Electronically Delivered

February 4, 2026

Licensee
St Cloud Carefree Living By Oxford Living
1225 Division Street East
Saint Cloud, MN 56304

RE: Project Number(s) SL20383016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on January 14, 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.

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

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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

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

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

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20383	A. BUILDING: _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING BY OXFORD LI\	1225 DIVISION STREET EAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL20383016-0 On January 12, 2026, through January 14, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 35 residents; all 35 receiving services under the Assisted Living Facility 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.	
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control	0 660		

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0 660	Continued From page 1 (a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included TB screening for one of three employees (licensed practical nurse/LPN-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: The licensee's Facility TB Risk Assessment dated	0 660		

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0 660	Continued From page 2 June 24, 2025, indicated the licensee was a low risk level. LPN-C was hired on April 8, 2024, to provide direct care services to residents. LPN-C's record lacked evidence of the following: - TB history and symptom screening. On January 14, 2026, at 2:23 p.m., licensed assisted living director (LALD)-B stated the history and symptom screening was not available in LPN-C's record. The licensee's TB Prevention and Control policy dated January 16, 2023, noted ell employees would have a baseline screening of current symptoms of active TB and assessing TB history. The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, noted screening included assessing for current symptoms of active TB disease and assessing TB history. Baseline TB screening should be documented in the employee's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that	0 680		

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0 680	Continued From page 3 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 observation, 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 receiving services under the assisted living license, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 680		

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0 680	Continued From page 4 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On January 12, 2026, at 10:00 a.m., during the facility tour with licensed assisted living director (LALD)-B, they surveyor observed the building to have three floors, including a main floor with offices, kitchen, dining room, resident rooms, and an elevator in the middle of the building that went to each floor. The second and third floors had resident rooms. The licensee's EPP dated January 3, 2026, lacked the following required content: - signed agreements with other facilities/providers to receive residents in the event of limitation/cessation of operations to maintain the continuity of services to residents. On January 14, 2026, at 2:40 p.m., LALD-B stated they lacked the signed agreements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency;	0 810		

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0 810	Continued From page 5 (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record 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	0 810		

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0 810	Continued From page 6 was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated January 15, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	0 810		
0 900 SS=D	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer	0 900		

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0 900	Continued From page 7 contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to execute a written contract prior to providing assisted living services for one of three 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: R2's record contained a Master Community Residency Agreement signed January 12, 2026. R2 admitted to the facility on July 10, 2024, with diagnoses including epilepsy, asthma, and muscle weakness. R2's Service Plan dated July 10, 2024, indicated R2 received services including assistance with activities, bathing, dressing, and medication	0 900		

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0 900	Continued From page 8 administration. A copy of a signed contract was requested from prior to the start of the survey, and on January 14, 2026, at 11:39 a.m., licensed assisted living director (LALD)-B stated via email "We could not find the paper trail copy of the exact agreement. What we did find were authorizations to pull her funds that she signed but no agreement was located." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 900		
01060 SS=E	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and	01060		

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01060	Continued From page 9 (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation to the resident, legal representative, and designated representative for two of two residents (R2, R3) who were hospitalized. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a 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	01060		

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01060	Continued From page 10 found to be pervasive). The findings include: R2 R2's diagnoses included epilepsy, asthma, and muscle weakness. R2's Service Plan dated July 10, 2024, indicated R2 received services including assistance with activities, bathing, dressing, and medication administration. R2's Progress Notes included the following: - June 7, 2025, at 4:43 p.m., R2 was sent to the hospital after having a seizure; and - June 10, 2025, at 3:26 p.m., R2 returned from the hospital. R2's record included an untitled document dated June 9, 2025, that noted the emergency relocation was effective on June 7, 2025. However, the form lacked: - the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OMHDD). R3 R3's diagnoses included hypertension, unspecified intellectual disabilities, and major depressive disorder. R3's Service Plan dated May 21, 2024, indicated R3 received services including assistance with bathing, activities, and medication administration. R3's Progress Notes included the following: - September 7, 2025, at 3:51 p.m., R3 had a fall in her bedroom. No injuries or pain reported by R3. Emergency services were not notified;	01060		

