



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 20, 2026

Licensee

Virginia Carefree Living by Oxford Living
421 10th Street South
Virginia, MN 55792

RE: Project Number(s) SL33023016

Dear Licensee:

On February 13, 2026, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on December 17, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

KKM



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 22, 2026

Licensee

Virginia Carefree Living By Oxford Living
421 10th Street South
Virginia, MN 55792

RE: Project Number(s) SL33023016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on December 17, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

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

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

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

0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00

2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$3,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$3,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,



Jessie Chenze, Supervisor

State Evaluation Team

Email: jessie.chenze@state.mn.us

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

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
(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: SL33023016-0 On December 15, 2025, through December 17, 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 35 residents; 35 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was issued December 17, 2025, for SL33023016-0 correction order tag identification 2310. The licensee took actions to mitigate risk on December 17, 2025, however, the order remains at a scope and level of level four, widespread (K).		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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for		0 470		

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post an accurate daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 15, 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee was familiar with current minimum assisted living requirements. Furthermore, RRN-D stated the current staffing schedule was the following: -a.m. shift, 1 registered nurse (RN), 1 unlicensed personnel (ULP) in secured, 1 ULP in unsecured, and 1 float ULP; -p.m. shift, 1 ULP in secured, 1 ULP in unsecured, and 1 float ULP; and -night shift, 1 ULP in secured, and 1 ULP in unsecured. The licensee had a change of ownership (CHOW) effective April 29, 2025, was licensed as an assisted living facility with dementia care (ALFDC), had a capacity of 38 residents, and had a current capacity of 35 residents. During the facility tour on December 15, 2025, from 2:25 p.m. through 3:30 p.m., the surveyor observed a staffing plan posted on white boards in the secured and unsecured units. The staffing plan posted was the following: -6:00 a.m. to 2:00 p.m., 3 ULP, 1 ULP in training; -10:00 a.m. to 10:00 p.m., 1 ULP; -2:00 p.m. to 10:00 p.m., 3 ULP; -10:00 p.m. to 6:00 a.m., 1 ULP; and -10:00 p.m. to 10:00 a.m., 1 ULP. The staffing plan posted did not indicate any	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 licensed nursing staff coverage. The licensee's Direct-Care Staffing Plan last reviewed on December 9, 2025, indicated the following: -a.m., 3 ULP; -p.m., 3 ULP; -NOC (night) 2 ULP; and -Licensed staff coverage, typically Monday through Friday, 40 RN hours coverage, 40 licensed practical nurse (LPN). On December 17, 2025, at 2:15 p.m., RRN-D stated the staffing plan posted did not include any license staff coverage. Furthermore, RRN-D stated license staff should have been included on the daily posted schedule. The licensee's 4.06 Staffing and Scheduling policy dated February 26, 2025, indicated the daily work schedule must be posted, at the beginning of each work shift in a central location in each building of a facility accessible to staff, residents, volunteers, and the public. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 470			
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents:	0 480			

Minnesota Department of Health

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0 480	Continued From page 4 (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 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	0 480			

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0 480	Continued From page 5 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 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480			
0 510 SS=F	144G.41 Subd. 3 Infection control program	0 510			

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0 510	Continued From page 6 (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during resident cares for one of two unlicensed personnel (ULP)-C. This had the potential to affect all residents of the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 15, 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee was familiar with current minimum assisted living requirements.	0 510			

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0 510	Continued From page 7 On December 16, 2025, at 6:07 a.m., the surveyor observed ULP-C perform scheduled morning wound care to R4. ULP-C donned (put on) gloves and removed left lower leg tubigrip (elasticated tubular bandage providing support for soft tissue injuries and swelling) and left heel bandages. Without changing gloves, ULP-C applied new bandage soaked in Dakins solution (broad-spectrum antimicrobial cleanser) and placed on left heel. Removed right glove to remove pieces of tape. Donned a new right glove and removed right lower leg tubigrip and right heel bandages, applied new bandage as above to right heel. Further, ULP-C rolled gauze and placed under small toes on both feet. The surveyor did not observe ULP-C use hand hygiene before donning gloves, between glove changes, between removing contaminated old bandages and replacing the new bandages. ULP-C stated she should have washed her hands in between glove changes, and she forgot. ULP-C's 30-day supervisory evaluation dated May 2, 2025, by a registered nurse (RN) indicated ULP-C was observed and deemed competent in infection control procedures. On December 17, 2025, at 2:10 p.m., regional registered nurse (RRN)-D stated ULPs are trained to use hand hygiene in between glove changes. ULP-C stated ULP-C should have removed the old bandages, used hand sanitizer or washed hands and donned new gloves. The licensee's Hand Washing policy dated April 4, 2025, indicated hand washing will be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing.	0 510			

