



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 21, 2026

Licensee

Babbitt Carefree Living by Oxford Living
1 Central Boulevard
Babbitt, MN 55706

RE: Project Number(s) SL29103016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 10, 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.

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 . . ."

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

Jessie Chenze, Supervisor

State Evaluation Team

Email: Jessie.Chenze@state.mn.us

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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: SL29103016-0 On December 8, 2025, through December 10, 2025, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider. At the time of the survey, there were 29 residents; 29 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 480	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			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 480	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 8, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 480	Continued From page 3	0 480			
0 620 SS=D	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.42 Subd. 6 (a) / 626.557, Subd. 3 Compliance with requirements for reporting ma (a) The assisted living facility must comply with the requirements for the reporting of maltreatment of vulnerable adults in section 626.557. The facility must establish and implement a written procedure to ensure that all cases of suspected maltreatment are reported. The requirement in Minnesota Statute section 626.557, Subd. 3 is: (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 620	Continued From page 4 known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to submit a report to the Minnesota Adult Abuse Reporting Center (MAARC) for one of one resident (R4) who eloped from the facility. 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	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 620	Continued From page 5 situation has occurred only occasionally). The findings include: The licensee held a current assisted living dementia care license effective April 29, 2025, with a current census of 29 residents. During the entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated the licensee had one resident who left the facility and walked to the local gas station without notifying staff. CNS-B stated staff notified the on-call triage nurse and the administration and local police were notified. CNS-B stated CNS-B was not working at the time of the event. Regional registered nurse (RRN) E stated the licensee did not file a MAARC report because the licensee's Elopement policy had been followed and would have filed a report if the policy had directed. R4's diagnoses included cognitive social and emotional deficit following a cerebral infarction and other signs and symptoms involving cognitive function and awareness. R4's Service Plan dated July 8, 2025, indicated R4 was at risk for elopement and staff were to monitor R4's whereabouts while resident was up and about or make statements about wanting to leave. A secured environment would be provided and supervised opportunities for R4 to be outdoors, when appropriate. R4's 90-Day Assessment dated September 23, 2025, indicated R4 was at risk for elopement and had cognitive deficit following cerebral infarction. R4 had a history of elopement; however, no longer showed signs of exit seeking behaviors.	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 620	Continued From page 6 R4's Progress Notes dated October 25, 2025, entered at 4:41 p.m., by a triage registered nurse (RN) indicated R4 had requested to go look at the birds which were located on the unsecured unit of the assisted living. Staff reported R4 had exited from the building and staff were unable to locate R4, so staff contacted the local police for assistance. The triage RN called CNS-B and CNS-B advised the triage RN to notify R4's family as CNS-B did not have access to resident records at the time. R4's Progress Notes dated October 25, 2025, at 4:19 p.m., indicated staff called and notified the on-call RN triage, R4 had been found by the police at a nearby gas station and R4 was escorted back to the facility. Staff reported to the triage RN, R4 appeared to be at his baseline physically and cognitively. Triage advised to update if R4 had any observed changes to baseline. Family and the licensee's RN were notified by triage RN. R4's Progress Notes dated October 29, 2025, entered by regional registered nurse (RRN)-E, indicated staff reported while R4 was on the unsecured assisted living unit, R4 was found outside by the police at a local gas station buying snacks. R4 was escorted back to the facility without incident and was observed without injury. R4's power of attorney (POA) had been notified of the incident. Staff were notified R4 was not allowed outside of the secured unit without supervision of staff or family as previously allowed in the past, until further discretion by R4's POA. R4's resident record lacked evidence a MAARC report had been filed.	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 620	Continued From page 7 On December 9, 2025, at 2:32 p.m., licensed practical nurse (LPN)-G stated R4 resided on the secured unit at the time of R4's elopement. LPN-G stated R4 was able to go to the unsecured unit for meals or attend group activities per R4's POA with supervision. LPN-G stated R4 did not have one on one supervision and was supervised by the activity staff or R4's family, which often lead bingo activities. CNS-B stated CNS-B was on leave at the time of R4's elopement and was flying out of the country the day after so RRN-E had taken over R4's incident. On December 10, 2025, at 9:08 a.m., RRN-E stated RRN-E was alerted of R4's elopement and it was RRN-E's understanding R4 resided in the secured unit and was allowed to go to the unsecured unit for meals and activities with minimal supervisor. RNN-E stated RNN-E spoke with R4's POA and POA was not concerned with R4 attempting to leave the building unattended and to keep with the same plan. RNN-E stated RNN-E did not file a MAARC report and referred to the elopement policy as per RN digression and RNN-E felt at that time R4's elopement was not reportable. The licensee's Elopement policy dated March 5, 2025, indicated elopement occurs when a resident in not where they can reasonably be expected to be, such as: -an Assisted Living resident leaves and does not return as planned or as predetermined by the sign-out book; or -an Assisted Living resident who required supervision for their safety due to the inability or unwillingness to make safe decisions leaves the grounds or other pre-determined, agreed upon area without an escort.	0 620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 620	Continued From page 8 When the resident returns to the building/home, or is located, a MAARC report would be submitted when indicated. The licensee's Vulnerable Adult Reporting and Investigation policy dated April 15, 2023, indicated in accordance with state and federal vulnerable adult laws, the licensee would report any suspected maltreatment (abuse, neglect or financial exploitation as defined in MN Statutes §626.5572) of our residents to the Minnesota Adult Abuse Reporting Center (MAARC). Staff would be trained on the Vulnerable Adult Act and our reporting policy during orientation and at least annually. Occurrences of suspected maltreatment would be internally investigated by a designated reporter. The licensee and its staff would not retaliate against any person who reported suspected maltreatment in good faith and would not retaliate against a vulnerable adult about whom a maltreatment report was made. All staff employed by the licensee are Mandated Reporters. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 620			
