



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 17, 2026

Licensee
Vitacare Living
1545 Harbor Street
Ogilvie, MN 56358

RE: Project Number(s) SL30706016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 18, 2026, 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 - \$500.00

St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - \$500.00

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$2,000.00**. 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.

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 that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

Telephone: 218-332-5175 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30706	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HARBOR STREET OGILVIE, MN 56358			
(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: SL30706016-0 On June 16, 2026, through June 18, 2026, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were seven residents; seven receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 110 SS=C	144G.10 Subdivision 1a Assisted living director license required	0 110			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 110	Continued From page 1 Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the licensed assisted living director (LALD) was listed as the Director of Record for the licensee. This had the potential to affect all the licensee's residents, staff, and visitors. This practice resulted in a level one violation (a violation that 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: During the entrance conference on June 16, 2026, at 8:24 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated LALD\LPN-A was the LALD for the licensee. The surveyor reviewed the Board of Executives for Long-Term Services and Support (BELTSS) website with LALD/LPN-A. The BELTSS website indicated LALD/LPN-A held a LALD license (effective January 27, 2026; expired October 31, 2026). The BELTSS website did not identify LALD/LPN-A as the Director of Record for the licensee.	0 110			

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0 110	Continued From page 2 On June 16, 2026, at 9:00 a.m., the surveyor searched for the licensee's name on the BELTSS website with LALD/LPN-A. The BELTSS website indicated there was no LALD listed for the Director of Record for the licensee, and the LALD/LPN-A was the previous Director of Record, which ended on May 19, 2025. On June 16, 2026, at 9:02 a.m., LALD/LPN-A stated LALD/LPN-A was new to the LALD position, and LALD/LPN-A had thought the licensee's regional LALD had submitted the required paperwork to BELTSS on behalf of LALD/LPN-A. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 110			
0 430 SS=C	144G.40 Subd. 2 Uniform checklist disclosure of services (a) All assisted living facilities must provide to prospective residents: (1) a disclosure of the categories of assisted living licenses available and the category of license held by the facility; (2) a written checklist listing all services permitted under the facility's license, identifying all services the facility offers to provide under the assisted living facility contract, and identifying all services allowed under the license that the facility does not provide; and (3) an oral explanation of the services offered under the contract. (b) The requirements of paragraph (a) must be completed prior to the execution of the assisted living contract.	0 430			

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0 430	Continued From page 3 (c) The commissioner must, in consultation with all interested stakeholders, design the uniform checklist disclosure form for use as provided under paragraph (a). This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to revise and provide an up-to-date Uniform Disclosure of Assisted Living Services & Amenities (UDALSA) to all residents. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility with dementia care license effective July 6, 2025, with an expiration date of July 5, 2026. During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On June 16, 2026, from 8:12 a.m. through 8:20 a.m., the surveyor toured the facility with licensed assisted living director/licensed practical nurse (LALD/LPN)-A. The surveyor did not observe a secured (requires a code entered on a keypad to exit the facility) building or any keypads on doors throughout the facility. The licensee's UDALSA dated June 24, 2025,	0 430			

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0 430	Continued From page 4 indicated the licensee had an assisted living facility with dementia care license. In Section 1: Dementia Care (pertains only to an Assisted Living with Dementia Care license) indicated the licensee had a secured unit or building for wandering or exit-seeking behavior. In addition, Section 6: Security and Monitoring indicated each door has a key code (keypad). The licensee's UDALSA lacked current documentation of services provided by the licensee, as the licensee was not a secured building and did not have key codes (keypads) at each door to exit the facility. On June 17, 2026, at 1:10 p.m., LALD/LPN-A stated the licensee did not have a secured building or keypads at each door to exit the facility. LALD/LPN-A further stated the licensee previously had a keypad system in place to secure the building, however, the licensee had removed the keypads and did not revise the UDALSA to reflect current services offered by the licensee. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0090, Subp. 4, effective October 2022, a facility shall provide an up-to-date checklist to each prospective resident and each prospective resident's representatives who request information about the facility. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 430			
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

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0 470	Continued From page 5 (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 interview and record review, the licensee failed to ensure the clinical nurse supervisor (CNS) developed and implemented a staffing plan to determine staffing levels to meet the needs of all residents, which included reviewing the staffing plan at least twice per year. This had the potential to affect all residents and staff.	0 470			

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0 470	Continued From page 6 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: The licensee held an assisted living with dementia care license and was licensed for a capacity of 10 residents, with a current census of seven residents. During the entrance conference on June 16, 2026, at 8:40 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated LALD/LPN-A and clinical nurse supervisor (CNS)-B developed a staffing plan and reviewed it quarterly. Housing manager (HM)-C stated the licensee's regular staffing schedule was the following: -one unlicensed personnel (ULP) worked 7:00 a.m. until 3:00 p.m.; -one ULP worked 3:00 p.m. until 11:00 p.m.; and -one ULP worked 11:00 p.m. until 7:00 a.m. The licensee's Direct-Care Staffing Plan dated May 12, 2026, indicated the average total number of residents on assisted living services was seven to eight. The evaluation of the direct-care staffing plan identified the following average number needed: -one full time registered nurse (RN); -one full time licensed practical nurse (LPN); and -one ULP to work each eight-hour shift.	0 470			