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0 510	Continued From page 8 Hands should be washed or decontaminated, before and after direct contact with a client, if removing from a contaminated body site to a clean body site during client care, after contact with environmental surfaces or equipment in the immediate vicinity of the client, and after removing gloves or gowns. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510			
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057.	0 650			

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0 650	Continued From page 9 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee record contained the required content for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on December 15, 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee was familiar with current minimum assisted living requirements. ULP-E was hired October 29, 2025, from a contract agency, to provide direct care services to residents at the facility. ULP-E's employee records included Part 1 Competency Evaluation ADLs/Skill and Part 2 Competency Evaluation Medication/Treatment dated October 29, 2025; however, both competency forms for each individual skills category was blank and did not indicate what skills and competencies were completed by ULP-C. Part 1 and Part 2 Competency Evaluations indicated the competencies must be completed	0 650			

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0 650	Continued From page 10 by the RN who observed the following task being performed in an appropriate and safe technique by a resident assistant on a resident or a [pseudo-resident]/volunteer. Please specify the date next to the task if different then the dated signed on the last page. Checking the box indicates training and competency had been completed and ULP had been deemed competent in the following tasks. On December 17, 2025, at 2:42 p.m., RRN-D stated the ULPs competency forms should be fully completed by checking the box of each competency skill completed to ensure each task was satisfactory completed for each topic. The licensee's Training and Competency of Unlicensed Staff policy dated January 16, 2023, in indicated the licensee would retain evidence fn the employee record of each person having completed the required orientation and training. Prior to providing services to a client, unlicensed personnel must satisfactorily complete a written, oral test or practical skills test on the topics as identified above. The RN will document the competency of all unlicensed personnel on all topics identified above in the unlicensed person's personnel file. The RN, with assistance from administrative personnel, is responsible for developing and maintaining a system to track the training and competency of all unlicensed personnel for the RN to use when determining which unlicensed personnel may perform a delegated task. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
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0 775	Continued From page 11	0 775			
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775			
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment	0 780			

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0 780	Continued From page 12 (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a 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	0 780			

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NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
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0 780	Continued From page 13 cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 780			
0 800 SS=D	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.	0 800			

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0 800	Continued From page 14 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (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	0 810			

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0 810	Continued From page 15 training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical	0 810			

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0 810	Continued From page 16 Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810			
01350 SS=F	144G.60 Subd. 5 Temporary staff When a facility contracts with a temporary staffing agency, those individuals must meet the same requirements required by this section for personnel employed by the facility and shall be treated as if they are staff of the facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure contracted staff met all requirements required for personnel employed by the licensee for four of four employees (unlicensed personnel (ULP)-E, ULP-J, ULP-K, ULP-O and registered nurse (RN)-N). 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 15, 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee was familiar with	01350			

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01350	Continued From page 17 current minimum assisted living requirements. ULP-E ULP-E was hired October 29, 2025, from a contract agency, to provide direct care services to residents at the facility. ULP-E's employee record lacked the following required topics: -an overview of 144G.63 Subd. 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; -handling of emergencies and use of emergency services; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -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; -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure; -initial two hours of mental illness and de-escalation training; and -trained in preparing medications and has demonstrated competency to the RN for	01350			

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01350	Continued From page 18 unplanned time away. (144G.71 Subd. 10) ULP-J ULP-J was hired September 1, 2025, from a contract agency, to provide direct care services to residents at the facility. ULP-J's employee record lacked the following required topics: -an overview of 144G.63 Subd. 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; -handling of emergencies and use of emergency services; -compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -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; -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure;	01350			