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 680	Continued From page 9 emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 8, 2025, at 11:14 a.m., executive director (ED)-A	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 680	Continued From page 10 was identified as responsible for managing and maintaining the licensee emergency preparedness plan. The licensee's emergency plan dated November 12, 2025, included templates from Care Providers of Minnesota dated September 2022, that were not completed with the licensee specific information. The following templates were left blank: -Form 1.03 Facility Population and Data (E-007); -Form 1.05 Incident Command Structure (0-007); -Form 1.06 Coordination and Cooperation with Emergency Preparedness Officials (E-009), and lacked the contact information for the emergency preparedness officials; -Form 2.04 Evacuation Forms (E-0020, 0023, 0035); -Form 2.05 Tracking Systems-Locations of Staff and Residents (E-0018) directed to see Appendix C and D for documents to assist tracking and there was no Appendix C or D for reference; and -Form 3.02 Primary and Back up Methods of Communication (E-0032). In addition, the licensee's EPP lacked the following content and/or policies and procedures to address: - subsistence needs for staff and residents during an emergency to include (medical supplies, pharmacy supplies, sewer and waste disposal); - the facility's role in providing care and treatment at alternative sites; - missing persons policy that was reviewed quarterly; - EP testing/annual requirements; and -written arrangements with other facilities or providers. On December 9, 2025, at 3:16 p.m., ED-A stated	0 680			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 680	Continued From page 11 the licensee's EPP was in working progress and ED-A was in the process of breaking down the original EP manual into more specific information pertaining to the licensee. ED-A stated the licensee was working on obtaining written agreements with other facilities and providers and there was no documented community wide or table-top exercises completed by the licensee. The licensee's Disaster Planning and Emergency Preparedness policy dated January 16, 2023, indicated the licensee would have a written emergency disaster plan that addresses a plan for evacuation, elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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	
0 775	Continued From page 12 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 8, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 810	Continued From page 13 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 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	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
0 810	Continued From page 14 December 8, 2025 for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	0 810			
01370 SS=D	144G.61 Subd. 2 (a) Training and evaluation of unlicensed personn (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,	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 15 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. 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 included all the required training for one of two unlicensed personnel, (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally The findings include: During the entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated Educare training (online training program) was assigned to employees by the administrators. ULP-F was hired July 15, 2025, to provide direct care services to the residents of the licensee. On December 9, 2025, at 6:28 a.m., the surveyor	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 16 observed ULP-F folding laundry. ULP-F stated she had been working for the licensee since July 2025. ULP-F stated ULP-F was scheduled to work 10:00 p.m. to 6:00 a.m., however, ULP-F was staying a little longer due to the snowstorm and was waiting for the day staff to arrive to release her. ULP-F stated ULP-F worked different shifts and provided care and services for the residents including medication administration. ULP-F's employee record included training transcripts; however, lacked documentation ULP-F completed the following required trainings: -basic infection control, including blood-borne pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; -training on prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness and confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident family; -procedures to use in handling various emergency situations; and	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 17 -awareness of commonly used health technology equipment and assisted devices. On December 19, 2025, at 11:29 a.m., regional registered nurse (RRN)-E stated staff should complete education and training though Educare (online training program) before working with residents and stated staff were assigned required Educare courses upon hire. RRN-E reviewed ULP-F's training transcripts and stated ULP-F had been assigned the required training courses; however, for whatever reason, had not completed before providing care and services to residents. The licensee's Training and Competency of Unlicensed Staff policy dated April 4, 2025, indicated unlicensed personnel would meet all orientation and training requirements and would be determined to be competent to perform all assigned tasks by the RN, before unlicensed personnel may provide any service to a resident. The following trainings and competency evaluation for all unlicensed personnel must include the following: -documentation requirements for all services provided; -reports of changes in the residents's condition to the supervisor designated by the facility; -basic infection control, including blood borne-pathogens; -maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including: -hair care and bathing; -care of teeth, gums, and oral prosthetic devices; -care and use of hearing aids; -dressing and assisting with toileting; -medication, exercise and treatment reminders; -standby assistance techniques and how to perform them;	01370			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 18 -medication, exercise, and treatment reminders; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -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; -awareness and confidentiality and privacy; -understanding appropriate boundaries between staff and residents and the resident family; -procedures to use in handling various emergency situations; and -awareness of commonly used health technology equipment and assisted devices. 