at 9:50 a.m. during a tour of the facility with director of nursing (DON)-B, the surveyor did not observe a posted staff schedule in a central location accessible to staff, residents, volunteers, and the public. DON-B stated they do not currently post the schedule for all to see. The schedule is only posted in the break room for the staff to see. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470			
0 510 SS=D	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.	0 510			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2025
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0 510	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health personnel care, medical and nursing standards for infection control related to glove use and handwashing during treatment and medication administration for one of two unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: ULP-E started working for the licensee on November 7, 2024, to provide direct care to the residents. On September 9, 2025, at 1:30 p.m., the surveyor observed ULP-E changing R2's colostomy bag and then removing their gloves, but ULP-E did not wash/sanitize their hands after glove removal. At this time, ULP-E stated he was trained to wash his hands after removing his gloves but he "forgot." On September 10, 2025, at 2:30 p.m., director of nursing (DON)-B stated the expectation is staff will wash their hands before and after glove use.	0 510			

Minnesota Department of Health

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0 510	Continued From page 6 The licensee's Hand Washing policy dated November 15, 2021, indicated hand washing shall be performed between client (resident) cares and whenever direct physical contact with a client (resident) takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: a. Before and after direct contact with a client (resident) b. If moving from a contaminated-body site to a clean-body site during client (resident)care c. After contact with environmental surfaces or equipment in the immediate vicinity of the client (resident) d. After removing gloves or gowns e. Before eating and after using a restroom f. Between clients (residents) No other information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	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 infomation: (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	0 650			

Minnesota Department of Health

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0 650	Continued From page 7 qualifications, responsibilities, and identification of staff persons providing supervision; (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 one of two unlicensed personnel (ULP)-E. 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: ULP-E started working for licensee on November 7, 2024, to provide direct care to the residents. On September 9, 2025, at 1:30 p.m., the surveyor observed ULP-E changing R2's colostomy bag. ULP-E's record lacked evidence of a current job	0 650			

Minnesota Department of Health

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0 650	Continued From page 8 description, including qualifications, responsibilities, and identification of staff persons providing supervision;. The licensee's Employee Records policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 660 SS=F	144G.42 Subd. 9 Tuberculosis prevention and control (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention	0 660			

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0 660	Continued From page 9 (CDC) which included completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for two of two unlicensed personnel (ULP-D, ULP-E). This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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 the residents). The findings include: The licensee's TB facility risk assessment dated June 24, 2025, indicated they were a low risk level. ULP-D ULP-D started working for licensee on April 16, 2025, to provide direct care to the residents. On September 9, 2025, at 1:00 p.m., the surveyor observed ULP-D passing morning medications to residents. ULP-D's record contained a serum testing for TB dated November 24, 2024, (212 days before hire date). ULP-D's record lacked evidence of TB symptom screening upon hire and TB testing via two-step TST or a blood test no more than 90 days before hire as required.	0 660			

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0 660	Continued From page 10 ULP-E ULP-E started working for licensee on November 7, 2024, to provide direct care to the residents. On September 9, 2025, at 1:30 p.m., the surveyor observed ULP-E changing R2's colostomy bag. ULP-E's record contained a TB symptom screening dated July 18, 2024. ULP-E's record lacked evidence of TB testing via two-step TST or a blood test. On September 10, 2025, at 2:00 p.m., director of nursing (DON)-B stated the normal process upon hire is the nurse would complete the TB symptom screening and start a two-step TB skin testing, and was not sure why that was not completed for ULP-D and ULP-E. The licensee's TB Prevention and Control policy dated January 16, 2023, indicated that all new employees/volunteers will have baseline TB screening completed prior to having direct contact with clients (residents). No further information 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	0 680			

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0 680	Continued From page 11 contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an all-hazards risk assessment emergency preparedness program and plan to include Appendix Z required elements. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 680			