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01350	Continued From page 19 -initial two hours of mental illness and de-escalation training; and -trained in preparing medications and has demonstrated competency to the RN for unplanned time away. (144G.71 Subd. 10) ULP-K ULP-K was hired November 2, 2025, from a contract agency, to provide direct care services to residents at the facility. ULP-K's employee record lacked the following required topics: -an overview of 144G.63 Subd. 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; -handling of emergencies and use of emergency services; compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -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	01350			

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01350	Continued From page 20 other relevant advocacy services; -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure; -initial two hours of mental illness and de-escalation training; and -trained in preparing medications and has demonstrated competency to the RN for unplanned time away. (144G.71 Subd. 10) ULP-O ULP-O was hired November 3, 2025, from a contract agency, to provide direct care services to residents at the facility. ULP-O's employee record lacked the following required topics: -an overview of 144G.63 Subd. 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; -handling of emergencies and use of emergency services; compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of	01350			

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01350	Continued From page 21 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; -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure; -initial two hours of mental illness and de-escalation training; and -trained in preparing medications and has demonstrated competency to the RN for unplanned time away. (144G.71 Subd. 10) RN-N RN-N was hired December 1, 2025, from a contract agency, to provide direct care services to residents at the facility. RN's employee record lacked the following required topics: -an overview of this chapter; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -handling of emergencies and use of emergency services; -the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; -the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; -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	01350			

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01350	Continued From page 22 other relevant advocacy services; -a review of the types of assisted living services the staff member will be providing and the facility's category of licensure; -initial eight hours of dementia training; and -initial two hours of mental illness and de-escalation training. On December 17, 2025, at 2:27 p.m., executive director (ED)-F stated the licensee did not assign any trainings to the contract staff, only the competencies with the RN for the ULPs. ED-F was unaware the contracted staff needed additional training. The licensee's Training and Competency of Unlicensed Staff policy dated January 16, 2023 indicated the RN and administrative personnel will implement systems to assure that contracted staff or staff from a temporary agency meets the same required orientation, screening, training and competency requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01350			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be	01690			

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01690	Continued From page 23 developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure accountability of controlled substances was maintained by failure to implement the policy for six of six residents (R1, R2, R3, R6, R7, R13). 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	01690			

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NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
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01690	Continued From page 24 failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: R1, R2, R3, R6, R7, R13's narcotic log records lacked daily counts as per licensee policy. On December 15, 2024, at 3:15 p.m., during medication storage review, registered nurse (RN)-B stated controlled medications were counted each shift. On December 15, 2025, at 3:27 p.m., the surveyor and registered RN-B observed a locked cabinet in the nurse's office with the following medications in blister pharmacy packs and Controlled Medication Master Logs dated as follows: -R1, dated November 7, 2025, received Tramadol (for pain) 50 milligrams (mg), 56 tablets; -R1, dated December 11, 2025, received Tramadol 50 mg, 30 tablets; -R2, dated November 12, 2015, (sic), received Lorazepam (for anxiety) 0.5 mg, 20 tablets; -R2, dated November 13, 2025, received haloperidol (for delirium) 0.5 mg, 10 tablets; -R3, dated November 19, 2025, received hydromorphone (for pain) 2 mg, 30 tablets; -R6, dated December 8, 2025, received Belbuca (for pain) 75 mg, 60 tablets, and on December 10, 2025, 30 tablets set up for home health aide (unlicensed personnel (ULP), 30 tablets remaining in overflow stock; -R7, dated October 6, 2025, received morphine (for pain)7.5 mg, 60 tablets; -R7, dated November 28, 2025, received alprazolam (for anxiety) 0.5 mg, 60 tablets, and on December 5, 2025, 30 tablets set up for home health aide (ULP), 30 tablets remaining in	01690			

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01690	Continued From page 25 overflow stock; and -R13, dated October 23, 2025, received lorazepam 0.5 mg, 60 tablets, on November 7, 2025, 60 tablets set up for home health aide (ULP), and on November 24, 2025, received 60 tablets, 60 tablets remaining in overflow stock. On December 15, 2025, at 3:35 p.m., RN-B stated when controlled medications would be received from pharmacy, RN-B would check the medications in and place in overflow locked cabinet until medications were needed in the medication carts. RN-B stated the medications were only counted when received or removed from the locked cabinet. RN-B stated this is the process that was used prior to her start of employment with the licensee. The licensee's Controlled Substances/Schedule II-V Drugs policy dated March 26, 2025, indicated overflow narcotic quantities will be verified at least twice per week and during any event overflow narcotics are accessed. Documentation of such will be completed by a licensed nurse and a witness on the Overflow Narcotics Total Log, which in conjunction with the Controlled Medication Master Logs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:	01750			