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01060	Continued From page 11 - September 8, 2025, at 8:45 a.m., local hospital called to verify services; - September 8, 2025, at 10:38 a.m., noted R3 "appears" to have been admitted to the local hospital for sepsis due to cellulitis; - September 8, 2025, at 2:20 p.m., R2 in the hospital due to falls; - September 12, 2025, at 10:53 a.m., R3 would be discharging from the local hospital to a rehabilitation facility; and - November 13, 2025, at 12:52 p.m., noted R3 returned to the facility from the rehabilitation facility. R3's record included an untitled document dated September 8, 2025, than noted the emergency relocation was effective September 7, 2025. It had a cover sheet dated September 8, 2025, for notice to the Office of Ombudsman for Long-Term Care. However, it lacked: - the contact information for the OMHDD. On January 14, 2025, at 9:55 a.m., licensed practical nurse (LPN)-C stated she sent copies to the Office of Ombudsman for Long-Term Care and placed the form in the resident records. LPN-C said she has not provided copies to residents or their representatives and does not know what others have done if they have completed the emergency relocation. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn	01370		

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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
01370	Continued From page 12 (a) Training and competency evaluations for all unlicensed personnel must include the following: (1) documentation requirements for all services provided; (2) reports of changes in the resident's condition to the supervisor designated by the facility; (3) basic infection control, including blood-borne pathogens; (4) maintenance of a clean and safe environment; (5) appropriate and safe techniques in personal hygiene and grooming, including: (i) hair care and bathing; (ii) care of teeth, gums, and oral prosthetic devices; (iii) care and use of hearing aids; and (iv) dressing and assisting with toileting; (6) training on the prevention of falls; (7) standby assistance techniques and how to perform them; (8) medication, exercise, and treatment reminders; (9) basic nutrition, meal preparation, food safety, and assistance with eating; (10) preparation of modified diets as ordered by a licensed health professional; (11) communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural background, and family; (12) awareness of confidentiality and privacy; (13) understanding appropriate boundaries between staff and residents and the resident's family; (14) procedures to use in handling various emergency situations; and (15) awareness of commonly used health technology equipment and assistive devices.	01370		

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	20383	A. BUILDING: _____ B. WING _____	01/14/2026

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01370	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as required prior to providing direct care services for one of one unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-B stated the licensee was aware of the required contents of the employee records. ULP-E was hired on November 25, 2025, to provide direct care services to residents. On January 13, 2026, at 7:25 a.m., the surveyor observed ULP-E administer medications to residents. ULP-E's record lacked evidence of the following: - documentation requirements for all services provided; - standby assistance techniques and how to perform them; and - communication skills that include preserving the dignity of the resident and showing respect for the resident and the resident's preferences, cultural	01370		

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01370	Continued From page 14 background, and family. On January 14, 2026, at 2:27 p.m., LALD-B stated she would look in the file for the missing information. However, no documented evidence was received to include the required content above. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01370		
01380 SS=D	144G.61 Subd. 2 (b) Training and evaluation of unlicensed personn (b) In addition to paragraph (a), training and competency evaluation for unlicensed personnel providing assisted living services must include: (1) observing, reporting, and documenting resident status; (2) basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; (3) reading and recording temperature, pulse, and respirations of the resident; (4) recognizing physical, emotional, cognitive, and developmental needs of the resident; (5) safe transfer techniques and ambulation; (6) range of motioning and positioning; and (7) administering medications or treatments as required. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure training and competency evaluations were completed as	01380		

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01380	Continued From page 15 required prior to providing direct care services for one of one unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on January 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-B stated the licensee was aware of the required contents of the employee records. ULP-E was hired on November 25, 2025, to provide direct care services to residents. On January 13, 2026, at 7:25 a.m., the surveyor observed ULP-E administer medications to residents. ULP-E's record lacked evidence of the following: - basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; and - recognizing physical, emotional, cognitive, and developmental needs of the resident. On January 14, 2026, at 2:27 p.m., LALD-B stated she would look in the file for the missing information. However, no documented evidence was received to include the required content above.	01380		

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01380	Continued From page 16 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living	01470		

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01470	Continued From page 17 services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of two employees (registered nurse/RN-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	01470		

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01470	Continued From page 18 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: RN-D was hired through a contract agency on December 19, 2025, to provide nursing assistance at the facility. RN-D's record lacked documented evidence of the following: - overview of the Assisted Living statutes; and - consumer advocacy services. On January 14, 2026, at 2:15 p.m., licensed assisted living director (LALD)-B stated she would check with the nursing agency for evidence of the training. However, no documented evidence was provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
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 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	01500		

