DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 10, 2026

Licensee
Cook Carefree Living by Oxford Living
151 4th Street Southeast
Cook, MN 55723

RE: Project Number(s) SL27092016

Dear Licensee:

On February 4, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 3, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

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Electronically Delivered

December 26, 2025

Licensee
Cook Carefree Living by Oxford Living
151 4th Street Southeast
Cook, MN 55723

RE: Project Number(s) SL27092016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 3, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

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

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

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING BY OXFORD LIVING	151 4TH STREET SE COOK, MN 55723

(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: SL27092016-0 On December 1, 2025, through December 3, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider and the following correction orders are issued. At the time of the survey, there were 24 residents; 24 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on December 2, 2025, issued for SL27092016-0, tag identification 2310. The licensee took action on December 2, 2025, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: 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 December 1, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to 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 December 2, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		

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0 780	Continued From page 4	0 780		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, 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	0 780		

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0 780	Continued From page 5 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 2, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780		
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the	0 800		

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0 800	Continued From page 6 facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 2, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 950 SS=C	144G.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain	0 950		

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0 950	Continued From page 7 information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure all resident assisted living contracts included a notice with the required verbiage for the residents to identify a designated representative. This had the potential to affect all residents who received services at the assisted living with dementia care facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 1, 2025, at 1:32 p.m., clinical nurse supervisor	0 950		

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0 950	Continued From page 8 (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. On page 12 of the licensee's undated Master Community Residency Agreement (assisted living contract) contained the following notice: Responsible Person: Residents are encouraged, but not required, to designate a family member or friend to sign this Agreement as the Resident's Responsible Person [sic]. Any person who signs as the Responsible Person may serve in one or more of the roles listed below. Resident to initial box, if declining to name a representative. Responsible party, legal representative, financially responsible person, and financial guarantor were options for the responsible person to elect. On December 3, 2025, at 9:23 a.m., CNS-B stated the licensee's designated representative section of the assisted living contract did not include the required verbatim notice for a resident to identify a designated representative. CNS-B further stated all residents had received the same designated representative information in the assisted living contract. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 950		
01550 SS=D	144G.64 (a) (4) Training in Dementia, Mental Illness, and De- (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b),	01550		

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01550	Continued From page 9 clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of two employees (housekeeping (HSKP)-E) received the required amount of dementia, mental illness, and de-escalation in the required time frame. 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 December 1, 2025, at 1:43 p.m., clinical nurse supervisor (CNS)-B stated the licensee was aware of required contents in an employee record. HSKP-E was hired on October 14, 2025, to provide HSKP services for residents at the assisted living with dementia care facility.	01550		

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01550	Continued From page 10 Throughout the survey on December 1, 2025, through December 3, 2025, the surveyor observed HSKP-E cleaning resident rooms. HSKP-E's employee record lacked evidence of four hours of initial dementia training, and two hours of initial training on mental illness and de-escalation. On December 1, 2025, at 12:58 p.m., HSKP-E stated HSKP-E worked full time for the licensee cleaning resident rooms and around the facility. On December 3, 2025, at 9:18 a.m., director of services (DS)-A stated the licensee assigned four hours of dementia training and two hours of mental illness and de-escalation training upon hire to all non-direct staff on Educare (on-line training platform), however, HSKP-E had not completed all required training assigned by the licensee. DS-A further stated HSKP-E had worked more than 160 hours for the licensee. The licensee's Training and Competency of Unlicensed Staff policy dated April 4, 2025, indicated staff who do not provide direct care, including maintenance, HSKP, and food service staff, must have at least four hours of initial training on topics specified under paragraph (5B) within 160 working hours of employment start date. The policy did not address mental illness and de-escalation training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		

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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
01750	Continued From page 11	01750		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) documented resident-specific instructions for medications for one of three residents (R5) whose medication administration was delegated to unlicensed personnel (ULP). 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 December 1, 2025, at 1:35 p.m., clinical nurse supervisor	01750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	12/03/2025