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;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01380	Continued From page 19 (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 included all the required training for one of two unlicensed personnel, (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally The findings include: During the entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated Educare training (online training program) was assigned to employees by the administrators. ULP-F was hired July 15, 2025, to provide direct care services to the residents of the licensee. On December 9, 2025, at 6:28 a.m., the surveyor observed ULP-F folding laundry. ULP-F stated she had been working for the licensee since July 2025. ULP-F stated ULP-F was scheduled to work 10:00 p.m. to 6:00 a.m., however, ULP-F was staying a little longer due to the snow storm and was waiting for the day staff to arrive to	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01380	Continued From page 20 release her. ULP-F's employee record included training transcripts; however, lacked documentation ULP-F completed the following required trainings: -reading and recording temperatures, pulse, and respirations of the resident; and -administering medications or treatments as required. On December 19, 2025, at 11:29 a.m., regional registered nurse (RRN)-F stated staff should complete education and training though Educare (online training program) before working with residents and staff were assigned required Educare courses upon hire. RRN-F reviewed ULP-F's training transcripts and stated ULP-F had been assigned the required training courses; however, for whatever reason, ULP-F had not completed the assigned trainings before providing care and services to residents. The licensee's Training and Competency of Unlicensed Staff policy dated April 4, 2025, indicated unlicensed personnel would meet all orientation and training requirements and would be determined to be competent to perform all assigned tasks by the RN, before unlicensed personnel may provide any service to a resident. The following trainings and competency evaluation for all unlicensed personnel must include the following: -observing, reporting, and documenting resident status -basic knowledge of body functioning and changes in body functioning, injuries, or other observed changes that must be reported to appropriate personnel; -reading and recording temperature, pulse, and respirations of the resident;	01380			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI		STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706			
(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
01380	Continued From page 21 -recognizing physical, emotional, cognitive, and developmental needs of the resident; -safe transfer techniques and ambulation; -range of motioning and positioning; and -administering medications or treatments as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01380			
01440 SS=D	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01440	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual had begun working for the licensee for one of one unlicensed personnel (ULP)-F. This practice resulted in a level two violation (a violation that did not harm a client'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 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated the licensee was familiar with the current minimum assisted living requirements. ULP-F was hired July 15, 2025, to provide direct care services to residents of the licensee. On December 9, 2025, at 6:28 a.m., the surveyor observed ULP-F folding laundry. ULP-F stated she had been working for the licensee since July 2025 and provides care and services to the residents at the facility including medication administration. ULP-F stated ULP-F was scheduled to work 10:00 p.m. to 6:00 a.m., however, ULP-F was staying a little longer due to the snowstorm and was waiting for the day staff to arrive to release her.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01440	Continued From page 23 ULP-F's employee record lacked documentation a supervision of ULP-F performing a delegated task within 30 calendar days of providing services had been completed by the registered nurse (RN). On December 9, 2025, at 11:32 a.m., clinical nurse supervisor (CNS)-B stated CNS-B had not completed a 30-day supervisory visit for ULP-F and was aware of the requirement. The licensee's Delegation of Nursing, Treatments or Therapy Tasks policy dated January 16, 2023, indicated the direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. A facility must retain documentation of supervision activities in the personnel records. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440			
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;	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01470	Continued From page 24 (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 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	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01470	Continued From page 25 incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of three employees (unlicensed personnel (ULP)-F). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated Educare training (online training program) was assigned to employees by the administrators. ULP-F was hired July 15, 2025, to provide direct	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01470	Continued From page 26 care services to residents of the licensee. On December 9, 2025, at 6:28 a.m., the surveyor observed ULP-F folding laundry. ULP-F stated she had been working for the licensee since July 2025 and provides care and services to the residents at the facility including medication administration. ULP-F stated ULP-F was scheduled to work 10:00 p.m. to 6:00 a.m., however, ULP-F was staying a little longer due to the snowstorm and was waiting for the day staff to arrive to release her. ULP-F's employee record lacked documented evidence of the following required orientation content: - overview of 144G assisted living statutes. On December 19, 2025, at 11:29 a.m., regional registered nurse (RRN)-F stated staff were assigned required trainings upon hire and ULP-F should have completed all assigned trainings though Educare (online training program) before working with residents. RRN-F reviewed ULP-F's training transcripts and stated ULP-F had been assigned the required training courses; however, for whatever reason ULP-F had not completed the assigned trainings before providing care and services to residents. The licensee's Training and Competency of Unlicensed Staff policy dated April 4, 2025, indicated unlicensed personnel would meet all orientation and training requirements before unlicensed personnel may provide any service to a resident to include a review of the types of assisted living services the employee will be providing and the facility's category of licensure. No further information was provided.	01470			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI		STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706			
(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
01470	Continued From page 27	01470			