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0 680	Continued From page 12 has affected or has the potential to affect a large portion or all the residents). The findings include: During the entrance conference on September 9, 2025, at 10:30 a.m., the surveyor asked for the licensee's emergency preparedness plan (EPP), which was provided and later reviewed by the surveyor. The licensee's EPP lacked an all-hazards vulnerability assessment in addition to the following required content: -maintain and categorize the probable risks -identify at risk population needs -process for cooperation and collaboration with local, tribe, regional, state and federal EP -subsistence needs for staff and patients -procedures for tracking staff and patients -procedure for medical documents -policy and procedures for volunteers -roles under a waiver declared by secretary -development of a communication plan -names and contact information -emergency officials contact information -primary and alternate means of communication -method of sharing information -emergency prep training and testing -emergency prep training program -emergency prep testing requirements On September 10, 2025, at 9:45 a.m. licensed assisted living director (LALD)-A stated he recently started working for the licensee and has been trying to gather the information for emergency preparedness, but he has not been able to find all the required information.	0 680			

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0 680	Continued From page 13 The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 1, 2021, indicated the 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. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 700 SS=F	144G.43 Subdivision 1 Resident record (b) Resident records, whether written or electronic, must be protected against loss, tampering, or unauthorized disclosure in compliance with chapter 13 and other applicable relevant federal and state laws. The facility shall establish and implement written procedures to control use, storage, and security of resident records and establish criteria for release of resident information. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident's personal health and medical information was kept private. 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) and was issued at a widespread scope (when problems are pervasive	0 700			

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0 700	Continued From page 14 or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 9, 2025, at 1:00 p.m., the surveyor observed ULP-D and ULP-E administering afternoon medication. Two laptops on the second floor were on top of medication carts open and not secured; resident information was able to be viewed. On September 10, 2025, at 8:27 a.m., the surveyor observed two medication carts in the secured unit, each with a laptop; one laptop was unlocked and tilted down but open and residents' pictures and names were visible. On September 10, 2025, at 12:30 p.m., the surveyor observed the medication cart in the secured unit, locked with two laptops both tilted downwards. One with the screen locked, and one with residents' names and pictures listed. On September 10, 2025, at 1:30 p.m., the surveyor observed the medication carts on second floor with laptops not secured; resident information was able to be viewed. On September 10, 2025, at 2:30 p.m., director of nursing (DON)-B stated the expectation is all laptops should be on a screen saver and retraining is needed. The licensee's Resident Record Requirements policy dated December 13, 2024, indicated to protect resident records, whether written or electronic, will be protected against loss,	0 700			

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0 700	Continued From page 15 tampering, or unauthorized disclosure. The facility shall store resident records in a secure/locked area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 700			
0 775 SS=I	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 and interview, the licensee failed to comply with the current State Fire Code in Minnesota Rules, chapter 7511. This had the potential to directly affect all residents, staff, and visitors. 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). Findings include: On September 11, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with maintenance manager (MM)-F and licensed assisted living director (LALD)-A. During the tour,	0 775			

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0 775	Continued From page 16 the surveyor observed: FIRE RATED DOORS: Resident rooms, utility/mech rooms and laundry rooms at the facility had fire rated assemblies and rated fire doors. The doors and rated assemblies all show evidence that automatically closing mechanism had been removed. Swinging fire doors shall close from the full-open position and latch automatically. SMOKE ALARMS: Facility has installed hard-wired smoke alarms in each resident room. In the 25+ surveyed rooms alarms were over 10 years past the manufacturer date. Per MN State Fire Code and manufacturer's instructions, single-and multiple-station smoke alarms shall be replaced when they exceed ten years from the date of manufacture. All smoke alarms shall be replaced with smoke alarms having the same type of power supply. CIGARETTE BUTT DISPOSAL: It was observed that used cigarette butts and ash were not properly being discarded into an approved cigarette dispenser. Used cigarette butts and ashes are required to be dispensed in the approved non-combustible containers. FIRE ALARM REPORT: Facility failed to provide the current annual fire alarm report. The last report on file was from May 17, 2023, which showed deficiencies in the system. Fire alarm systems shall be inspected and tested at least annually, the building owner shall be responsible to maintain the fire and life safety systems in an operable condition at all times.	0 775			