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0 470	Continued From page 7 The licensee's Direct-Care Staffing Plan dated June 24, 2024, and March 17, 2025, respectively, indicated the same number of staff was required as noted above. The licensee's staffing plan lacked evidence of the staffing plan being reviewed at least twice per year. On June 17, 2026, at 1:16 p.m., LALD/LPN-A stated the licensee reviewed the staffing plan yearly and the licensee was not aware the staffing plan needed to be reviewed at least twice per year. The licensee's Staffing, Direct-Care Staffing Plan and Daily schedule policy dated April 17, 2023, indicated the staffing plan will be evaluated for the appropriately [sic] of staffing levels in the facility and revised as needed at a minimum of two times per year. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with	0 480			

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0 480	Continued From page 8 one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part	0 480			

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0 480	Continued From page 9 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated June 16, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
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	0 510			

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0 510	Continued From page 10 nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during wound care for one of three employees (licensed assisted living director/licensed practical nurse (LALD/LPN)-A). 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: During the entrance conference on June 16, 2026, at 8:36 a.m., LALD/LPN-A, clinical nurse supervisor (CNS)-B, and housing manager (HM)-C stated the licensee provided simple wound care services to residents at the facility. On June 17, 2026, at 7:59 a.m., the surveyor	0 510			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER VITACARE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HARBOR STREET OGILVIE, MN 56358		
(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
0 510	Continued From page 11 observed LALD/LPN-A wash LALD/LPN-A's hands, put on gloves, and entered R6's room. LALD/LPN-A placed a disposable chuck under R6's right leg and removed the soiled dressing from the back of R6's lower leg. Without changing gloves, LALD/LPN-A sprayed wound cleanser on R6's wound and held a clean gauze pad to R6's wound for approximately two minutes. LALD/LPN-A removed LALD/LPN-A's left glove and without completing hand hygiene put on a new glove. LALD/LPN-A spread a topical ointment on R6's clean bandage and removed LALD/LPN-A's left glove. Without completing hand hygiene, LALD/LPN-A put on a new glove, applied and secured R6's bandage to R6's lower right leg. The surveyor did not observe LALD/LPN-A complete hand hygiene before or after putting on and removing gloves. On June 17, 2026, at 1:49 p.m., CNS-B stated employees were expected to complete hand hygiene before and after using gloves. LALD/LPN-A further stated employees were expected to wash hands if the gloves were visibly soiled, or hand sanitizer was supposed to be used during glove changes. The licensee's Procedure for Using Gloves policy dated May 2, 2025, indicated to wash hands before and after use of gloves. In addition, if additional tasks must be performed for the resident, change the gloves and wash hands before putting on new gloves before starting the next task [sic]. The licensee's Hand Hygiene policy dated May 2, 2025, indicated hands should be washed after removing gloves. The policy further indicated hands should be washed if moving from a contaminated-body site to a clean-body site	0 510			

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0 510	Continued From page 12 during resident care. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content to include posting the 911 emergency number in common areas at the assisted living. 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	0 640			

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0 640	Continued From page 13 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: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. During a self-guided tour on June 16, 2026, from 9:30 a.m. until 9:34 a.m., the surveyor did not observe 911 posted in any common areas of the assisted living facility. On June 16, 2026, at 9:34 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the 911 posting was previously posted near the telephone, however, LALD/LPN-A was not sure what happened to the 911 posting. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 660 SS=D	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	0 660			

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0 660	Continued From page 14 include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (unlicensed personnel (ULP)-D). 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: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment	0 660			

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0 660	Continued From page 15 Worksheet for Health Care Settings Licensed by MDH was completed on March 16, 2026, and the facility was determined to be a low risk level. ULP-D was hired on August 8, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On June 16, 2026, at 1:52 p.m., the surveyor observed ULP-D administer R2's scheduled afternoon medication. ULP-D's employee record contained an undated negative TB screen. ULP-D's first step TST was administered on October 29, 2025, at 9:30 a.m., and was read on October 31, 2025, at 7:54 a.m. (48 hours had not passed after the TST was administered. ULP-D's second step TST was administered on November 12, 2025, at 1:00 p.m., and was read on November 14, 2025, at 12:53 p.m. (48 hours had not passed after the TST was administered). On June 17, 2026, at 1:32 p.m., CNS-B stated TSTs were supposed to be read 48 to 72 hours after administration, however, ULP-D's first and second TSTs were read before 48 hours had passed since the administration of each TST. The licensee's TB Prevention and Control policy dated May 2, 2025, indicated prior to contact with residents, each staff person will be screened for TB either by a two-step TST or single interferon gamma release assay (IGRA). In addition, after the TST is administered, the staff must wait 48 to 72 hours and have the skin test reaction read. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	0 660			

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0 660	Continued From page 16 (21) days	0 660			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents, staff, and visitors.	0 680			