01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure staff received dementia training in the required areas and time frame in accordance with 144G.64 for one of two employees (unlicensed personnel (ULP-F)).	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01540	Continued From page 28 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 held an assisted living with dementia care license effective April 29, 2025, with an expiration date of April 28, 2026. During the entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated Educare training (online training program) was assigned to employees by the administrators. CNS-B stated the licensee staffed one ULP on the secured unit and one ULP on the unsecured unit from 10:00 p.m. to 6:00 a.m. ULP-F was hired July 15, 2025, to provide direct care services to residents of the licensee. On December 9, 2025, at 6:28 a.m., the surveyor observed ULP-F folding laundry. ULP-F stated she had been working for the licensee since July 2025, and provided care and services to the residents of the licensee. ULP-F stated ULP-F was scheduled to work 10:00 p.m. to 6:00 a.m., and worked independently during the over night shift. ULP-F stated due to the snowstorm; ULP-F was working a little longer waiting for the day staff to arrive to release her.	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01540	Continued From page 29 ULP-F's employee record included Educare transcripts indicated ULP-F completed 1.75 hours of dementia training out of the eight hours required within 120 working hours . In addition, ULP-F's record lacked evidence ULP-F completed the initial two hours of mental illness and de-escalation training and the following required topics: -an explanation of Alzheimer's disease and other dementias; -assistance with activities of daily living; -communication skills; -recognizing symptoms of common mental illness diagnoses, including but not limited to; -mood disorders; -anxiety disorders; -trauma and stressor related disorders; -personality and psychotic disorders; -substance use disorders and substance misuse; -de-escalation techniques and communication; and -crisis resolution and suicide prevention, including procedures for contacting county crisis response teams and 988 suicide and crisis lifelines. On December 9, 2025, at 11:29 a.m., regional registered nurse (RRN)-E stated staff should complete education and training though Educare (online training program) before working with residents and stated staff were assigned required Educare courses upon hire. RRN-E reviewed ULP-F's training transcripts and stated ULP-F had been assigned the required training courses; however, for whatever reason, ULP-F had not completed the dementia trainings noted above. The licensee's ALDC Additional Dementia Staff Training policy dated August 1, 2021, indicated it was the policy of the licensee that staff who work with residents with Alzheimer's disease and other	01540			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
01540	Continued From page 30 dementias have proper training for the tasks assigned. Dementia training would be provided regardless of whether the licensee has a specialized dementia care unit. Staff training will include the following topics: -An explanation of Alzheimer's disease and other dementias; -Assistance with activities of daily living; -Problem solving with challenging behaviors; -Communication skills; and -Person-centered planning and service delivery. Direct-care employees must have completed at least eight hours of initial training within 80 working hours of the employment start date. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01620 SS=D	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	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 31 resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) completed a comprehensive reassessment for one of one resident (R4) who eloped from the facility.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 32 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 held a current assisted living dementia care license effective April 29, 2025, with a current census of 29 residents. During entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated the license was familiar with current minimum assisted living requirements. CNS-B stated resident assessments were completed upon admission, at day 14, every 90 days and with changes in condition. R4's diagnoses included cognitive social and emotional deficit following a cerebral infarction (lack of oxygen to the brain resulting in issue death) and other signs and symptoms involving cognitive function and awareness. R4's Service Plan dated July 8, 2025, indicated R4 was at risk for elopement and staff were to monitor R4's whereabouts while R4 was up and about and/or made statements about wanting to leave. A secured environment would be provided and supervised opportunities for R4 to be outdoors, when appropriate. R4's 90-Day Assessment dated September 23,	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 33 2025, indicated R4 was at risk for elopement and had cognitive deficit following cerebral infarction. R4 had a history of elopement; however, no longer showed signs of exit seeking behaviors. R4's Progress Notes dated October 25, 2025, entered at 4:41 p.m., by a triage registered nurse (RN) that indicated R4 had requested to go look at the birds which were located on the unsecured unit of the assisted living. Staff reported R4 had exited from the building and were staff unable to located R4, so staff contacted the local police for assistance. The triage RN called CNS-B and advised the triage RN to notify R4's family as CNS-B did not have access to resident records at the time. R4's Progress Notes dated October 25, 2025, at 4:19 p.m., indicated staff called and notified the on-call RN triage, R4 had been found by the police at a nearby gas station and escorted R4 back to the facility. Staff reported to the triage RN, R4 appeared to be at his baseline physically and cognitively. Triage advised to updated if R4 had any observed changes to baseline. Family and the licensee's RN were notified by triage RN. R4's Progress Notes dated October 29, 2026, entered by regional registered nurse (RRN)-E, indicated staff reported while R4 was on the unsecured assisted living unit, R4 was found outside by the police at a local gas station buying snacks. R4 was escorted back to the facility without incident and was observed without injury. R4's power of attorney (POA) had been notified of the incident. Staff were notified R4 was not allowed outside of the secured unit without supervision of staff or family as previously allowed in the past until further discretion by R4's POA.	