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0 775	Continued From page 17 SPRINKLER REPORT: Facility failed to produce a current annual sprinkler report. The last wet sprinkler system report on file was from January 31, 2022. Past report also has deficiencies; there are also inspection tags stating the system was inspected on May 11, 2024, from a separate contractor from the 2022 report. Per MN State Fire Code, water-based automatic fire extinguishing systems shall be inspected and tested annually. SPRINKLER HEADS: Sprinkler heads throughout the facility have accumulated dust and debris. Heads should be kept clear to ensure life safety system performs as intended. CARBON MONOXIDE ALARM: Facility doesn't have carbon monoxide alarms in the facility, there are two gas water heaters in the facility. Mechanical rooms that have fuel fired appliances will be equipped with a carbon monoxide detector connected to the fire alarm panel or each resident living area will have a carbon monoxide alarm in accordance with MN State fire code. DELAYED EGRESS Delayed controlled egress doors in the memory care area, leading back into the common areas of the facility except for one that is controlled egress. Exterior egress doors are controlled egress, meaning staff, residents, and visitors have to pass more than 2 controlled egress doors before entering an exit. Facility delayed egress system was not equipped with a separate de-activate system in the fire command center or other approved location in	0 775			

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0 775	Continued From page 18 place to override the system. During a facility tour on September 11, 2025, at 1:30 p.m., LALD-A and MM-F, verified the above listed observations while accompanying on the tour. It was noted during the interview that LALD-A started on August 4, 2025, and MM-F started May of 2025. Request have been made to correct the deficiencies with the life safety systems to the ownership group and are awaiting approval to proceed with corrections. TIME PERIOD FOR CORRECTION: Two (2) day.	0 775			
0 790 SS=I	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and residents.	0 790			

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0 790	Continued From page 19 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 September 11, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with maintenance manager (MM)-F and licensed assisted living director (LALD)-A The following was observed. FIRE EXTINGUISHER: During the tour, the portable fire extinguisher cabinets throughout the facility showed that last service was performed December 2023. Per MN State Fire Code, fire extinguishers are required to be professionally serviced annually. On September 11, 2025, at 1:00 p.m., LALD-A and MM-F, verified this deficient finding. TIME PERIOD FOR CORRECTION: Two (2) days.	0 790			
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and	0 800			

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0 800	Continued From page 20 repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, 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 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 September 11, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with maintenance manager (MM)-F and licensed assisted living director (LALD)-A The following was observed. CEILING: Main level laundry, mechanical, and chapel ceilings have old water damage evidence. Paint and other material are missing or failing. Laundry	0 800			

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0 800	Continued From page 21 room also has a hole in the ceiling where duct work was completed. Failing ceiling and holes can reduce the fire separation between the upper and lower levels. FLOOR: In the memory care area, the main hallway rug in front of resident rooms has a tear. This uneven surface causes a risk to residents, staff and visitors of trips, falls and other injuries. CONCRETE: Surrounding area concrete to include the sidewalk around the facility has several areas of cracks, gaps and uneven surfaces. The condition of the surface area around the facility increases the risk and trips, falls and other injuries. On September 11, 2025, at 1:30 p.m., MM-F/LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and	0 810			

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0 810	Continued From page 22 (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop the fire safety and evacuation plan with the required content and provide the required training. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 810			

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0 810	Continued From page 23 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 September 11, 2025, from 11:30 a.m. to 3:30 p.m., the surveyor toured the facility with maintenance manager (MM)-F and licensed assisted living director (LALD)-A. The following was observed: Surveyor observed the fire safety and evacuation plan (FSEP) was not located in a central location for staff, residents and visitor accessibility. Facility kept the FSEP in an office that was secured after hours, weekends and holidays. LALD-A stated that FSEP binder would be kept in central location going forward. September 11, 2025, LALD-A and MM-F provided documents on the FSEP, fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN: The licensee's FSEP, titled "Fire", undated, failed to include the following: STAFF ACTIONS: The FSEP included standard employee procedures but failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate). The provided FSEP was from a third-party provider	0 810			