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01750	Continued From page 26 (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure as needed (PRN) medications included specific instructions for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnosis included congestive heart failure (CHF), atrial fibrillation, and diabetes. On December 16, 2025, at 7:00 a.m., the surveyor observed ULP-C administer R3 as needed pain medication and scheduled morning medication. R3's Service Plan dated November 17, 2025, indicated R3 received assistance with medication administration, assistance with toileting, mobility,	01750			

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01750	Continued From page 27 transferring, showering, behavior monitoring, safety checks, laundry, and housekeeping. R3's record indicated the registered nurse (RN) completed a 90-day assessment on November 20, 2025, R3 was unable to safely self-administer medications for the following reason, poor vision, had (sic) grasp and forgetfulness. R3's November and December 2025, electronic medication administration record (EMAR) indicated the following PRN medications: -haloperidol 0.5 mg, take one tablet by mouth every 4 hours as needed for delirium, disturbing hallucinations or nausea. OK to crush. One dose every four hours despite indication. OK to crush; and -lorazepam 0.5 mg, take one tablet by mouth every four hours as needed for anxiety, nausea or delirium. R3's November 1 through December 16, 2025, EMAR indicated R2 received the following PRN medications as above: -haloperidol 0.5 mg, November 1, 2, 3 (times 2), 6, 8, 17; and -lorazepam 0.5 mg, November 2 (times 2), 3, 6 (times 2), 7, 8, 17, 27, December 2, 11 (times 2), 13. R3's Individual Medication Management Plan dated August 30, 2025, indicated medications were administered by facility staff and documentation related to medications are located on the medication administration record. R3's record lacked specific written instructions for R3's PRN delirium medications, including which medication to be administered first.	01750			

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01750	Continued From page 28 On December 17, 2025, at 2:17 p.m., regional registered nurse (RRN)-D stated R3's record did not contain specific instructions for administration of delirium medications, and which medication to administer first. RRN-D stated she is unsure why specific instructions were not added to the EMAR. The licensee's Medication Management Services policy dated January 16, 2023, indicated when administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure the RN has specified in writing, specific instructions for each resident and documented instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750			
01890 SS=E	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were labeled with the expiration date for time sensitive medications for two of two residents (R10, R11). This practice resulted in a level two violation (a violation that did not harm a resident's health or	01890			

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01890	Continued From page 29 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 15, 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee provided medication management services to the residents. On December 15, 2025, at 3:12 p.m., the surveyor and registered nurse (RN)-B observed the following medications in the assisted living medication cart: -R10's opened Latanoprost (used to lower eye pressure) 50 micrograms (mcg) eye drops lacked and open and expiration date; -R10's opened Cosopt (used to lower eye pressure) 20 milligrams (mg)/5 ml eye drops lacked opened and expiration date; and -R11's Brio Ellipta (used to open airways) 100 mcg/25 mcg inhaler lacked open and expiration date. On December 15, 2025, at 3:20 p.m., RN-B stated the unlicensed personnel (ULP) were aware time sensitive medications need to be labeled with open and expiration dates and was unsure why staff did not label the medications. The manufacturer instructions for Lantanoprost dated March 2022, indicated to discard eye drops four weeks after opening.	01890			

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01890	Continued From page 30 The manufacturer instructions for Cosopt dated December 2022, indicated to discard eye drops four weeks after opening. The manufacturer's instructions for Brio Ellipta dated November 2024, indicated to discard inhaler six weeks after opening. The licensee's Medication Management Services policy dated January 16, 2023, indicated a prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890			
01950 SS=F	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the	01950			

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01950	Continued From page 31 proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and 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) instructed unlicensed personnel (ULP) in the proper method to perform treatment/therapies and failed to ensure the ULP demonstrated competency for one of one employee (ULP-C) who performed delegated wound cares. 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: ULP-C was hired on March 18, 2025, to provide direct care services to residents of the facility. On December 16, 2025, at 6:07 a.m., the surveyor observed ULP-C perform scheduled morning wound care to R4. ULP-C donned (put on) gloves and removed left lower leg tubigrip (elasticated tubular bandage providing support for soft tissue injuries and swelling) and left heel bandages. Without changing gloves, ULP-C	01950			