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 34 R4's October, November and December 2025, Checkoff Lists included R4's daily activity plan indicated R4 enjoyed going to the unsecured unit to attend Bingo. Staff were to escort R4 to and from bingo weekly and R4's sister would sit with R4. R4's abuse prevention plan, dated October 1, 2023, indicated R4 was at risk for elopement and R4 was not allowed out of the secured unit without staff or family supervision. R4's medical record lacked a comprehensive reassessment or implementation of any new safety interventions following R4's elopement incident. On December 9, 2025, at 2:32 p.m., licensed practical nurse (LPN)-G stated R4 resided on the secured unit at the time of R4's elopement. LPN-G stated R4 was able to go to the unsecured unit for meals or attend group activities per R4's POA with supervision. LPN-G stated R4 did not have one on one supervision and was supervised by the activity staff or R4's family, which often lead bingo activities. CNS-B stated CNS-B was on leave at the time of R4's elopement and was flying out of the country the day after so RRN-E had taken over R4's incident. CNS-B stated an incident report had not been completed at the time of R4's elopement. CNS-B stated R4 had not been reassessed after the elopement to assess risks or implement any new interventions. On December 10, 2025, at 9:08 a.m., RRN-E stated the staff followed the licensee's elopement policy. RRN-E stated a reassessment was not conducted; however, R4's individual abuse prevention plan was updated to include R4's risk of elopement and interventions to monitor R4's whereabouts and R4 was not allowed out of the	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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 35 secured unit without staff or family supervisor. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statutes, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee's Assessments, Reviews and Monitoring policy dated January 16, 2023, indicated the licensee would 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. Carefree Living will also conduct a nursing assessment or reassessment upon admission, within 14 calendar days, every 90 calendar days, and with a change in condition. The licensee's Elopement Policy and Procedure dated March 5, 2025, indicated residents at risk for elopement would be identified in the initial and	01620			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01620	Continued From page 36 ongoing assessments. Elopement occurs when a resident in not where they can reasonably be expected to be, such as: 1. A Memory Care resident leaves the secured unit without the knowledge of staff and is not in visual supervision at all times while outside of the secured unit; or 2. An Assisted Living resident leaves and does not return as planned or as predetermined by the sign-out book; or 3. An Assisted Living resident who requires supervision for their safety due to the inability or unwillingness to make safe decisions leaves the grounds or other pre-determined, agreed upon area without an escort. When the resident returns to the building/home, or is located, the RN updates the resident's assessment (which may include wandering/elopement risk assessment), service plan, and individualized abuse prevention plan as needed and orients staff to any new interventions or procedures to reduce the risk of future incidents. No further information was provided. TIME PERIOD FOR CORRECTION: Two-day (2) days	01620			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the	02040			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02040	Continued From page 37 residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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 8, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040			
02180 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA	02180			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02180	Continued From page 38 (e) Behavioral symptoms that negatively impact the resident and others in the assisted living facility with dementia care must be evaluated and included on the service or care plan. The staff must initiate and coordinate outside consultation or acute care when indicated. (f) Support must be offered to family and other significant relationships on a regularly scheduled basis but not less than quarterly. (g) Existing housing with services establishments registered under chapter 144D prior to August 1, 2021, that obtain an assisted living facility license must provide residents with regular access to outdoor space. A licensee with new construction on or after August 1, 2021, or a new licensee that was not previously registered under chapter 144D prior to August 1, 2021, must provide regular access to secured outdoor space on the premises of the facility. A resident's access to outdoor space must be in accordance with the resident's documented care plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure behavioral symptoms identified were addressed on the service plan for one of one resident (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).	02180			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02180	Continued From page 39 The findings include: R2's diagnoses included depression, R2's Service Plan dated May 9, 2025, indicated R2 received the following services: medication administration, transfer assist, bathing, dressing, bed mobility, housekeeping, laundry and safety checks. R2's service plan lacked any identified behaviors or interventions. R2's Admission Assessment dated February 3, 2025, indicated R2 was not taking any psychotropic or anti-anxiety medications and did not have any behavioral symptoms/expressions. R2's 90-Day Assessment dated August 6, 2025, indicated R2's targeted behaviors included verbally aggression and R2 was on psychotropic and anti-anxiety medications. R2's assessment indicated R2 had non-pharmalogical approaches in use to manage targeted behaviors; however, did not list non-pharmalogicial approaches or if approaches were effective. R2's 90-Day Assessment dated November 4, 2025, indicated R2's targeted behaviors included verbal aggression and anxiousness and was on psychotropic and anti-anxiety medications. R2's assessment indicated there were non-pharmacological approaches in use; however, did not list the pharmalogical approaches or if approaches were effective. R2's Progress Notes dated August 15, 2025, at 2:01 p.m., indicated R2 was upset with staff and had been verbally aggressive. Staff had attempted to redirect R2 without effect and licensed practical nurse (LPN)-G encouraged staff to administer R2's as PRN (as needed)	02180			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02180	Continued From page 40 medications. R2's Progress Notes dated September 8, 2025, indicated LPN-G discussed with R2's provider of R2's mood and frequency of being short and demanding towards staff. R2's Progress Notes dated September 10, 2025, indicated R2's prescriber ordered to increase R2's Lexapro 5 milligrams (mg) at bedtime, Buspar 5 mg twice a day, to continue Buspar 5 mg daily as needed. R2's Progress Notes dated October 7, 2025, at 3:19 p.m., indicated staff requested clinical nurse manager (CNS)-B to speak with R2 due to R2 yelling and swearing at staff. While speaking with staff, CNS-B could hear R2 yelling at another staff member from the hallway. CNS-B attempted to address behaviors toward staff with R2 and R2 denied yelling and calling staff names and R2 would not acknowledge recent occurrence. R2's November and December 2025, Service Checkoff List did not include R2's behavioral symptoms/expressions or individualized behavioral interventions for staff to utilize to minimize behaviors or re-direct. On December 9, 2025, at 2:05 p.m., CNS-B stated R2's record lacked behavior monitoring and any specific interventions for staff to utilize with behaviors. CNS-B stated normally, if a resident exhibited behaviors, the resident's care plan would include identified behaviors with a list of specific interventions for each behavior for staff to utilize. CNS-B stated staff received training during monthly meetings about behaviors and using appropriate interventions to re-direct	02180			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02180	Continued From page 41 residents. R2's record lacked documentation that identified R2's behavioral symptoms and evaluation to determine potential interventions to minimize behaviors. Interventions will be identified on the care plan or service plan." The policy lacked wording to include identifying behavioral symptoms that negatively impacted the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02180			