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0 810	Continued From page 24 and had not been updated to the specific facility. RESIDENT ACTIONS: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. UNIQUE AND UNUSUAL RESIDENT NEEDS: The facility uses an electronic care plan website for standard resident evacuation procedures. The FSEP does not include instructions on how to use or what do in the loss of power/internet event for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. On September 11, 2025, at 1:30 p.m., LALD-A stated they understood the areas of their policy that were incomplete and would work on bringing them into compliance. TRAINING: The licensee failed to provide evacuation training to residents at least once per year. LALD-A lacked documentation showing any training was offered or training was scheduled for a future date for residents on the fire safety and evacuation plan. The licensee failed to provide training to employees on the FSEP upon hire and at least twice per year. LALD-A stated he has not been shown or knows where past trainings are kept. No other training documentation was provided. On September 11, 2025, at 1:30 p.m., LALD-A	0 810			

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0 810	Continued From page 25 stated they understood the requirements for training residents and staff and would implement a training program that was compliant with statute requirements. DRILLS The licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month. LALD-A and MM-F stated drills had not consistently taken place in the last two years. MM-F provided documentation for a fire drill on August 21, 2025. On September 11, 2025, at 1:30 p.m., MM-F and LALD-A, stated there were no additional documented drills for the facility. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 830 SS=F	144G.45 Subd. 3 Local laws apply Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to follow applicable	0 830			

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0 830	Continued From page 26 state and local laws, regulations, standards, ordinances, and codes related to smoking for one of one resident (R15). 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: R15 was admitted to the licensee for services on March 27, 2024, with a diagnosis of nicotine dependency, chronic obstructive pulmonary disease, and other general symptoms. On September 10, 2025, at 12:30 p.m. during a walk through the building with licensed assisted living director (LALD)-A and director of nursing (DON)-B, DON-B and the surveyor entered R15's room. When knocking on the door, R15 stated "wait a minute," and eventually came to the door to open it. The room smelled strongly of cigarette smoke and the window was open. An ashtray and a pack of cigarettes were sitting on the sofa. There were no signs of burns in carpet or upholstery. R15's service plan dated August 1, 2025, indicated R15 received assistance with laundry, housekeeping, and medication management. R15's assessment dated June 10, 2025,	0 830			

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0 830	Continued From page 27 indicated R15 was assessed for safe independent smoking by the RN. R15's assessment also indicated he had a history of smoking inside his room during cold months. The licensee's Resident Smoking Policy dated May 18, 2022, all residents will be assessed by a licensed nurse for smoking upon admission, with significant changes and at least every 90 days. All concerns about the ability of the resident to safely smoke without assistance and/or their ability or willingness to follow the rules of smoking only in either designated outdoor areas or off-campus will be brought to the attention of the facility manager. This policy applies to both standard smoking as well as electronic smoking devices. Residents must have the willingness to follow the rules and ability to smoke entirely independently and safely. Noncompliance with the rules may result in eviction by the facility manager. The Minnesota Department of Health's Minnesota Clean Indoor Air Act (MCIAA) amendment effective on August 1, 2019, noted smoking was prohibited indoors of all public places to include health care facilities and clinics. MCIIA defined "Indoor Area" to be "a space between a floor and a ceiling that is at least half enclosed by walls, doorways or windows (open or closed) around the perimeter. A wall includes retractable dividers, garage doors, plastic sheeting or any other temporary or permanent physical barrier." State statute 144.414 Prohibitions; Subdivision 3 Health care facilities and clinics. (a) Smoking is prohibited in any area of a hospital, health care clinic, doctor's office, licensed residential facility for children, or other health care-related facility,	0 830			

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0 830	Continued From page 28 except that a patient or resident in a nursing home, boarding care facility, or licensed residential facility for adults may smoke in a designated separate, enclosed room maintained in accordance with applicable state and federal laws. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 830			
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 (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 execute a written contract with the required content for two of four residents (R3, R4) who resided in the licensee's facility. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a	0 910			

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0 910	Continued From page 29 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R3's resident agreement dated September 1, 2022, indicated on page one of the document that the person authorized to accept service of notices and orders included a name, phone number, and email for "Spectrum Health" (the previous company). R4's resident agreement dated July 30, 2024, indicated on page one of the document that the person authorized to accept service of notices and orders included a name, phone number, and email for "Spectrum Health" (the previous company). On September 8, 2025, at 2:46 p.m., licensed assisted living director (LALD)-A stated they have made changes to the new contract but were told by the previous owner that they did not have to provide new contracts to the residents. On September 10, 2025, at 10:45 a.m., director of nursing (DON)-B stated they did not send out new contracts because the new company did not think they needed to when they took over. The licensee's Resident Record Requirements policy dated December 13, 2024, indicated contents of a resident record include the following for each resident: -all records of communications pertinent to the resident's services.	0 910			