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01500	Continued From page 19 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 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	01500		

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01500	Continued From page 20 (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 interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of one employee (licensed practical nurse/LPN-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: LPN-C was hired on April 8, 2024, to provide direct care services to residents. LPN-C's record lacked documented evidence of the following required annual training: - review of the provider's policies and procedures. On January 14, 2026, at 2:23 p.m., licensed assisted living director (LALD)-B stated the required training was not available in the employee's record. No further information was provided.	01500		

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01500	Continued From page 21 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse 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	01620		

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01620	Continued From page 22 services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed an assessment with a change in condition for one of three residents (R1), and failed to assess residents after a fall and develop and implement new interventions related to the root cause of falls for two of two residents (R1, 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 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:	01620		

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01620	Continued From page 23 CHANGE IN CONDITION R1's diagnoses included cerebral infarction, type 2 diabetes, and anxiety disorder. On January 13, 2026, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G perform a blood glucose check and insulin administration to R1 in the vacant activity room. R1's blood glucose reading was 347 milligrams/deciliter (mg/dL) R1's Service Plan dated August 6, 2025, indicated R1 received services including assistance with activities, housekeeping and medication set-up. However, it lacked identification of assistance with blood glucose checks. R1's Progress Notes included the following: - October 23, 2025, at 1:45 p.m., Lantus insulin ordered; - October 23, 2025, at 2:00 p.m., resident refusing to take Lantus. Licensed practical nurse talked with R1 on importance of taking medications and dangers of not taking them; - November 6, 2025, at 8:23 a.m., resident agreeing to start Lantus; - November 10, 2025, at 8:20 p.m., blood glucose 576 ml/dL. Triage nurse instructed staff to administer insulin when R1 returned from smoking, encourage to drink water and move around, recheck insulin in one hour and call back; - November 10, 2025, at 9:45 p.m., insulin administered, R1 exercising, not doing well with water intake. Triage nurse advised staff to recheck blood glucose on next shift and call back with result; - November 10, 2025, at 11:26 p.m., R1 refusing	01620		

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01620	Continued From page 24 to drink water and stop eating snacks and saying he does not care about blood glucose and is done with doing checks. Blood glucose 510 mg/dL. Triage nurse instructed staff to monitor and recheck in one hour and call back; - November 11, 2025, at 7:43 p.m., R1's blood glucose 556 mg/dL, eating snacks and drinking soda. Triage advised staff to recheck blood glucose in 30 minutes and call back, encourage water and activity and observe for symptoms; - November 13, 2025, at 7:29 p.m., high blood glucose with no symptoms. Triage advised staff to recheck in one hour if R1 allowed it. Lantus insulin was administered as ordered. It noted R1 had been running high for the past few days, did not want to drink water or exercise, likes to watch TV and eat snacks high in sugar; - November 13, 2025, at 9:37 p.m., R1's blood glucose 522 mg/dL. No signs or symptoms, and had been eating candy and pizza along with alcohol. Staff advised to observe and report further symptoms since he did not want his blood glucose rechecked; - November 18, 2025, at 4:18 a.m., R1 noncompliant with checking blood glucose, refusing since November 13, 2025, and refusing Lantus insulin since November 14, 2025; - December 11, 2025, at 11:14 a.m., R1's blood glucose 440 mg/dL and he had taken his Lantus insulin the last two nights. No symptoms, encourage water consumption and moving around; - December 18, 2025, at 7:10 p.m., R1 sent to the hospital when reported he was not feeling well; - December 22, 2025, at 12:11 p.m., R1 admitted to the hospital for diabetic ketoacidosis and returned today. Lantus increased to 24 units at bedtime, Novolog insulin four units at meals three times a day; - December 29, 2025, at 6:34 p.m., blood glucose	01620		