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0 680	Continued From page 17 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: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee's EPP dated April 27, 2023, lacked the following required content: - annual review of the EPP; - quarterly review of the missing resident plan; - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed.	0 680			

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0 680	Continued From page 18 On June 17, 2026, at 1:23 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee had not reviewed the EPP recently. LALD/LPN-A further stated the licensee reviewed the missing resident plan "many times", however, LALD/LPN-A stated the missing resident plan was not documented as reviewed quarterly. LALD/LPN-A stated LALD/LPN-A was unable to locate exercises completed for the years of 2024 and 2025, however, LALD/LPN-A stated a severe weather drill was completed on April 24, 2026. The licensee's undated Missing Resident policy indicated the assisted living director and CNS will review the missing resident plan at least quarterly and document any changes to the plan. The licensee's Emergency and Disaster Preparedness policy dated April 24, 2023, indicated the facility conducts exercises to test the EPP at least twice per year. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and CNS must review the missing person plan at least quarterly and document any changes to the plan. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All	0 680			

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0 680	Continued From page 19 Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 730 SS=F	144G.43 Subd. 3 Contents of resident record Contents of a resident record include the following for each resident: (1) identifying information, including the resident's name, date of birth, address, and telephone number; (2) the name, address, and telephone number of the resident's emergency contact, legal representatives, and designated representative; (3) names, addresses, and telephone numbers of the resident's health and medical service providers, if known; (4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records; (5) the resident's advance directives, if any; (6) copies of any health care directives, guardianships, powers of attorney, or conservatorships; (7) the facility's current and previous assessments and service plans; (8) all records of communications pertinent to the resident's services; (9) documentation of significant changes in the resident's status and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care	0 730			

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0 730	Continued From page 20 professional; (10) documentation of incidents involving the resident and actions taken in response to the needs of the resident, including reporting to the appropriate supervisor or health care professional; (11) documentation that services have been provided as identified in the service plan; (12) documentation that the resident has received and reviewed the assisted living bill of rights; (13) documentation of complaints received and any resolution; (14) a discharge summary, including service termination notice and related documentation, when applicable; and (15) other documentation required under this chapter and relevant to the resident's services or status. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure resident records included documentation of services provided for two of two residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor	0 730			

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0 730	Continued From page 21 (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and schizophrenia. R2's Individual Service Plan (ISP)- CA printed June 17, 2026, indicated R2's services included medication administration, blood glucose checks, and assistance with bathing, dressing, grooming, and housekeeping. On June 16, 2026, at 1:52 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled afternoon medication. R2's Service Recap Summary- Monthly dated June 2026, indicated the following: -June 11, 12, 13, and 14, respectively, indicated R2 did not have dressing documented in the morning; -June 1, 2, 5, 6, 7, 9, 10, 11, 12, 13, and 14, respectively, indicated R2 did not have manage symptoms- mental health documented in the morning; -June 1, 2, 5, 6, 7, 12, 13, and 14, respectively, indicated R2 did not have safety checks documented in the morning; -June 4, 13, and 14, respectively, indicated R2 did not have manage symptoms- mental health documented in the midday; -June 13, and 14, respectively, indicated R2 did not have oral cares documented in the midday; -June 8, 12, and 13, respectively, indicated R2 did not have manage symptoms- mental health documented in the evening; and -June 12, and 13, respectively, indicated R2 did not have safety checks documented in the evening.	0 730			

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0 730	Continued From page 22 R3 R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), and congestive heart failure (CHF). R3's ISP- CA printed June 17, 2026, indicated R3's services included medication administration, oxygen management, managing behaviors, and assistance with bathing, grooming, dressing, and housekeeping. On June 16, 2026, at 12:52 p.m., the surveyor observed ULP-D administer R3's scheduled afternoon medication. R3's Service Recap Summary- Monthly dated June 2026, indicated the following: -June 5, indicated R3 did not have a safety check documented at 5:00 a.m.; -June 1, 2, 5, 6, 7, 9, 10, 11, 12, 14, and 15, respectively, indicated R3 did not have ambulation documented in the morning; -June 11, 12, 14, and 15, respectively, indicated R3 did not have dressing documented in the morning; -June 1, 2, 5, 6, 7, 8, 9, 10, 11, 12, 14, and 15, respectively, indicated R3 did not have elevate legs documented in the morning; -June 1, 2, 5, 6, 7, 8, 10, 11, 12, 14, and 15, respectively, indicated R3 did not have glasses care documented in the morning; -June 1, 2, 5, 6, 7, 9, 10, 11, 12, 14, and 15, respectively, indicated R3 did not have manage behaviors documented in the morning; and -June 1, 2, 5, 6, 7, 9, 10, 11, 12, 14, and 15, respectively, indicated R3 did not have oxygen management documented in the morning.	0 730			