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01950	Continued From page 32 applied new bandage soaked in Dakin solution (broad-spectrum antimicrobial cleanser) and placed on left heel. Removed right glove to remove pieces of tape. Donned a new right glove and removed right lower leg tubigrip and right heel bandages, applied new bandage as above to right heel. Further, ULP-C rolled gauze and placed under small toes on both feet. The surveyor did not observe ULP-C use hand hygiene between gloves changes or change gloves between removing old bandages and replacing with new bandages. ULP-C stated she should have washed her hands in between glove changes, and she forgot. R4's service plan dated November 5, 2025, included wound care two times a day. R4's December 2025, electronic medication administration record indicated the following treatments at 7:00 a.m.: Bilateral Toe Dressing -Toes: Please fold gauze or apply foam beneath small toes on both feet and tape in place. This is to reduce pressure on tips of the toes when she is walking. 1. Introduce yourself to the resident and explain the skin care and dressing change procedure. 2. Review dressing change procedure and any special instructions given by the RN. 3. Removing old dressing: a) Wash hands and put on gloves. b) Loosen any adhesive item such as tape or band-aid edge. c) Remove old dressing (if dressing is stuck, moisten with water unless other specific instructions on the service plan). Gently pulling, if dressing remains attached despite	01950			

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01950	Continued From page 33 moisture, notify RN prior to proceeding for further direction. d) Dispose of soiled dressing in the garbage after observing drainage. Remove soiled gloves and dispose, then apply clean gloves (sic) 6. Observe skin. Note area that is broken / impaired. Check for any signs or symptoms of infection and report to the nurse immediately: -increase in redness, swelling, tenderness, or size of wound; -pus or increased or changed drainage; -foul odor; and -fever (100 F (Fahrenheit) or greater). Observe the wound: Report to RN immediately any concerns. -Cleanse the wound: 1. Gently wash wound with soap and water unless other method is indicated on procedure sheet. 2. Gently pat the wound dry with a clean towel (put in laundry after single use) or use paper towel and dispose. -Dressing the wound: 1. Apply appropriate dressing per RN instructions. 2. Mark your initials and the date & time on the dressing. 3. Remove gloves and wash / sanitize hands. 4. Accurately document skin care and dressing change. 5. Return dressing supplies to secure location. 6. Always follow facility protocols, observe for any signs of complications, and consult with the nurse for specific resident needs or concerns. FOR: Non-pressure chronic ulcer of other part of right foot with fat layer exposed. -Dakin solution 0.25% Irrigate with Dakin as directed once for one dose. Use daily as directed for wound care. FOR: Non-pressure chronic ulcer of other part of	01950			

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01950	Continued From page 34 right foot with fat layer exposed -Wound Care, change dressings to heels twice daily: 1. Clean the wounds on the RIGHT and LEFT heel with mild soap and water or a wound cleanser. There is 1 wound to R heel, 2 present on Left. 2. Cover the RIGHT and LEFT heel wound with a Dakin moistened gauze (this should not be soaked, but damp) cut to the size of the wound. 3. Cover with dry gauze, and tape. If the wound is still draining through the dressing, then secure the dry gauze with an ABD pad and/or kerlix. Use Dakin solution to moisten gauze. Do not use wound cleanser to moisten the gauze. Change dressings twice daily. 4. Observe skin. Note any areas that are broken/impaired. Check for signs and symptoms of infection and report to the nurse immediately: -increased redness, swelling, tenderness, or size of wound; -pus or increased/changed drainage; -foul odor; and -fever (100 F or greater). 5. Observe wound: Report immediately any concerns. FOR: Non-pressure chronic ulcer of other part of right foot with fat layer exposed. ULP-C's 30 day supervisory evaluation dated May 2, 2025, by a RN indicated skills observed and deemed competent in infection control procedures. ULP-C's training record lacked evidence of training and demonstration of competency for performing delegated wound cares to R4. On December 16, 2025, at 9:26 a.m., surveyor	01950			