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01620	Continued From page 25 423 mg/dL and had received insulin at 4:30 p.m., had no symptoms. Triage advised staff to recheck blood glucose in 30 minutes and call back with results, drink water and walk around his room or hallways; - December 30, 2025, at 4:12 p.m., blood glucose 442 mg/dL. Triage advised staff to encourage water and movement, forgo dessert and eat more protein, give scheduled Novolog insulin and call back with the evening blood glucose result if it remains high and encourage movement; - December 30, 2025, at 7:42 p.m., blood glucose 403 mg/dL. Triage advised staff to administer insulin, encourage water and activity, and monitor for signs or symptoms of high blood glucose; and - December 31, 2025, at 1:14 p.m., blood glucose 472 mg/dL and did take Novolog insulin, but not allowing staff to recheck the blood glucose. R1 drinking soda at the time. Licensed practical nurse (LPN) advised to give Novolog and if refused to send to the hospital. R1's medical record contained Uniform Assessment Tools as follows: - April 22, 2025; noted type 2 diabetes, takes Jardiance; - August 6, 2025, noted type 2 diabetes, takes Jardiance; - November 4, 2025, noted type 2 diabetes, takes Jardiance but refuses Lantus insulin. R1's Medication Administration Record (MAR) for January 2026, noted blood sugar checks four times per day, and instructed staff to notify nursing with blood glucose less than 100 mg/dL or greater than 350 mg/dL. It noted the following out of range blood glucose readings: - January 2, 2026, at 7:00 a.m., 374 mg/dL; - January 2, 2026, at 11:00 a.m., 374 mg/dL; - January 3, 2026, at 11:00 a.m., 401 mg/dL;	01620		

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	20383	A. BUILDING: _____ B. WING _____	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST CLOUD CAREFREE LIVING BY OXFORD LI\	1225 DIVISION STREET EAST SAINT CLOUD, MN 56304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01620	Continued From page 26 - January 3, 2026, at 4:15 p.m., 391 mg/dL; - January 4, 2026, at 7:00 p.m., 354 mg/dL; - January 5, 2026, at 11:00 a.m., 406 mg/dL; - January 6, 2026, at 4:15 p.m., 356 mg/dL; - January 6, 2026, at 7:00 p.m., 408 mg/dL; - January 7, 2026, at 7:00 a.m., 370 mg/dL; - January 7, 2026, at 11:00 a.m., 369 mg/dL; - January 9, 2026, at 11:00 a.m., 379 mg/dL; - January 9, 2026, at 4:15 p.m., 395 mg/dL; - January 11, 2026, at 11:00 a.m., 393 mg/dL; and - January 12, 2026, at 11:00 a.m., 366 mg/dL. On January 13, 2026, at 2:35 p.m., RN-A stated she had only started the previous week, and added no assessments had been completed with the elevated blood glucose readings but should have been done with this change in condition. FALLS R1 R1's diagnoses included cerebral infarction, type 2 diabetes, and anxiety disorder. R1's Service Plan dated August 6, 2025, indicated R1 received services including assistance with activities, housekeeping and medication set-up. R1's Resident Incident Reports noted the following: - August 26, 2025, at 12:50 a.m., resident was found on his back on the bathroom floor in his room. No complaints of pain and no injuries noted. R1 stated he was going to the bathroom and lost his balance and fell. The incident investigation dated September 8, 2025, at 1:05 p.m., noted a history of falls,and follow up and prevention noted education to resident and staff, remind resident to use his walker, and physical	01620		

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01620	Continued From page 27 therapy to evaluate and treat; - August 29, 2025, at 2:18 a.m., noted resident fell in the bathroom in his room. No injury noted. R1 stated he slipped in the bathroom. The incident investigation dated September 8, 2025, at 2:14 p.m., noted a history of falls, assessment completed, and education provided to resident and staff. No new interventions were noted; - September 8, 2025, at 6:17 a.m., resident was found on the bathroom floor, and stated he got up to go the bathroom and fell. No pain or injuries were noted. The incident investigation dated September 9, 2025, at 2:19 p.m., noted a history of falls, assessment completed, and education provided to resident and staff. No new interventions were noted; and - September 19, 2025, at 12:34 a.m., resident was found on the bedroom floor next to his bed. R1 stated he was trying to go the bathroom, tripped, and fell. No pain or injuries noted. The incident investigation dated September 24, 2025, at 10:41 a.m., noted a history of falls, education provided to resident and staff. It noted resident to use the call light for assistance when needed. No new interventions were noted. On January 13, 2026, at 2:45 p.m., RN-A stated no new interventions were noted on the incident reports and added it would be expected to have new interventions after falls. R2 R2's diagnoses included epilepsy, asthma, and muscle weakness. On January 14, 2026, at 2:45 p.m., the surveyor observed R2 in her room. R2's Service Plan dated July 10, 2024, indicated R2 received services including assistance with	01620		