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0 730	Continued From page 23 R2 and R3's records lacked documentation of the services noted above, or the reason why the service was not provided to R2 and R3. On June 17, 2026, at 2:00 p.m., CNS-B stated ULPs were expected to document in the resident's chart right after completing each task. Licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated ULPs were not completing all the required charting, however, the services were being provided to each resident. LALD/LPN-A further stated documentation was part of the licensee's current quality management program and the licensee was working with the ULPs to ensure all services were documented or the reason why the service was not provided. The licensee's Resident Records policy dated May 2, 2025, indicated resident records included documentation that services have been provided as identified in the service plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 730			
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, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in	0 775			

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0 775	Continued From page 24 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not	0 780			

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NAME OF PROVIDER OR SUPPLIER VITACARE LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HARBOR STREET OGILVIE, MN 56358			
(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
0 780	Continued From page 25 including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 18, 2026, for the specific violations related	0 780			

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0 780	Continued From page 26 the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 810 SS=I	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810			

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0 810	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter	01290			

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01290	Continued From page 28 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health care facility identification number (HFID) for one of six employees (human resources (HR)-E). 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: During the entrance conference on June 16, 2026, at 8:38 a.m., housing manager (HM)-C stated the licensee was aware of required contents in an employee record.	01290			

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01290	Continued From page 29 HR-E was hired on December 15, 2021, to manage the human resource department for the licensee. The licensee's undated NETStudy 2.0 Roster Report indicated HR-E was not affiliated with the licensee's HFID. HR-E's employee record contained a cleared background study dated November 3, 2025, with the HFID 30617 for the licensee's sister assisted living facility and not the correct HFID 30706 for the licensee. On June 16, 2026, at 1:24 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated HR-E was a current employee for the licensee, directed the human resources department, HR-E was responsible to complete background studies on the NETStudy 2.0 website, and HR-E had access to the licensee's resident electronic medical records system. LALD/LPN-A further stated HR-E's background study was completed under the licensee's sister facility and was not affiliated with the licensee's HFID. The licensee's Background Checks policy dated June 2, 2025, indicated all employees, contractors, and regularly scheduled volunteers are subject to background studies under section 144.057. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			

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01440	Continued From page 30	01440			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for one of two employees (unlicensed personnel (ULP)-D). 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	01440			

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01440	Continued From page 31 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: During the entrance conference on June 16, 2026, at 8:38 a.m., housing manager (HM)-C stated the licensee was aware of required contents in an employee record. ULP-D was hired on August 8, 2025, to provide direct care services to residents at the assisted living with dementia care facility. On June 16, 2026, at 1:52 p.m., the surveyor observed ULP-D administer R2's scheduled afternoon medication. ULP-D's employee record included a Nurse Observation Clearance for New Hires dated August 11, 2025, which indicated licensed assisted living director/licensed practical nurse (LALD/LPN)-A observed ULP-D complete a blood glucose check and medication administration pass. ULP-D's employee record lacked documentation of an appropriate licensed health professional or registered nurse (RN) supervising ULP-D performing a delegated task within 30 days of beginning work with the licensee after ULP-D had begun to provide delegated tasks for residents. On June 17, 2026, at 1:37 p.m., LALD/LPN-A stated the licensee's previous RN was offsite when ULP-D's 30-day supervision was due, and	01440			

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01440	Continued From page 32 the RN had delegated LALD/LPN-A to complete the 30-day supervision. LALD/LPN-A further stated clinical nurse supervisor (CNS)-B had completed all 30-day supervisions since December 2025 when CNS-B became employed by the licensee. The licensee's Supervision of ULP dated May 2, 2025, indicated direct supervision of unlicensed staff providing delegated nursing tasks, delegated treatments or assigned therapy tasks must be performed within 30 days after the person begins work for our (licensee) facility and has been trained and determined competent to perform all the tasks assigned. THE RN will directly supervise staff performing delegated nursing tasks and the appropriate licensed health professional will supervise unlicensed staff performing any delegated treatments or assigned therapies. Per Assisted: 144G.08 Definitions, Subp. 29. "Licensed Health professional" means a person, other than a RN or LPN, who provides assisted living services within the scope of practice of that person's health occupation license, registration, or certification as a regulated person who is licensed by an appropriate Minnesota state board or agency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01440			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training	01500			

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01500	Continued From page 33 for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following	01500			

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01500	Continued From page 34 topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of two employees (unlicensed personnel (ULP)-F). 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: During the entrance conference on June 16, 2026, at 8:38 a.m., housing manager (HM)-C stated the licensee was aware of required contents in an employee record.	01500			

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01500	Continued From page 35 ULP-F was hired on November 21, 2009, and effective August 1, 2021, began to provide direct care services to residents at the assisted living with dementia care facility. On June 17, 2026, at 7:17 a.m., the surveyor observed ULP-F administer R2's scheduled morning medication. ULP-F's employee record lacked the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person as an annual training topic. On June 17, 2026, at 1:38 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated the licensee assigned principles of person-centered planning as part of annual training content, however, LALD/LPN-A stated ULP-F had not completed the course. The licensee's Assisted Living with Dementia Care Annual Training policy dated February 25, 2026, indicated all assisted living employees will complete annual education including the topic of principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620			

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01620	Continued From page 36 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 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	01620			