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0 910	Continued From page 30 -the documentation required under this chapter and relevant to the resident's services or status. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 910			
01060 SS=F	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 (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:	01060			

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01060	Continued From page 31 (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 observation, interview, and record review, the licensee failed to provide a written notice with the required content for an emergency relocation for the licensee's one resident (R2) who was hospitalized. 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: R2's was admitted to the facility February 26, 2015, with a diagnosis of chronic kidney disease, hypertension, and bipolar disease. R2's service plan dated August 15, 2025,	01060			

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01060	Continued From page 32 indicated the resident received assistance with activities of daily living (ADLs) and medication management. On September 8, 2025, at 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with ADLs. R2's progress notes dated April 28, 2025, at 2:46 p.m., noted R2 was admitted to the hospital with confusion, weakness and dehydration and would probably go to a transitional care unit after discharge. On May 20, 2025, at 1:45 p.m., R2's progress notes indicated she had returned to the facility. R2's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative 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 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 September 10, 2025, at 10:30 a.m., registered nurse (RN)-C stated R2's record did	01060			

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01060	Continued From page 33 not contain an emergency relocation because the process had not been started yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse	01620			

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01620	Continued From page 34 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 of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a reassessment not to exceed 90 days for two of four residents (R2, R3) as required. 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	01620			

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01620	Continued From page 35 found to be pervasive). The findings include: R2 R2's was admitted to the licensee on February 26, 2015, with a diagnosis of chronic kidney disease, hypertension, and bipolar disease. R2's service plan dated August 15, 2025, indicated R2 received assistance with activities of daily living (ADLs) and medication management. R2's record indicated assessments by the RN had completion dates as follows: - January 27, 2025; - May 20, 2025 (113 days from the previous assessment) On September 8, 2025, at 1:00 p.m., the surveyor observed unlicensed personnel (ULP)-D assisting R2 with ADLs. R3 R3's was admitted to the licensee on August 30, 2019, with a diagnosis of diabetes. R3's service plan dated September 4, 2025, indicated R3 received assistance with ADLs and medication management. R3's record indicated assessments by the RN had completion dates as follows: - February 20, 2025; - May 22, 2025 (91 days from the previous assessment) - September 4, 2025 (105 days from the previous assessment)	01620			

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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
01620	Continued From page 36 On September 9, 2025, at 2:40 p.m., the surveyor observed ULP-E administer medication to R3. On September 10, 2025, at 10:45 a.m., director of nurse (DON)-B stated that she is aware that assessments should be completed every 90 days, and knew they were not always completed timely. The licensee's Assessment, Reviews, and Monitoring policy dated January 16, 2023, indicated 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			
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the medication refrigerators maintained an acceptable temperature to ensure the	01880			

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01880	Continued From page 37 medications were stored according to manufacturer's recommendations. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On September 9, 2025, at 11:30 a.m., the surveyor toured the facility with director of nursing (DON)-B, including a review of the medication refrigerator on the first and second floors. On the first floor, there was a locked refrigerator with a thermometer that read 50 degrees. DON-B stated she was not aware of medication refrigerator temperatures being checked; only the kitchen refrigerators, and they would have to replace all medications in the refrigerator including the refrigerator. A unlicensed personal (ULP) stated with the previous documentation software, they used to have a task on the night shift to record the medication refrigerator temperatures, but they did not have that listed as a task anymore. The refrigerator contained the following medications: - four unopened boxes of Humalog insulin pens 100 units per milliliter (ml) for R13. - four unopened boxes of Lantus 100 units/ml insulin for R12. - four unopened boxes of Aspart 100 units/ml for R14.	01880			