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ST CLOUD CAREFREE LIVING BY OXFORD LI\	1225 DIVISION STREET EAST SAINT CLOUD, MN 56304

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01620	Continued From page 28 activities, bathing, dressing, and medication administration. R2's Resident Incident Report noted the following: - December 24, 2025, at 9:33 a.m., resident reported having fallen into her TV looking for her glasses. R2 had a head laceration, was bleeding from her forehead, and was sent to the hospital. The report lacked an incident investigation. On January 13, 2025, at 3:00 p.m., RN-A stated the incident report lacked an investigation or new interventions and would expect this be conducted. The licensee's Assessments, Reviews and Monitoring policy dated January 16, 2023, noted ongoing reassessments must be conducted as needed based on changes in the needs of the resident but not to exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
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	01730		

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01730	Continued From page 29 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 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 licensee failed to develop and	01730		

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01730	Continued From page 30 implement a current individualized medication management plan to include all required content for one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 January 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A stated the licensee provided medication management services to the residents at the facility. R1's diagnoses included cerebral infarction, type 2 diabetes, and anxiety disorder. On January 13, 2026, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G perform a blood glucose check and insulin administration to R1 in the vacant activity room. R1's Service Plan dated August 6, 2025, indicated R1 received services including assistance with activities, housekeeping and medication set-up. R1's prescriber orders dated December 31, 2025, included Lantus insulin 8 units every bedtime. R1's Medication Management Plan dated	01730		

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01730	Continued From page 31 November 4, 2025, noted there were no medications with special manufacturer's instructions for storage, even though R1 received assistance with insulin administration. On January 13, 2025, at 2:35 p.m., RN-A stated the medication plan lacked the above required content. The licensee's Medication Management policy dated January 16, 2023, noted the individualized medication management record would include a description of storage of mediations consistent with the manufacturer's directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01730		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced	01760		

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01760	Continued From page 32 by: Based on observation, interview, and record review, the licensee failed to verify accuracy of prescriber orders when transcribing orders for one of three 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: R2's diagnoses included epilepsy, asthma, and muscle weakness. On January 14, 2026, at 2:45 p.m., the surveyor observed R2 in her room. R2's Service Plan dated July 10, 2024, indicated R2 received services including assistance with activities, bathing, dressing, and medication administration. R2's prescriber orders dated November 18, 2025, included: - discontinue as needed methocarbamol. R2's January 2026, Medication Administration Record (MAR) included: - methocarbamol 500 milligrams (mg) one tablet three times a day as needed for pain. On January 14, 2025, at 9:55 a.m., licensed practical nurse (LPN)-C and registered nurse	01760		

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01760	Continued From page 33 (RN)-D stated the order had been discontinued but not removed from the MAR as it should have been. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment management policies and procedures under the supervision and direction of a registered nurse (RN).	01930		

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01930	Continued From page 34 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 January 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-B and RN-A stated the licensee provided treatment management services to the licensee's residents. The licensee's provided policies lacked: - requesting and receiving orders or prescriptions for treatments or therapies; - providing the treatment or therapy; - educating and communicating with residents about treatments or therapies they are receiving; - monitoring and evaluating the treatment or therapy; and - communicating with the prescriber. On January 14, 2026, at 3:00 p.m., the missing policies were reviewed with LALD-B, and she stated she would provide them. However, no further documents were received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930		

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01940	Continued From page 35	01940		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include in the service plan a written statement of the treatment or therapy services that would be provided for	01940		

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01940	Continued From page 36 one of three residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 January 12, 2026, at 9:30 a.m., licensed assisted living director (LALD)-B and registered nurse (RN)-A stated the licensee provided treatment management services to the residents at the facility. R1's diagnoses included cerebral infarction, type 2 diabetes, and anxiety disorder. On January 13, 2026, at 8:25 a.m., the surveyor observed unlicensed personnel (ULP)-G perform a blood glucose check and insulin administration to R1 in the vacant activity room. R1's Service Plan dated August 6, 2025, indicated R1 received services including assistance with activities, housekeeping and medication set-up. However, it lacked identification of assistance with blood glucose checks. R1's Medication Administration Record (MAR) for January 2026, noted blood sugar checks at 7:00 a.m., 11:00 a.m., 4:15 p.m., and 7:00 p.m., with staff initials through January 12, 2026 at 11:00	01940		