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01620	Continued From page 37 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 resident reassessment and monitoring completed by a registered nurse (RN) was conducted no more than 14 calendar days after initiation of services for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on June 16, 2026, at 8:31 a.m., clinical nurse supervisor (CNS)-B stated the licensee completed resident assessments prior to admission, on admission, within 14 days of admission, and then at least every 90 days or with a resident change of condition. R2 was admitted to the facility on May 7, 2026.	01620			

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01620	Continued From page 38 R2's Admission Assessment dated May 9, 2026, was completed by CNS-B. On June 16, 2026, at 1:52 p.m., the surveyor observed unlicensed personnel (ULP)-D administer R2's scheduled afternoon medication. R2's record contained a Clinical Update Assessment dated June 1, 2026, was completed by CNS-B, however, was completed 25 days after R2 was admitted to the facility. R2's record lacked a 14-day assessment conducted no more than 14 calendar days after the initiation of services. On June 17, 2026, at 1:58 p.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated when R2 was admitted to the facility, R2's brother took R2 to stay with him for the weekend and CNS-B had signed the admission assessment on May 9, 2026, however, it was completed upon admission. CNS-B stated CNS-B was not sure why R2 did not have a 14-day assessment as one should have been completed. The licensee's undated Initial and On-going Assessment of Residents policy indicated a RN will complete a 14-day assessment 14-days after start of services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620			
01640 SS=F	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to	01640			

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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
01640	Continued From page 39 (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of three residents (R6). In addition, the licensee failed to ensure the service plan included a resident or resident representative's signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided for two of three residents (R2, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01640			

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01640	Continued From page 40 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: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. SERVICE PLAN REVISION R6's diagnoses included end-stage renal (kidney) disease, hypertension (HTN-high blood pressure), and anxiety. On June 17, 2026, at 7:59 a.m., the surveyor observed licensed assisted living director/licensed practical nurse (LALD/LPN)-A complete wound care on R6's right lower leg. R6's prescriber orders dated November 19, 2025, included an order for wound care completed three times per week. R6's Service Plan- Modification dated October 6, 2025, indicated wound care twice daily by unlicensed personnel (ULP), however, R6's service plan lacked wound care three times per week by the registered nurse (RN) or LPN. On June 17, 2026, at 11:12 a.m., LALD/LPN-A stated R6's service plan was not revised to reflect current wound care for R6. LALD/LPN-A further stated the wound care completed by the RN or LPN was entered as a service instead of a treatment and did not revise the service plan.	01640			

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01640	Continued From page 41 On June 17, 2026, at 1:51 p.m., CNS-B stated the RN was responsible for keeping resident service plans up to date, and R6's service plan should have been revised to reflect current wound care services. SERVICE PLAN AUTHENTICATION R2 R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), and schizophrenia. On June 16, 2026, at 1:52 p.m., the surveyor observed ULP-D administer R2's scheduled afternoon medication. R2's Individual Service Plan (ISP)- CA printed June 17, 2026, did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. R3 R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), and congestive heart failure (CHF). On June 16, 2026, at 12:52 p.m., the surveyor observed ULP-D administer R3's scheduled afternoon medication. R3's ISP- CA printed June 17, 2026, did not include a resident or resident representative signature and a licensee signature or other authentication by the licensee to document agreement on the services to be provided. On June 17, 2026, at 12:03 p.m., LALD/LPN-A stated the licensee was unable to locate R2 and	01640			

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01640	Continued From page 42 R3's previously signed service plans and provided the surveyor with a service plan for R2 and R3 with a printed date of June 17, 2026 (one day after survey initiation). LALD/LPN-A stated CNS-B was new to employment with the licensee and was still learning the requirements for service plans. The licensee's Contents of Service Plans policy dated May 2, 2025, indicated service plans and any revisions to services [sic] plans will have a signature or other authentication by the facility and by the resident. In addition, service plans are reviewed and revised as needed based upon on-going resident assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of	01730			

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01730	Continued From page 43 diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to develop and maintain a current individualized medication management plan for each resident to include all required content for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01730			

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01730	Continued From page 44 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: During the entrance conference on June 16, 2026, at 8:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A, clinical nurse supervisor (CNS)-B, and housing manager (HM)-C stated the licensee provided medication management services to residents at the facility. R6's diagnoses included end-stage renal (kidney) disease, hypertension (HTN-high blood pressure), and anxiety. R6's Service Plan- Modification dated October 6, 2025, indicated R6 received medication administration four times per day. R6's prescriber orders dated November 19, 2025, included an order for collagenase clostridium histolyticum 250 unit/gram apply topically to affected areas with dressing changes. On June 17, 2026, at 7:59 a.m., the surveyor observed LALD/LPN-A complete wound care on R6's right lower leg. Immediately following the observation, LALD/LPN-A placed R6's wound care cleanser, collagenase ointment, and wound care supplies on the top shelf in R6's closet. R6's Individualized Medication Management Plan dated March 31, 2026, indicated R6's	01730			