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01880	Continued From page 38 The manufacturer's instructions for Humalog insulin pens dated 2023, indicated to store unused Pens in the refrigerator at 36°F to 46°F (2°C to 8°C). Do not freeze insulin. The manufacturer's instructions for Lantus insulin pens dated August 2022, indicated before opening store the insulin pens in the refrigerator (36-46 degrees F). Do not allow the Lantus to freeze. The manufacturer's instructions for Aspart insulin dated February 2023, indicated unopened Aspart should be stored in the refrigerator at (36-46 degrees F). Do not freeze. The licensee's Storage of Medications policy dated January 16, 2023, indicated medications needing refrigeration will be stored between 36-46 degrees F. This will be logged daily on a flow sheet and any temperatures outside of this range are to be reported to nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880			
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug.	01890			

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01890	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications were dated when opened for one of one resident (R4). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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: R4 was admitted to the facility on July 30, 2024, with diagnoses that included amnesia, muscle weakness, and sleep apnea On September 9, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R4 and assist with applying her brace and suspenders. R4's service plan dated April 10, 2025, indicated R4 received assistance with activities of daily living (ADLs), and medication administration. R4's medication administration record (MAR) dated September 2025, indicated R4 took azelastine nasal spray (for seasonal allergies), fluticasone inhaler (for seasonal allergies), Cosopt eye drops (to treat glaucoma), and latanoprost eyedrops (to treat glaucoma) On September 9, 2025, at 8:30 a.m., the	01890			

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01890	Continued From page 40 surveyor observed ULP-D administer morning eyedrops to R4. R4's latanoprost eye drops lacked an open date or expiration date. On September 9, 2025, at 2:30 p.m., director of nursing (DON)-B stated she was aware of the requirement to mark medications with an open/expiration date but was not sure if the current owners were aware of the process. The manufacturer instructions for latanoprost eye drops dated August 2011, indicated that once a bottle is opened for use, it may be stored at room temperature for up to six weeks. The licensee's Storage of Medications policy dated January 16, 2023, indicated medication is set up for immediate or later administration by a nurse, a legend drug must be kept in its original container bearing the original prescription label with legible information stating the prescription number, name of drug, strength and quantity of drug, expiration date of time-dated drug, directions for use, client's (resident) name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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	01910			

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01910	Continued From page 41 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: Based on interview and record review, the licensee failed to document in the resident's record the disposition of the medications as required 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include:	01910			

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01910	Continued From page 42 R1 was admitted to the licensee on August 1, 2022, with a diagnosis of bipolar disorder, memory loss, and depressive disorder. R1's service plan dated July 8, 2025, indicated R1 received assistance with bathing and medication management. R1's progress notes dated July 26, 2025, indicated R1 was hospitalized. R1's progress notes dated July 31, 2025, indicated R1 was transferred from the hospital to a transitional care unit, and another note dated August 22, 2025, indicated R1 was moved to a skilled nursing facility. R1's record included a document titled the inventory and destruction of controlled and uncontrolled substances form dated August 11, 2025, indicating the method of destruction was onsite. Medications to include: cephalexin 500 mg (milligram), (antibiotic) 14 tablets acetaminophen 500 mg, (for pain) 8 tablets, loperamide 2 mg (for loose stools) 53 tablets divalproex 500 mg (for treatment of bipolar disorder) 3 tablets On September 9, 2025, at 12:30 p.m., director of nursing (DON)-B showed the surveyor a medication closet in the nurses's office containing nine grocery bags, two boxes, and six drawers of discontinued medications that had not been destroyed or logged in the resident's record. DON-B stated when she started, about a month ago, she found the closet of discontinued or discharged medications that had not been logged	01910			

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01910	Continued From page 43 or destroyed and has been working on getting the medications logged and destroyed. DON-B stated she had found additional medications for R1 and created a new inventory form and completed it after the survey had started. At the same time, registered nurse (RN)-C stated R1 was hospitalized and then had moved to a nursing home because she needed a higher level of care. RN-C further stated since R1 was only going to the hospital at first, her medications were not sent with her. The licensee's Disposition of Medications policy dated January 16, 2023, indicated any medications managed by our agency that are left with our agency after the death or termination of services for a client (resident) for whom the drug was prescribed, or any prescription drug permanently discontinued, must be destroyed by the RN or LPN with one other person as a witness. Discontinued or unused drugs will be destroyed no longer than 90 days after the time they are discontinued and as soon as reasonably possible after the death or discharge of the client (resident). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910			
02040 SS=F	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	02040			