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01750	Continued From page 12 (CNS)-B stated the licensee provided medication management services to residents at the facility. R5's diagnoses included hypertension (HTN-high blood pressure), diabetes, and shortness of breath. R5's Service Plan dated January 11, 2024, indicated R5's services included medication administration. R5's prescriber orders dated November 21, 2025, included an order for Breztri Aerosphere 160-9-4.8 micrograms (mcg)/actuation (ACT) inhale two puffs into lungs twice daily. R5's Medication Administration Record (MAR) dated November 2025, and December 2025, respectively, indicated Breztri Aerosphere 160-9-4.8 mcg/ACT inhale two puffs into the lungs twice daily. On December 2, 2025, at 7:10 a.m., the surveyor observed ULP-F administer R5's scheduled morning medications. ULP-F handed R5 the Breztri inhaler, R5 inhaled two puffs from the Breztri inhaler, R5 handed the Breztri inhaler back to ULP-F, ULP-F administered R5's oral medications with water. The surveyor did not observe ULP-F offer R5 to rinse R5's mouth and spit out the water after administration of the Breztri inhaler. R5's record lacked resident specific instructions for R5 to rinse mouth and spit after administration of the Breztri inhaler. On December 2, 2025, at 9:54 a.m., ULP-F stated R5's MAR did not have written instructions to have R5 rinse mouth and spit water out after	01750		

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01750	Continued From page 13 administration of R5's Breztri inhaler. ULP-F stated ULP-F was trained to follow specific instructions written on a resident's MAR for medication administration. On December 3, 2025, at 9:30 a.m., CNS-B stated resident medication should include any specific instructions for administration for ULPs to follow, however, R5's Breztri inhaler lacked specific instructions for ULPs. Licensed practical nurse (LPN)-C stated the specific instructions were written on the resident's MAR unless the physician did not include specific instructions on the prescriber order. The manufacturer's instructions for Breztri dated July 2020, indicated after inhalation, rinse mouth with water without swallowing. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated (licensee name) will develop and maintain a current individualized medication management record for each resident based on the resident's assessment which included any resident-specific [sic] 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. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication	01760		

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01760	Continued From page 14 Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were administered per prescriber orders for one of six residents (R4) observed during medication administration. 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 December 1, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility.	01760		

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01760	Continued From page 15 R4's diagnoses included macular degeneration (blurry or distorted vision), hypertension (HTN-high blood pressure), and lower back pain. R4's Service Plan dated October 1, 2023, indicated R4's services included medication administration. R4's prescriber orders dated November 13, 2025, included an order for diclofenac gel 1% apply 2 (two) grams (g) topically to large joint or low back twice daily. R4's Medication Administration Record (MAR) dated November 2025, and December 2025, respectively, indicated diclofenac gel 1% apply 2 g topically to large joint or low back twice daily. On December 2, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-F apply approximately a dime size amount of diclofenac gel 1% to R4's lower back. The surveyor did not observe ULP-F use a dosing card to verify 2 g of diclofenac gel 1%. On December 2, 2025, at 9:58 a.m., ULP-F stated ULP-F applied approximately a dime size amount of diclofenac gel 1% to R4's lower back. ULP-F further stated ULP-F was not aware diclofenac gel 1% came with a dosing card for measuring 2 g of diclofenac gel 1%. On December 3, 2025, at 9:28 a.m., CNS-B stated ULPs were trained to use the ruler (dosing card) to measure the appropriate amount of diclofenac gel 1% applied topically to R4. The manufacturer's instructions for Voltaren (diclofenac) dated July 2009, indicated the proper amount of Voltaren Gel should be measured	01760		

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01760	Continued From page 16 using the dosing card supplied in the drug product carton. In addition, the dosing card should be used for each application of drug product. The licensee's Medication Errors policy dated April 4, 2025, indicated person who discovers the error or the person responsible for the error will contact the registered nurse (RN) immediately and explain the situation with details including the resident's name, the medication name, dosage and amount and other relevant information [sic]. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated when administration of medications is delegated to ULPs, the assisted living facility must ensure that the RN has instructed the ULP the proper methods to administer the medications, and the ULP has demonstrated the ability to competently follow the procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one	01880		

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01880	Continued From page 17 refrigerator storing medications maintained an acceptable temperature and medications were stored according to manufacturer's recommended temperature. 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: During the entrance conference on December 1, 2025, at 1:35 p.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to residents at the facility. On December 2, 2025, at 9:47 a.m., the surveyor reviewed the secured medication refrigerator in the unlicensed personnel (ULP) office with ULP-F. ULP-F stated the current temperature of the medication refrigerator was 37 degrees Fahrenheit (F) and the temperature was checked daily by ULPs. The medication refrigerator contained the following medications: -24 unopened Novolog 100 units/milliliter (mL)- 3 mL insulin pens for R5; -10 unopened Lantus 100 units/mL- 3 mL insulin pens for R5; and -30 unopened Humulin 70/30 insulin pens for R2. The licensee's Record Medication Fridge (refrigerator) Temp (temperature) dated November 2, 2025, through December 1, 2025, indicated the medication refrigerator temperature	01880		