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01730	Continued From page 45 medications were stored in the locked medication cart or locked cabinet in office. R6's individualized medication management plan did not match current medication storage for R6. On June 17, 2026, at 1:53 p.m., CNS-B stated R6's wound care supplies and topical ointment were kept in R6's closet and R6 did not self administered the medication. CNS-B further stated when CNS-B reviewed R6's medication management plan it should have been updated to reflect current storage for R6's ointment applied to R6's wound. The licensee's Individualized Medication, Treatment, and Therapy Management Plans policy dated May 2, 2025, indicated the RN will develop a medication management plan, which included a description of medication storage based upon the resident's needs, preferences, risk of diversion, and in keeping with the manufacturer's instructions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730			
01890 SS=F	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 46 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with legible information including the expiration date for time sensitive medications for one of one medication cart. In addition, the licensee failed to monitor for expired medications. 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: During the entrance conference on June 16, 2026, at 8:29 a.m., licensed assisted living director/licensed practical nurse (LALD/LPN)-A, clinical nurse supervisor (CNS)-B, and housing manager (HM)-C stated the licensee provided medication management services to residents at the facility. On June 16, 2026, at 1:59 p.m., the surveyor reviewed the locked medication cart with unlicensed personnel (ULP)-D and observed the following: TIME SENSITIVE MEDICATIONS -R4's opened Lantus 100 units/mL insulin pen was not labeled with an open date or expiration date -R3's opened latanoprost 0.005% eye drop was	01890			

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01890	Continued From page 47 not labeled with an open date or expiration date EXPIRED MEDICATIONS -opened stock bottle of polyethylene 17 grams expired April 2026 -opened stock bottle of Tums expired May 2026 -opened stock bottle of melatonin 5 mg expired April 2026 Immediately following the observation, ULP-D stated the nurse checks the medication cart at least monthly for expired medications. ULP-D further stated ULPs were expected to label time sensitive medications with the open date and ULP-D was not aware certain eye drops were time sensitive. On June 17, 2026, at 1:47 p.m., CNS-B and LALD/LPN-A stated the nurses did medication cart audits to check for expired medications and ensure time sensitive medications were labeled. CNS-B further stated the pharmacy provided time sensitive labels on medications and ULPs were expected to document the open date and expiration date on each label. The manufacturer's instructions for use of Lantus dated May 2019, indicated to discard the Lantus insulin pen 28 days after opening, even if the insulin pen still contains Lantus. The manufacturer's instructions for the use of latanoprost dated September 2020, indicated once the bottle is opened for use, it may be stored for up to six weeks. The licensee's Storage of Medications policy dated May 2, 2025, indicated until the medication is set up for immediate or later administration, a legend drug (medication) must be kept in its	01890			

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01890	Continued From page 48 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 the time-dated drug, directions for use, resident's name, prescriber's name, date of issue and the name and address of the licensed pharmacy that issued medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
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 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 observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	02040			

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02040	Continued From page 49 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 18, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days	02040			
02310 SS=F	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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R3) with hospital bed rails.	02310			

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02310	Continued From page 50 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: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), and congestive heart failure (CHF). R3's Individual Service Plan (ISP)- CA printed June 17, 2026, indicated R3's services included medication administration, oxygen management, managing behaviors, and assistance with bathing, grooming, dressing, and housekeeping. On June 16, 2026, from 8:12 a.m., through 8:20 a.m., the surveyor toured the facility with licensed assisted living director/licensed practical nurse (LALD/LPN)-A. The surveyor observed upper bilateral hospital bed rails on R3's bed. R3's Bed Safety Assessment dated June 11, 2026, indicated R3 had bilateral upper hospital side rails (bed rails) attached to R3's bed. R3 used the bed rails to promote independence with bed mobility and were appropriate based upon resident preference and assessment. The bed rails did not function as a restraint, no risk for	02310			

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02310	Continued From page 51 injury, no medications that affected mental status, risk and benefits were discussed, and education was provided. The bed rails met the Food and Drug Administration (FDA) guidelines. In addition, Zones 1, 2, and 3 were less than 4 ¾ inches, and Zone 4 was less than 2 3/8 inches. R3's record lacked evidence of documentation of the accurate zone measurements for zones 1, 2, 3, and 4 on R3's bed rails. On June 17, 2026, at 2:08 p.m., CNS-B stated CNS-B assessed R3's bed rails every 90 days on the bed rail assessment form provided. CNS-B further stated CNS-B was not aware the actual measurement of each zone needed to be documented on resident's bed rail assessments. The licensee's Devices and Device Assessment policy dated May 2, 2025, indicated a nurse will complete a device assessment every 90 days and will document the results of the assessment in the resident's record. The policy did not address documentation of each bed rail zone. The 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 Minnesota Department of Health (MDH)	02310			