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02040	Continued From page 44 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: Based on interview and record review, the licensee failed to conduct mitigation for hazard vulnerability or safety risk assessment on or around the facility property. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all residents). The findings include: During record review on September 11, 2025, from 11:00 a.m. to 2:30 p.m., with maintenance manager (MM)-F and licensed assisted living director (LALD)-A. The licensee failed to provide a hazard vulnerability assessment (HVA). Facility did not have a HVA completed with any hazards assigned with a vulnerability assessment along with mitigations.	02040			

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02040	Continued From page 45 On September 11, 2025, at 1:30 p.m. LALD-A and MM-F stated they understood the requirements and would implement mitigations for hazards identified on an HVA. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			
02170 SS=E	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive	02170			

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02170	Continued From page 46 relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an individualized written activity evaluation that addressed all six provisions and failed to develop an individualized activity plan based on the evaluation, for one of two residents (R4) who received services under the Assisted Living with Dementia Care license and resided in the secured unit. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a 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: The licensee had an Assisted Living with Dementia Care license. R4 was admitted to the facility in the secured unit on July 30, 2024, with diagnoses that included amnesia, muscle weakness, and sleep apnea	02170			

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02170	Continued From page 47 On September 9, 2025, at 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-D administer medications to R4 and assist with applying her brace and suspenders. R4's service plan dated April 10, 2025, indicated R4 received services to assist with activities of daily living (ADLs), and medication administration. R4's record contains an activity assessment dated August 12, 2024, that was blank. On September 11, 2025, at 10:00 a.m., activities director (AD)-H stated he is new and has not completed activity assessments and he is the only person for activities. AD-H stated he focuses on activities in the main dining room for everyone, but he will be providing a calendar of activities for the staff to start doing activities in the secured unit. The licensee's Assisted Living with Dementia Care policy was requested but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310			

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02310	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for two of two residents (R3, R9) with siderails or assistive devices. This resulted in an immediate correction order on September 10, 2025. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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: R3 R3 began receiving services from the licensee on August 30, 2019, with a diagnosis of diabetes. R3's Service Plan dated September 5, 2025, indicated she received services including medication administration, and assistance with activities of daily living (ADLs). R3's record included a comprehensive assessment dated September 5, 2025, which indicated under the bed mobility section, that R3 does not have a bedrail. On September 8, 2025, at 1:00 p.m., the surveyor observed unlicensed personal (ULP)-E administering morning medication to R3 in R3's	02310			