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01880	Continued From page 18 was checked daily and had written notify nurse if refridgerator [sic] temperature is below 36 degrees or above 46 degrees. The temperature documentation indicated seven out of 29 opportunities the medication refrigerator temperature was less than 36 degrees F. On December 3, 2025, at 9:26 a.m., licensed practical nurse (LPN)-C stated the temperature of the medication refrigerator was checked daily and documented in the electronic medical record system. CNS-B stated the medication refrigerator temperature was supposed to be kept between 36 degrees F to 46 degrees F. CNS-B further stated if the temperature was out of range ULPs were expected to notify a nurse, follow the nurse's instructions to either adjust the temperature or moved the medications to a different refrigerator, and a follow up temperature would be completed with documentation. The manufacturer's instructions for Novolog dated May 2019, indicated to store unopened Novolog in the refrigerator at 36 degrees F to 46 degrees F. Do not freeze Novolog. The manufacturer's instructions for Lantus dated May 2019, indicated to store unopened Lantus in the refrigerator at 36 degrees F to 46 degrees F. Do not allow Lantus to freeze. The manufacturer's instructions for Humulin dated June 2022, indicated to store unopened Humulin in the refrigerator at 36 degrees F to 46 degrees F or up to 14 days at room temperature. The licensee's 2.00 Medication Management Services policy dated January 16, 2023, indicated (licensee name) will store all prescription medications in securely locked and substantially	01880		

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01880	Continued From page 19 constructed compartments according to the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation and interview, 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 pattern scope (when more than a	02040		

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02040	Continued From page 20 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated November 19, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02280 SS=C	144G.90 Subd. 5 Notice to residents; change in ownership or m (a) A facility must provide written notice to the resident, legal representative, or designated representative of a change of ownership within seven calendar days after the facility receives a new license. (b) A facility must provide prompt written notice to the resident, legal representative, or designated representative, of any change of legal name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the manager of the facility, if applicable; and (2) the authorized agent. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice to the residents, legal representative, or designated representative of a change of ownership (CHOW)	02280		

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	27092	A. BUILDING: _____ B. WING _____	12/03/2025

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02280	Continued From page 21 with all required content. This had the potential to affect all residents residing at the assisted living with dementia care facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 1, 2025, at 1:32 p.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. The licensee had a CHOW effective April 29, 2025. The licensee provided a copy of a CHOW letter to residents and families dated March 21, 2025, which identified the licensee's president, chairman, and director of operations. The letter did not include the manager of the facility, if applicable, or the authorized agent for the licensee. On December 3, 2025, at 10:36 a.m., assisted living director in residency (ALDIR)-J stated the licensee purchased all resident contracts with the CHOW, and ALDIR-J had thought the letter provided to residents and families met the requirements for notification of the CHOW. On December 3, 2025, at 11:32 a.m., CNS-B stated the CHOW letter provided by the licensee did not include all required content, however, the	02280		

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	27092	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02280	Continued From page 22 licensee was in the works of updating the information to provide to residents and their families. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02280		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care, medical or nursing standards for one of one resident (R4) who utilized bedrails. This resulted in an immediate correction order on December 2, 2025. 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:	02310		

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02310	Continued From page 23 During the entrance conference on December 1, 2025, at 1:32 p.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R4's diagnoses included macular degeneration (blurry or distorted vision), hypertensions (HTN-high blood pressure), and lower back pain. R4's Service Plan dated October 1, 2023, indicated R4's services included medication administration, bathing, and housekeeping. On December 1, 2025, at 8:36 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R4's scheduled morning medication. During the observation, the surveyor observed a consumer bedrail on R4's left side of R4's bed. The consumer bed rail was two upside-down, black, U-shaped metal bars with one bar able to rotate 90 degrees out from the bed to provide additional stability. ULP-F stated R4 used the bed rail to sit up in bed. R4's AL (assisted living) Uniform Assessment Tool dated September 25, 2025, indicated R4 used a reclining chair and did not have a bed mobility device such as a bedrail, grab bars, or other device. The Uniform Assessment Tool indicated R4 was independent for transfers and bed mobility and was continent of bladder and bowels. R4's record lacked documentation R4 was assessed to have a consumer bedrail, the purpose of the bedrail, the bedrail was determined to not act as a restraint, the consumer bed rail was installed and maintained per manufacturer's guidelines, the risk versus benefits were discussed with R4/R4's	02310		