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02310	Continued From page 52 website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated May 4, 2026, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Measurements; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements." Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. No further information was provided.	02310			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30706	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
NAME OF PROVIDER OR SUPPLIER VITACARE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HARBOR STREET OGILVIE, MN 56358		
(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 53	02310			
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure privacy was maintained for two of three residents (R5, R2) while receiving treatments. This practice resulted in a level two violation (a	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30706	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/18/2026
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02410	Continued From page 54 violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on June 16, 2026, at 8:25 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R5 R5's prescriber orders dated June 25, 2025, included an order for blood glucose checks three times per day. On June 16, 2026, at 11:36 a.m., the surveyor observed unlicensed personnel (ULP)-D complete a blood glucose test for R5 at the dining room table with four other residents seated at the table. ULP-D completed R5's blood glucose check and stated to R5 the reading was 283 milligrams (mg)/deciliter (dL). The surveyor did not observe ULP-D ask R5 if R5 wanted to move to a private area to complete the blood glucose test or ask the other four residents seated at the table if they were okay with a blood glucose test being performed in front of them. R2 R2's prescriber orders dated May 13, 2026, included an order for blood glucose checks twice daily.	02410			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER VITACARE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HARBOR STREET OGILVIE, MN 56358		
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02410	Continued From page 55 On June 16, 2026, at 11:41 a.m., the surveyor observed ULP-D complete a blood glucose test for R2 at the dining room table with three other residents seated at the table. ULP-D completed R2's blood glucose check and stated to R2 the reading was 104 mg/dL. The surveyor did not observe ULP-D ask R2 if R2 wanted to move to a private area to complete the blood glucose test or ask the other three residents seated at the table if they were okay with a blood glucose test being performed in front of them. On June 17, 2026, at 7:08 a.m., the surveyor observed ULP-F complete a blood glucose test for R2 at the dining room table with three other residents seated at the table. ULP-F completed R2's blood glucose check and stated to R2 the reading was 177 mg/dL. The surveyor did not observe ULP-F ask R2 if R2 wanted to move to a private area to complete the blood glucose test or ask the other three residents seated at the table if they were okay with a blood glucose test being performed in front of them. On June 16, 2026, at 2:12 p.m., ULP-D stated residents at the facility preferred to have their blood glucose tests completed at the table prior to eating. ULP-D further stated ULP-D had asked residents in the past if they prefer to go to a private area for their blood glucose, however, residents usually declined moving to a private area to complete the blood glucose test. On June 17, 2026, at 12:00 p.m., ULP-F stated ULP-F did not ask R2 if R2 wanted to move to a private area to complete the blood glucose test. ULP-F further stated blood glucose tests are normally completed at the dining room table as mealtimes get very busy and it is faster to complete the blood glucose test at the dining	02410			

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER VITACARE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 1545 HARBOR STREET OGILVIE, MN 56358		
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02410	Continued From page 56 room table rather than moving a resident to a private area. On June 17, 2026, at 1:45 p.m., CNS-B stated residents should have been offered to be moved to a private area prior to each blood glucose test. Licensed assisted living director/licensed practical nurse (LALD/LPN)-A stated other residents seated at the dining room table should have been asked if they were comfortable with the blood glucose test being done. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

Vitacare Living
1545 Harbor Street
Ogilvie, MN 56358
Kanabec County
Parcel:

Phone:
tina.johnson@vitacareliving.com

License Info

License: HFID 30706

Risk:
License:
Expires on:
CFPM: TINA JOHNSON
CFPM #: 56745; Exp: 2/25/2028

Inspection Info

Report Number: F1037261156
Inspection Type: Full - Single
Date: 6/16/2026 Time: 11:35:05 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 2
Total Priority 2 Orders: 2
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.14 *Priority Level: Priority 2 CFP#: 48*

MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.

COMMENT: PROVIDE A TEST KIT FOR MEASURING THE SANITIZING SOLUTION THAT'S PURCHASED FOR USE ON FOOD CONTACT SURFACES.

Comply By: 6/23/2026 Originally Issued On: 6/16/2026

! New Order: 4-500 Equipment Maintenance and Operation

4-501.114A *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0805A Use the approved sanitizer according to the rule and the EPA approved manufacturer's label.

COMMENT: DISCONTINUE USING SANITIZERS THAT REQUIRE RINSING ON FOOD CONTACT SURFACES.

PROVIDE AN APPROVED FOOD CONTACT SURFACE SANITIZER AND APPLICABLE TEST KIT. FACT SHEET SENT AND LINKS TO APPROVED SANITIZERS SENT WITH THE REPORT.

Comply By: 6/16/2026 Originally Issued On: 6/16/2026

! New Order: 4-700 Sanitizing Equipment and Utensils

4-703.11B *Priority Level: Priority 1 CFP#: 16*

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

COMMENT: TINA SENT DISHWASHER TEMPERATURE TEST STRIP. DISHWASHER CYCLE MEASURED 150 DEG F. ADJUST OR REPAIR DISHWASHER TO REACH A MINIMUM OF 160 DEG F AT THE PLATE LEVEL.

SANITIZE DISHES IN AN ALTERNATIVE METHOD, SUCH AS FULLY SUBMERGING IN 50-100 PPM CHLORINE SOLUTION AFTER RUNNING THROUGH THE DISHWASHER, UNTIL THE DISHWASHER IS ADJUSTED OR REPAIRED AND SANITIZING DISHES TO 160 DEG F.