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 provide care and services according to acceptable health care medical or nursing standards for medication administration by one of three employees (unlicensed personnel (ULP)-F) not following the medication administration procedure. 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	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02320	Continued From page 42 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 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services to the residents of the facility. On December 9, 2025, at 6:28 a.m., the surveyor entered the facility and observed R3 sitting at the dining table waiting for breakfast. The surveyor observed a clear plastic cup of crushed and whole medications mixed with yogurt and an Advair inhaler (used for shortness of breath) on the table next to R3. No staff were present. ULP-F's had a hire date of July 15, 2025. ULP-F's employee record included Competency Evaluation Medications/Treatments dated July 23, 2025, that indicated ULP-F completed training and competency testing on medication administration. R3's diagnoses included Alzheimer's Disease and chronic respiratory failure with hypoxia (inadequate oxygen supply). R3's Service Plan dated April 18, 2024, indicated R3 received medication administration services. R3's Medication Management Plan dated July 8, 2025, indicated R3's medications were to be	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02320	Continued From page 43 administered by facility staff. R3's 90-Day Assessment dated September 30, 2025, indicated R3 was only able to self-administer Vics Vaporub. R3's Medication Administration Record (MAR) December 2025, included ULP-F's initials indicating ULP-F administered the following scheduled 5:00 a.m. and 6:00 a.m., medications: -levothyroxine 112 micrograms for low thyroid levels; -calcium plus vitamin D 600 milligrams (mg)/5 micrograms (mcg) for supplementation; -divalproex 125 mg for Alzheimer's Disease; -fluticasone/salmeterol 250/50 mcg for chronic respiratory failure; -lisinopril 40 mg for high blood pressure; and -vitamin D3 25 mcg for supplementation. On December 9, 2025, at 7:27 a.m., the surveyor observed R3 hand ULP-F R3's Advair inhaler to put back into the medication cart. At 7:32 a.m., ULP-H stated R3 had medication scheduled for 5:00 a.m. and 6:00 a.m., so ULP-F who worked on the night shift (10:00 p.m. to 6:00 a.m.) administered R3's morning medications. ULP-H stated R3's MAR did not indicate R3 was able to self-administer medications after setup except for Vicks Vaporub. On December 12, 2025, at 2:05 p.m., CNS-B stated staff were to watch each resident take their medications unless the residents MAR directed otherwise. CNS-B stated R3's MAR did not indicate R3 was able to self-administer medications except for Vicks Vaporub. The licensee's Medication Management Services	02320			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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	
02320	Continued From page 44 policy dated January 16, 2023, indicated when administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: -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; -specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and -communicated with the unlicensed personnel about the individual needs of the resident. The licensee's undated Part 2 Competency Evaluation Medications/Treatments training form, indicated for oral medication administration to prepare medications per instructions on the EMAR (electronic medical record) and to observe the resident swallowing the medications and always follow facility protocols. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320			
02410 SS=E	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02410	Continued From page 45 lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure privacy was maintained for two of two residents (R6, R5) during medication and treatment administration services. 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: During the entrance conference on December 8, 2025, at 11:14 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02410	Continued From page 46 management and treatment and services to residents at the facility. R6 R6 diagnoses included dementia and dry eyes. R6's Service Plan dated July 28, 2025, indicated R6 received medication administration services. R6's prescriber orders dated October 20, 2025, included olopatadine 0.1% one drop into each eye daily for dry eyes. On December 9, 2025, at 7:14 a.m., the surveyor observed unlicensed personnel (ULP)-H prepare R6's medications and administer R6's eye drops at the dining table with five other residents present eating breakfast. The surveyor did not observe ULP-H ask R6's permission to administer eye drops in a public setting or offer to move R6 to a private area prior to eye drop administration. R5 R5's diagnosis included diabetes type II. R5's Service Plan dated November 24, 2025, indicated R5 received blood glucose (sugar) monitoring twice a day. R5's prescriber orders dated October 10, 2025, include blood glucose monitoring twice a day. On December 10, 2025, at 8:40 a.m., the surveyor observed ULP-H monitor R5's blood glucose (sugar) at the dining room table with other residents present and clinical nurse supervisor CNS-B and licensed practical nurse (LPN)-G were present at the time of the observation. CNS-B stated staff were able to	02410			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/10/2025
NAME OF PROVIDER OR SUPPLIER BABBITT CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 1 CENTRAL BOULEVARD BABBITT, MN 55706		
(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
02410	Continued From page 47 provide treatments and administer medications in a public setting with the resident's permission. CNS-B stated CNS-B had not considered other residents during the administration of treatments in a public setting especially during mealtimes. LPN-G stated blood glucose monitoring should not be completed at the dining table due to exposure to blood and it could become an infection control concern. The licensee's Minnesota Bill of Rights Assisted Living Residents dated November 8, 2022, indicated case discussion, consultation, examination, and treatments are confidential and must be conducted discretely. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	02410			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