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01950	Continued From page 35 inquired to ULP-C if ULP-C was trained by a registered nurse (RN) for R4's wound care. ULP-C shrugged her shoulders and stated R4's wound cares change frequently. ULP-C stated ULP-C reads the EMAR and performs wound cares as per the EMAR instructions. On December 17, 2025, at 2:10 p.m., regional registered nurse (RRN)-D stated ULPs are trained to use hand hygiene in between glove changes. RRN-C stated ULP-C should have removed the old bandages, used hand sanitizer or washed hands and donned new gloves. RRN-D stated RRN-D was doubtful ULP-C or other staff were competency tested on the wound treatment for R4. The licensee's Hand Washing policy dated April 4, 2025, indicated hand washing will be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated, before and after direct contact with a client, if removing from a contaminated body site to a clean body site during client care, after contact with environmental surfaces or equipment in the immediate vicinity of the client, and after removing gloves or gowns. The licensee's Delegation of Nursing, Treatment and Therapy Tasks dated January 16, 2023, indicated when an RN delegates tasks to unlicensed personnel, that person must ensure that prior to the delegation the ULP is trained in the proper methods to perform tasks or procedures for each resident and is able to demonstrate the ability to competently follow the procedures and perform the tasks.	01950			

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01950	Continued From page 36 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	02040			