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02310	Continued From page 49 room. The surveyor noted a hospital bed with bilateral top half siderails in the up position. On September 10, 2025, at 12:00 p.m., registered nurse (RN)-C stated R3's hospital bed must have been delivered on the weekend, and a side rail assessment had not been completed yet. In addition, there was no evidence the resident and/or resident representative was educated on the risks and benefits of side rail use. On September 10, 2025, at 12:30 p.m., director of nursing (DON)-B stated R3 had a new hospital bed, but they had not completed a side rail assessment yet. DON-B stated she was aware of the process, but it had not been completed. R9 R9 began receiving services from the licensee on April 15, 2024, with a diagnosis of dementia. R9's Service Plan dated May 5, 2025, indicated she received services to include medication administration, reminders, housekeeping, and laundry. R9's record included comprehensive assessments dated May 5, 2025, indicating in the bed mobility section that R9 is independent in bed mobility and does not have a side rail or grab bars. On September 10, 2025, at 2:00 p.m. during a walk through the building with DON-B and licensed assisted living director (LALD)-A, the surveyor observed R9's room to have a hospital bed with bilateral commercial U-shaped rails	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING BY OXFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 50 attached to the upper portion of the bed. On September 10, 2025, at 3:00 p.m., RN-C reviewed R9's electronic medical record and stated R9's record did not include an assistive device assessment. In addition, R9's record did not include education on the risks and benefits of it's use, or checking the consumer product and safety commission (CPSC) for recalls. In addition, after reviewing all of the resident records, RN-C further stated none of the residents using side rails or commercial assistive devices have had an assessment completed. The Food and Drug Administration (FDA), "A Guide to Bed Safety," revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Assessing Bed Assist Devices, last revised January 16, 2023, indicated the registered nurse will educate the client (resident), the client's (resident's) representative and/or family members about the risks related to side rails. The RN will complete the Risk Agreement Bed Positioning Device Assessment and provide the resident or the resident repetitive the Guide to bed safety pamphlet and complete the bed rail positioning assessment.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20191	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER BURNSVILLE CAREFREE LIVING BY OXFORD		STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST NICOLLET BOULEVARD BURNSVILLE, MN 55337			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
02310	Continued From page 51 No further information was provided. TIME PERIOD FOR CORRECTION: Immediate Immediate action was taken to mitigate risk; however, the scope and level remains at I.	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info	License Info	Inspection Info
BURNSVILLE CAREFREE LIVING BY 600 EAST NICOLLET BOULEVARD Burnsville, MN 55337 Dakota County Parcel: Phone:	License: HFID 20191 Risk: License: Expires on: CFPM: Michelle Lyn Gustafson CFPM #: 63255; Exp: 10/03/2025	Report Number: F1018251064 Inspection Type: Full - Single Date: 9/8/2025 Time: 8:39:30 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>

No orders were issued for this inspection report.

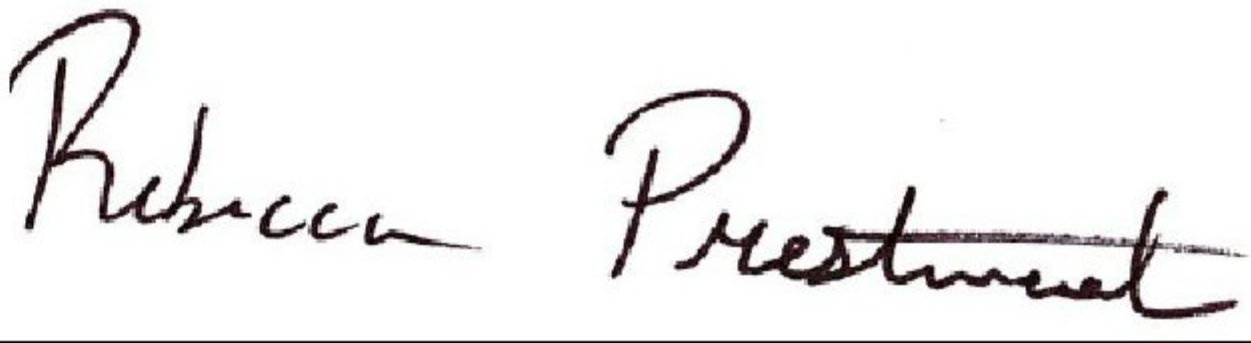
Food & Beverage General Comment

- Viewed employee illness log and discussed illness policy.
- Discussed pest control.
- Establishment has a needle point thermometer for checking food temperatures.
- Establishment uses all pasteurized eggs and margarine.

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 F1018251064 from 9/8/2025

Michelle Gustafson
Kitchen Manager


Rebecca Prestwood, REHS
Public Health Sanitarian 3
651-201-3777
rebecca.prestwood@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

BURNSVILLE CAREFREE LIVING BY
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251064
Inspection Type: Full
Date: 9/8/2025
Time: 8:39:30 AM

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

Location: Steam Table at 179 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 41 Degrees F.

Comment:

Violation Issued?: No



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St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info

BURNSVILLE CAREFREE LIVING BY
Burnsville
County/Group: Dakota County

Inspection Info

Report Number: F1018251064
Inspection Type: Full
Date: 9/8/2025
Time: 8:39:30 AM

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** 3-Compartment Sink

Location: Dishwashing Area **Equal To** 200 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Chlorine; **Sanitizing Process:** Dish Machine

Location: Dishwashing Area **Equal To** 100 Degrees F.

Comment:

Violation Issued?: No