Comply By: 6/18/2026 Originally Issued On: 6/16/2026

New Order: 5-100 Water

5-102.13 *Priority Level: Priority 2 CFP#: 31*

MN Rule 4626.1005 Water from a public water system must be sampled and tested as required by chapter 4720, rules for public water supplies.

COMMENT: WATER TEST RESULTS WERE AVAILABLE FROM 2024. TEST WATER ANNUALLY AND HAVE WATER TEST RESULTS AVAILABLE UPON REQUEST. TINA STATED SHE WILL EMAIL THE WATER TEST RESULTS UPON RECEIPT.

Comply By: 7/7/2026 Originally Issued On: 6/16/2026

Food & Beverage General Comment

DISCUSSED ORDERS, DISHWASHING, WIPING CLOTHS, BARE HAND CONTACT, EMPLOYEE ILLNESS RECORDING, MENU AND HIGH RISK FOOD ITEMS. ALL ANIMAL FOODS ARE FULLY COOKED AND ONLY PASTEURIZED EGGS WERE ONSITE. NO COOLING COMPLETED ONSITE; ALL HOT FOODS ARE PREPARED FOR SAME DAY SERVICE.

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 St Cloud District Office inspection report number F1037261156 from 6/16/2026

TINA



Michelle Hovanes,
Public Health Sanitarian 2
320-223-7307
michelle.hovanes@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

Page: 1

Establishment Info

Vitacare Living
Ogilvie
County/Group: Kanabec County

Inspection Info

Report Number: F1037261156
Inspection Type: Full
Date: 6/16/2026
Time: 11:35:05 AM

Food Temperature: **Product/Item/Unit:** PACKAGED CHEESE STICK; **Temperature Process:** Cold-Holding

Location: Upright Cooler at 40 Degrees F.

Comment: BACK ROOM

Violation Issued?: No

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

Location: Upright Cooler at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** NOODLES IN MEAT SAUCE; **Temperature Process:** Cooking

Location: Oven at 168 Degrees F.

Comment:

Violation Issued?: No



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Page: 1

Establishment Info

Vitacare Living
Ogilvie
County/Group: Kanabec County

Inspection Info

Report Number: F1037261156
Inspection Type: Full
Date: 6/16/2026
Time: 11:35:05 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 150 Degrees F.
Comment:
Violation Issued?: Yes

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30706016	Date: 6/18/2026
Facility Name: Vitacare Living	
Facility Address: 1545 Harbor St., Oglivie, MN 56358	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Any device that has the physical appearance of life safety or fire protection equipment but that does not perform that life safety or fire protection function shall be prohibited. [Minn. Stat. 144G.45 subd. 2; MSFC 901.4.5]

Comments: There were two devices that appeared to be smoke alarms that were installed on the ceiling in the office and living room in the facility but did not function as smoke alarms. Facility staff indicated that the devices were cameras that were disguised as smoke alarms. The false smoke alarms should be removed and no devices with the appearance of life safety devices should be installed unless they serve the purpose that they appear to serve.

3. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. Door handles, pulls, latches, locks and other operating devices shall be installed 34 inches (864 mm) minimum and 48 inches (1219 mm) maximum above the finished floor. Locks used only for security purposes and not used for normal operation are permitted at any height. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9, MSFC 1010.1.9.2]

Comments: A locking device was installed on the front door approximately 77 inches above the floor. The equipped device was installed too high and required special knowledge and effort to unlock. Facility staff stated that the device is not in use and that it would be removed.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: The smoke alarms were not properly interconnected throughout the facility when tested during the survey. Smoke alarms should be interconnected such that the activation of any one smoke alarm causes all other alarms to sound.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide fire protection procedures for staff to the surveyor during the survey. The FSEP did not include any policies for staff procedures during evacuation. Site-specific plans should be included for residents in the FSEP.

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

Comments: The licensee failed to provide fire protection procedures for residents to the surveyor during the survey. The FSEP did not include any policies for resident procedures during evacuation. Site-specific plans should be included for residents in the FSEP.

3. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide record of unique resident needs for evacuation during a fire or similar emergency. The specific needs of each resident for evacuation should be documented, and those records should be maintained as accurate and up to date.

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

Comments: The licensee failed to provide record of staff training on the FSEP. Staff should be trained on the FSEP upon hire and at least twice a year thereafter.

5. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to provide record of resident training on the FSEP. Residents should be offered training at least once a year.

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

Comments: The licensee provided fire drill records which indicated the last fire drill was conducted on April 15, 2025, at 1pm. No further records were located and facility staff indicated that fire drills were not occurring regularly. Fire drills should be performed at least twice per shift per year and at least once every other month.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

Comments: The licensee failed to provide an accurate and up to date safety risk assessment for the facility. The safety risk assessment provided to the surveyor during survey indicated it was last reviewed in 2023 and contained information that was inaccurate, including identifying controlled egress locking devices which were not present during the survey. Facility staff indicated that the records were out of date and were incorrect, but that they would review and update the safety risk assessment.