BABBITT CAREFREE LIVING BY OXF
1 Central Boulevard
Babbitt, MN 55706
St Louis County
Parcel:

Phone:

License Info

License: HFID 29103

Risk:
License:
Expires on:
CFPM: Michelle Gehrke
CFPM #: 60983; Exp: 04/04/2028

Inspection Info

Report Number: F1032251132
Inspection Type: Full - Single
Date: 12/8/2025 Time: 11:25:50 AM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 3
Delivery:

! New Order: 3-300B Protection from Contamination: cross-contamination, eggs

3-302.11A(1) Priority Level: Priority 1 CFP#: 15

MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.

COMMENT: raw bacon stored above potatoes. store meat below produce.

Comply By: Complied On Site Originally Issued On: 12/8/2025

New Order: 4-200 Equipment Design and Construction

4-204.112A Priority Level: Priority 3 CFP#: 36

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

COMMENT: add thermometer to walk-in cooler and upright cooler

Comply By: Complied On Site Originally Issued On: 12/8/2025

New Order: 4-600 Cleaning Equipment and Utensils

4-601.11C Priority Level: Priority 3 CFP#: 49

MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.

COMMENT: mold in ice bin, drain and clean

Comply By: 12/26/2025 Originally Issued On: 12/8/2025

New Order: 5-200A Plumbing: approved materials/design

5-201.11B Priority Level: Priority 3 CFP#: 51

MN Rule 4626.1040B Maintain the plumbing system in good repair.

COMMENT: sink leaking by dishwasher, continually flowing water

Comply By: 12/31/2025 Originally Issued On: 12/8/2025

New Order: 6-300 Physical Facility Numbers and Capacities

6-301.12C Priority Level: Priority 2 CFP#: 10

MN Rule 4626.1445C Provide and maintain at each handwash sink in toilet rooms and other areas that are not used for food preparation or warewashing, a supply of individual disposable towels, a continuous towel system that supplies the user with a clean towel, or a heated hand drying device.

COMMENT: provide paper towels

Comply By: Complied On Site Originally Issued On: 12/8/2025

Food & Beverage General Comment

went over mandatory illness reporting, hand washing procedure, no bare hand food contact, and when to exclude sick employees from returning to work.

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 F1032251132 from 12/8/2025

Michelle Gehrke
kitchen manager

Ben Kubes,
Public Health Sanitarian 3
218-302-6194
ben.kubes@state.mn.us



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

Temperature Observations/Recordings

Page: 1

Establishment Info

BABBITT CAREFREE LIVING BY OXF
Babbitt
County/Group: St Louis County

Inspection Info

Report Number: F1032251132
Inspection Type: Full
Date: 12/8/2025
Time: 11:25:50 AM

Food Temperature: **Product/Item/Unit:** pasta sauce; **Temperature Process:** Cooking

Location: stove at 167 Degrees F.

Comment:

Violation Issued?: No

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

Location: Walk-in Cooler at 40 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** ham; **Temperature Process:** Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment:

Violation Issued?: No



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

Sanitizer Observations/Recordings

Page: 1

Establishment Info

BABBITT CAREFREE LIVING BY OXF
Babbitt
County/Group: St Louis County

Inspection Info

Report Number: F1032251132
Inspection Type: Full
Date: 12/8/2025
Time: 11:25:50 AM

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Equal To 160 Degrees F.

Comment:

Violation Issued?: No

Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Wiping Cloth Bucket

Location: Equal To 400 PPM

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1032251132		Food Establishment Inspection Report		Page <u>1</u> of <u>1</u>										
 Duluth District Office Minnesota Department of Health 11 East Superior Street, Suite 290 Duluth, MN 55802		No. of Risk Factor/Intervention/Violations		0	Date: 12/8/2025									
		No. of Repeat Risk Factor/Intervention/Violations			Time: 11:25:50 AM									
		Score (optional)			Dur: min									
Establishment: BABBITT CAREFREE LIVING BY OXF		Address: 1 Central Boulevard		City/State: Babbitt, MN	Zip: 55706	Phone:								
License/Permit #: HFID 29103		Permit Holder:		Purpose of Inspection: Full	Est. Type:	Risk Category:								
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS														
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation										
Compliance Status			COS	R	Compliance Status		COS	R						
Supervision			Time/Temperature Control for Safety											
1	IN	Person in charge present, demonstrate knowledge and performs duties			18	IN	Proper cooking time & temperatures							
2	IN	Certified Food Protection Manager			19	IN	Proper reheating procedures for hot holding							
Employee Health			Consumer Advisory											
3	IN	knowledge, responsibilities, and reporting			20	IN	Proper cooling time and temperature							
4	IN	Proper use of restriction and exclusion			21	IN	Proper hot holding temperatures							
5	IN	Response to vomiting, diarrheal events			22	IN	Proper cold holding temperatures							
Good Hygienic Practices			Highly Susceptible Populations											
6	IN	Proper eating, tasting, drinking, tobacco use			23	IN	Proper date marking & disposition							
7	IN	No discharge from eyes, nose, and mouth			24	N/A	Time as public health control;procedures & record							
Preventing Contamination by Hands			Food/Color Additives and Toxic Substances											
8	IN	Hands clean and properly washed			25	IN	Food additives; approved & properly used							
9	IN	No bare hand contact with RTE foods, alternatives			26	IN	Toxic substances properly identified;stored;used							
10	IN	Adequate handwashing sinks supplied and access			Conformance with Approved Procedures									
Approved Source			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											
11	IN	Food obtained from approved source												
12	IN	Food Received at proper temperature												
13	IN	Food in good condition, safe & unadulterated			Proper Use of Utensils									
14	IN	Records available: shellstock tags, parasite dest.			43		In-use utensils; Properly stored							
Protection From Contamination			Utensils, Equipment and Vending											
15	IN	Food separated and protected			44		Utensils, equipment & linens; properly stored, dried, handled							
16	IN	Food-contact surfaces; cleaned & sanitized			45		Single-use & single-service articles, properly stored and used							
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food			46		Gloves used properly							
GOOD RETAIL PRACTICES							Physical Facilities							
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.							50		Hot & cold water available; adequate pressure					
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			51		Plumbing installed; proper backflow devices			
			COS	R				COS	R	52		Sewage & waste water properly disposed		
Safe Food and Water			Proper Use of Utensils						53		Toilet facilities; properly constructed, supplied & cleaned			
30	IN	Pasteurized eggs used where required						54		Garbage & refuse properly disposed; facilities maintained				
31		Water & ice from approved source						55		Physical facilities installed, maintained & clean				
32	N/A	Variance obtained for specialized processing methods						56		Adequate ventilation & lighting; designated areas used				
Food Temperature Control			Utensils, Equipment and Vending						57		Compliance with MCIAA			
33		Proper cooling methods used; adequate equipment for temperature control						58		Compliance with licensing and plan review				
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												
Person in Charge (signature)														
Inspector (signature)							Follow-up: Follow-up Date:							

Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

Project No: SL29103016	Date: 12/8/2025
Facility Name: Babbit Carefree Living by Oxford	
Facility Address: 1 Central Boulevard Babbit, MN 55706	

☒ **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. 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: Several fire doors in the facility were propped opened. The original construction drawings were reviewed showing they were in fact required fire doors. (kitchen doors, resident room doors) All kick down style hold opens shall be removed.

3. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. All clinical staff shall have the keys, codes, or other means necessary to operate the locking device. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: No switch/button was provided to unlock all the doors in the dementia care wing in an emergency.

4. Egress doors shall be readily operable from the egress side without the use of a key or special knowledge. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

Comments: The NE exit door in the dementia care wing was hard to open and the door skin was catching on the ground when opened.

5. The means of egress shall be illuminated at all times the building is occupied. [Minn. Stat. 144G.45 subd. 2; MSFC 1008]

Comments: The emergency lights in the mechanical/sprinkler riser and electrical rooms failed to operate when push button tested.

6. Extension cords shall be maintained in good condition without splices, deterioration or damage. [Minn. Stat. 144G.45 subd. 2; MSFC 604.5.3]

Comments: The electrical cord to the bird cage was frayed near the plug and on top of the cage.

7. Single- and multiple-station smoke alarms shall be replaced when they fail to respond to operability tests or exceed ten years from the date of manufacture. Smoke alarms shall be replaced with smoke alarms having the same type of power supply. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.8.1]

Comments: The smoke alarms in the dementia care wing are over 10 years old from date of manufacture.

8. In buildings that contain a fuel-burning appliance or fireplace, or attached private garage, carbon monoxide detection shall be installed in dwelling units within ten feet of bedrooms. Where a fuel burning appliance is located in a bedroom or its attached bathroom, carbon monoxide detection shall be installed within the bedroom. Carbon monoxide detection can be provided by carbon monoxide alarms installed in dwelling or sleeping units or a carbon monoxide detection system installed in the room or space that contains the fuel-burning appliance. [Minn. Stat. 144G.45 subd. 2; MSFC 915]

Comments: There was no carbon monoxide protection in the dementia care wing.

9. Water-based automatic sprinkler systems shall be inspected and tested annually. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6.1]

Comments: Fire sprinkler heads blocked in IT and storage rooms and escutcheons out of place in the Nurse's Office

☒ **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: Employee actions shall be added to the plan for the dementia care door release when added and the use of the yellow flags outside each resident room and the floor plan added to the fire safety evacuation plan book.

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

Comments: Fire drills were completed but with all shifts present. They shall be conducted on each shift with only the number of employees on that shift present.

☒ **TAG IDENTIFICATION: 2040**

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Twenty One (21) days

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

Comments: No safety risk assessment was provided. The ED-A stated they did not have one specifically for dementia care.