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02310	Continued From page 24 representative on the use of the consumer bed rail, and the licensee reviewed the Consumer Product Safety Commission (CPSC) website to ensure R4's bedrail was not recalled. On December 2, 2025, at 1:25 p.m., CNS-B stated CNS-B was completing an updated assessment on R4 for R4's consumer bedrail. CNS-B further stated the licensee was not aware R4 had a consumer bedrail installed on R4's bed, otherwise an assessment and risk versus benefits would have been completed on R4's bedrail. The consumer bed rail was secured to R4's box spring and mattress with little movement when the surveyor grasped the bedrail. The surveyor reviewed the CPSC website, which indicated the Slander 22173-5850 had no specific recall to that model. 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) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated October 13, 2025 indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to	02310		

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	27092	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING BY OXFORD LIVING	151 4TH STREET SE COOK, MN 55723

(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 25 the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's bedrails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - 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". Additionally, the MDH website indicated for consumer bedrails the CSPC website needed to be checked for consumer bedrails at least every 90 days. 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).	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	27092	A. BUILDING: _____ B. WING _____	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COOK CAREFREE LIVING BY OXFORD LIVING	151 4TH STREET SE COOK, MN 55723

(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 26 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 Statues, 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. The licensee's Assessing Bed Assist Devices dated January 16, 2023, indicated the registered nurse (RN) will complete the risk agreement with the resident/resident's representative, and complete an assessment on the bed positioning device, which includes: -complete bedrail positioning assessment in online medical record system; -measure zones of entrapment for bedrails; -acquire manufacturer's instructions for installation; -verify the resident's rails are properly installed; -check the CPSC website for bedside rail recall information; -obtain doctor order and renew annually; and -add bedrail task to service plan for ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

Food & Beverage Inspection Report

Establishment Info

COOK CAREFREE LIVING BY OXFORD
151 4th Street SE
Cook, MN 55723
St Louis County
Parcel:

Phone: 218-666-0200

License Info

License: HFID 27092

Risk: Medium
License:
Expires on:
CFPM: Andrea Simonson
CFPM #: 118349; Exp: 8/2/2026

Inspection Info

Report Number: F7983251126
Inspection Type: Full - Single
Date: 12/1/2025 Time: 01:20:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.14B *Priority Level: Priority 3 CFP#: 41*
MN Rule 4626.0285B Wiping cloths used for wiping counters and other equipment surfaces must be held in an approved sanitizing solution and laundered daily.
COMMENT:
SANITIZER WAS NOT DETECTED IN THE WIPING CLOTH BUCKET. THE SOLUTION WAS REPLACED WITH FRESH QUATERNARY AMMONIUM SANITIZER SOLUTION.
Comply By: Complied On Site Originally Issued On: 12/1/2025

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:
TEST STRIPS WERE NOT PROVIDED FOR THE QUATERNARY AMMONIUM SANITIZER.
Comply By: 12/15/2025 Originally Issued On: 12/1/2025

New Order: 4-500 Equipment Maintenance and Operation
4-501.11AB *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0735AB All equipment and components must be in good repair and maintained and adjusted in accordance with manufacturer's specifications.
COMMENT:
THE TEMPERATURE GAUGE ON THE WAREWASHING MACHINE DID NOT INDICATE THE TEMPERATURE OF THE RINSE WATER. A NEW WAREWASHING MACHINE IS PROPOSED.
Comply By: 12/15/2025 Originally Issued On: 12/1/2025

! **New Order: 5-200A Plumbing: approved materials/design**
5-201.11A *Priority Level: Priority 1 CFP#: 51*
MN Rule 4626.1040A Provide a plumbing system that is designed, constructed, installed, and repaired with approved materials, equipment, and devices complying with chapter 4714 and Minnesota Statutes, sections 326B.43 to 326B.49.
COMMENT:
THE DRAIN LINE FROM THE ICE-MAKING MACHINE DID NOT DISCHARGE TO THE FLOOR DRAIN THROUGH AN AIR GAP.
Comply By: 12/15/2025 Originally Issued On: 12/1/2025

Food & Beverage General Comment

1) Discussed excluding food employees ill with vomiting or diarrhea, eliminating bare hand contact with ready-to-eat food, and ensuring that in-house inspections of daily operations are conducted on a periodic basis to ensure that food safety policies and procedures are followed.