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01940	Continued From page 37 a.m. to indicate they had been performed. On January 13, 2025, at 2:35 p.m., RN-A stated the service plan lacked the above required content. The licensee's Service Plan policy dated January 16, 2023, noted the service plan would include a description of the services to be provided. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of three employees, (licensed practical nurse/LPN-C), followed appropriate medication administration procedures. 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	02320		

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02320	Continued From page 38 was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included hypertension, unspecified intellectual disabilities, and major depressive disorder. R3's Service Plan dated May 21, 2024, indicated R3 received services including assistance with bathing, activities, and medication administration. On January 13, 2026, at 8:48 a.m., the surveyor observed unlicensed personnel (ULP)-E set up medications for R3. R3 then exited her room and wheeled herself to the dining room without stopping when ULP-E informed her the medications were ready for her. ULP-E then went to speak with LPN-C, who spoke with R3 in the dining room. At 9:10 a.m., LPN-C administered medications set up by ULP-E to R3. When LPN-C left the area, she stated she knew she should not administer medications that had been set up by a peer but there were no spare medications, and R3 was not willing to take them from ULP-E. On January 13, 2026, at 2:30 p.m., registered nurse (RN)-A stated medications should be set up and administered by the same person. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Establishment Info

ST CLOUD CAREFREE LIVING BY
1225 DIVISION STREET EAST
St Cloud, MN 56304
Benton County
Parcel:

Phone:

License Info

License: HFID 20383

Risk:
License:
Expires on:
CFPM: Christine Ann Christiansen
CFPM #: 5392; Exp: 11/18/2028

Inspection Info

Report Number: F1046261014
Inspection Type: Full - Single
Date: 1/12/2026 Time: 11:00:42 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 1
Delivery:

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT: OBSERVED CRACKED PLASTIC MEASURING CUP IN THE STORAGE RACK. DISCARD MULTI-USE EQUIPMENT THAT IS NO LONGER EASILY CLEANABLE.
Comply By: Complied On Site Originally Issued On: 1/12/2026

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 F1046261014 from 1/12/2026

Establishment Representative

Nicole Larrison,
Public Health Sanitarian 1
320-640-3534
nicole.larrison@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

ST CLOUD CAREFREE LIVING BY
St Cloud
County/Group: Benton County

Inspection Info

Report Number: F1046261014
Inspection Type: Full
Date: 1/12/2026
Time: 11:00:42 AM

Food Temperature: Product/Item/Unit: MASHED POTATO**; Temperature Process:** Hot-Holding
Location: Steam Table at 165 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MEATLOAF**; Temperature Process:** Hot-Holding
Location: Steam Table at 179 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: SHREDDED CHEESE**; Temperature Process:** Cold-Holding
Location: Walk-in Cooler at 40 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

Establishment Info

ST CLOUD CAREFREE LIVING BY
St Cloud
County/Group: Benton County

Inspection Info

Report Number: F1046261014
Inspection Type: Full
Date: 1/12/2026
Time: 11:00:42 AM

Sanitizing Chemical: Product: Chlorine**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 100 PPM
Comment:
Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia**; Sanitizing Process:** 3-Compartment Sink
Location: 3-Comp Sink **Equal To** 400 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1046261014

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 1/12/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00:42 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
ST CLOUD CAREFREE LIVING BY	1225 DIVISION STREET EAST	St Cloud, MN	56304	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 20383		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

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

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

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

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

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

GOOD RETAIL PRACTICES

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

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

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

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

Person in Charge (signature)

Inspector (signature)

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL20383016-0	**Date:** 1/15/2026
Facility Name: ST CLOUD CAREFREE LIVING	
Facility Address: 1225 E Division St, St Cloud, Minnesota 56304	

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: Licensed assisted living director (LALD)-B provided a policy that was from a third party and did not include specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks.

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

   Comments: LALD-B stated they did not believe they had a policy in place.

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

   Comments: LALD-B stated they had provided the training to staff but were unable to provide documentation.

4. 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: LALD-B stated they had provided the training to residents but were unable to provide documentation.