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F7983251126 from 12/1/2025

Andrea Simonson
Person in Charge

Gary Collyard,
Public Health Sanitarian 3
218-302-6147
gary.collyard@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

COOK CAREFREE LIVING BY OXFORD
Cook
County/Group: St Louis County

Inspection Info

Report Number: F7983251126
Inspection Type: Full
Date: 12/1/2025
Time: 01:20:00 PM

Food Temperature: Product/Item/Unit: Foods Frozen**; Temperature Process:** Cold-Holding
Location: Walk-In Freezer at N/A Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Cooked Chicken**; Temperature Process:** Cold-Holding
Location: Walk-In Refrigerator at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Butter**; Temperature Process:** Cold-Holding
Location: Walk-In Refrigerator at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: Milk**; Temperature Process:** Cold-Holding
Location: GE Refrigerator/Freezer at 37 Degrees F.
Comment:
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Wash Water**; Temperature Process:** Warewashing
Location: Warewashing Machine at 158 Degrees F.
Comment: Third cycle.
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: Utensil Surface**; Temperature Process:** Warewashing
Location: Warewashing Machine at 160 Degrees F.
Comment: Third cycle.
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

COOK CAREFREE LIVING BY OXFORD
Cook
County/Group: St Louis County

Inspection Info

Report Number: F7983251126
Inspection Type: Full
Date: 12/1/2025
Time: 01:20:00 PM

Sanitizing Chemical: **Product:** Quaternary Ammonium**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 0 PPM
Comment: Before correction.
Violation Issued?: Yes

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

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

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL27092016-0	**Date:** December 2, 2025
Facility Name: COOK CAREFREE LIVING	
Facility Address: 151 4TH STREET SE, COOK, MN 55723	

☒ **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. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: A controlled egress locking system was installed on the emergency exit doors in the dementia care unit. Regional director of maintenance (RDM)-I stated a signal or switch was not installed that had the capability to break power to this egress locking system.

3. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: To exit the building from the secure dementia care unit, it required passing through two doors with controlled egress locks. There was a door that divided the dementia care unit into two sides. This door was propped open and had a controlled egress locking system installed. Additionally, all emergency exit doors for the dementia care unit had controlled egress locking systems installed.

4. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments:
   - The employee office labeled fire door was propped open with a wedge and unoccupied at 1:20 p.m.
   - The wellness center labeled fire door was propped open with a kick down door stop.

5. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.8.1]

Comments: A key operated lock was installed on the gate for the dementia care courtyard. Egress doors/gates shall be readily openable from the egress side without the use of a key, special knowledge or effort. The gate was not locked during the facility tour. Regional director of maintenance (RDM)-I stated the gate was kept unlocked and residents were supervised by employees when using the courtyard. RDM-I stated a key for this gate lock was available.

6. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: Burnt cigarettes had been disposed of on the concrete patio in the designated resident smoking area at the front of the building. One burnt cigarette was discarded along the building foundation.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 1; Pattern **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Smoke alarms are provided outside and in immediate vicinity of each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: A smoke alarm was not installed outside the sleeping room in unoccupied resident dwelling unit 101.

2. Smoke alarms 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:
   - Hardwired and wireless battery-operated smoke alarms were installed in the one-bedroom dwelling units. The hardwired and wireless smoke alarms were not interconnected when regional maintenance director (RDM)-I tested the smoke alarms. Existing hardwired smoke alarms (receiving power from the building electrical system) are required to be maintained as installed previously and when battery-operated smoke alarms are installed, interconnect all smoke alarms so actuation of one alarm causes all alarms to activate in the dwelling unit.
   - The wireless smoke alarms in occupied resident dwelling unit 100 were not interconnected when RDM-I tested the smoke alarms.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Seven (7) days

1. The physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment are in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. [Minn. Stat. 144G.45 subd.2]

   Comments: The door closer hardware was disconnected from the door dividing the two sides of the dementia care unit. Existing door hardware needs to be maintained as installed.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Pattern **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: A safety risk assessment with mitigation for the physical environment had not been completed. Director of Services (DS)-A provided a hazard vulnerability assessment with mitigation for emergency preparedness.