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02040	Continued From page 37 a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated December 16, 2025, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040			
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks;	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
(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
02170	Continued From page 38 (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop an individualized activity plan for one of one resident (R2) who resided in an assisted living with dementia care 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 a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee had a change of ownership (CHOW) effective April 29, 2025, was licensed as an assisted living facility with dementia care (ALFDC), had a capacity of 38 residents, and had a current capacity of 35 residents. During the entrance conference on December 15,	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
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02170	Continued From page 39 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee was familiar with current minimum assisted living requirements. R2's diagnosis included unspecified dementia. R2's Service Plan dated October 17, 2025, indicated R2's services included bathing, dressing, grooming, toileting, ambulation, transferring, medication administration, housekeeping and laundry. R2's Service Plan indicated life enrichment activities were available on weekdays and to encourage R2 to attend all activities and escort if outside of the memory care unit. On December 16, 2025, the surveyor observed R2 sitting at the dining table eating breakfast on the secured unit. R2's Individualized Activity Plan dated October 20, 2025, included an evaluation of the activity areas which were required, however, R2's record did not include an individualized activity plan with structured and non-structured activities specific for R2. R2's assessment dated October 10, 2025, indicated R2 was confused, had memory loss and poor decision making. R2's record lacked an activity evaluation, and a written individualized activity plan based on the activity evaluation. On December 17, 2026, at 1:43 p.m., the surveyor received an email from RRN-D indicating R2 did not have an individualized activity evaluation or plan completed. No further information was provided.	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
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02170	Continued From page 40	02170			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
02280 SS=C	144G.90 Subd. 5 Notice to residents; change in ownership or m (a) A facility must provide written notice to the resident, legal representative, or designated representative of a change of ownership within seven calendar days after the facility receives a new license. (b) A facility must provide prompt written notice to the resident, legal representative, or designated representative, of any change of legal name, telephone number, and physical mailing address, which may not be a public or private post office box, of: (1) the manager of the facility, if applicable; and (2) the authorized agent. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice to the residents, legal representative, or designated representative of a change of ownership (CHOW) with all required content. This had the potential to affect all residents residing at the assisted living facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	02280			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
(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
02280	Continued From page 41 During the entrance conference on December 15, 2025, at 1:30 p.m., regional registered nurse (RRN)-D stated the licensee was familiar with current minimum assisted living requirements. The licensee had a CHOW effective April 29, 2025. The licensee provided a copy of a CHOW letter to residents and families dated March 21, 2025, which identified the licensee's president, chairman, and director of operations. The letter did not include the manager of the facility, if applicable, or the authorized agent for the licensee. On December 17, 2025, at 11:50 a.m., RRN-D stated the CHOW letter provided by the licensee did not include all required content for the notification of CHOW. Furthermore, RRN-D stated all residents received the notification letter, and was aware of the missing content from other sister facilities already surveyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02280			
02310 SS=K	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER VIRGINIA CAREFREE LIVING BY OXFORD LIVI			STREET ADDRESS, CITY, STATE, ZIP CODE 421 10TH STREET SOUTH VIRGINIA, MN 55792		
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02310	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for three of three residents (R6, R7, R8) with an assistive device (consumer bed rails). This practice resulted in a level four violation (a violation that harmed a resident's health or safety, not including serious injury or death, or a violation that was likely to lead to serious injury 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). This practice resulted in an immediate order for correction on December 17, 2025. The findings include: On December 16, 2025, from 1:25 p.m. through 1:45 p.m., registered nurse (RN)-I and surveyor observed the following consumer bed rails unsecured to beds: -R6's bed included a U-shaped consumer-style bed rail on the upper ride side of the bed; -R7's bed included a U-shaped consumer-style bed rail on the upper ride side of the bed; and -R8's bed included U-shaped consumer-style bed rail on the upper ride side of the bed. R6's diagnosis included acute cystitis without hematuria. R6's service plan dated October 29, 2025, indicated R6 received services including	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
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02310	Continued From page 43 assistance with medication administration, behavior management, assistance with showering, laundry and housekeeping. R7's diagnosis included illness, unspecified. R7's service plan dated December 4, 2024, indicated R7 received services including assistance with medication management, bathing, grooming, dressing, housekeeping and laundry. R8's diagnosis included congestive heart failure. R8's service plan dated February 21, 2025, indicated R8 received services including assistance with medication administration, toileting, behavior management, assistance with grooming, laundry and housekeeping. LACKING RECALL CHECKS/UNSECURED R7's AL (assisted living) Uniform assessment Tool dated December 12, 2025, indicated R7 had a non-hospital bed device. R7 used bed rail to assist for assist with getting in and out of bed. R7 was educated and provided the risks and benefits of bed rails. On December 16, 2025, the surveyor observed R7's manufacturer instructions RN-I located in R7's paper record. R7's record lacked evidence the consumer product safety commision (CPSC) website had been periodically checked to identify whether the bed rail had been recalled. LACKING INSTALLATION INSTRUCTIONS/RECALL CHECK/UNSECURED R6's AL Uniform assessment Tool dated	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
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02310	Continued From page 44 November 10, 2025, indicated the manufacturer of the consumer bed rail. However, the assessment indicated the bed rail was installed per manufacture instructions. The assessment indicated R8 was using the bed rail to assist getting in and out of bed. The assessment further indicated R8 was educated and provided the risks and benefits of bed rails, and R8 verbalized understanding. R8's AL Uniform assessment Tool dated November 10, 2025, did not indicate the manufacturer of the consumer bed rail. However, the assessment indicated the bed rail was installed per manufacture instructions. The assessment indicated R8 was using the bed rail to assist getting in and out of bed. The assessment further indicated R8 was educated and provided the risks and benefits of bed rails, and R8 verbalized understanding. R6 and R8's record lacked the consumer bed rail manufacturer installation instructions and lacked evidence the CPSC website had been periodically checked to identify whether the bed rail had been recalled. On December 16, 2025, at 3:00 p.m., RN-I stated RN-I was from a sister facility and was asked to assist at the facility with survey. RN-I stated RN-I was aware consumer bed rails must be secured to the bed, assessed and monitored for recalls every 90 days. Furthermore, RN-I stated RN-I could not locate R6 and R8's consumer bed rail manufacturer instructions. RN-I stated R6, R7 and R8's consumer bed rails were not installed properly or checked for recalls. The Minnesota Department of Health (MDH) website, Assisted Living Resources &	02310			

Minnesota Department of Health

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02310	Continued From page 45 Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When	02310			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 33023	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2025
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02310	Continued From page 46 bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The licensee's Assessing Bed Assist Devices revised January 16, 2023, indicated the RN will review the appropriateness, effectiveness, and placement of the bed assist devices during the assessment visits every 90 days and with changes in the client's condition, either improved or declined. No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			



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

Food & Beverage Inspection Report

Page: 1

Establishment Info

VIRGINIA CAREFREE LIVING BY
421 10TH STREET SOUTH
Virginia, MN 55792
St Louis County
Parcel:

Phone:

License Info

License: HFID 33023

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1032251141
Inspection Type: Full - Single
Date: 12/15/2025 Time: 1:15PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 0
Total Priority 2 Orders: 4
Total Priority 3 Orders: 1
Delivery:

New Order: 2-100 Supervision

2-102.11JKLMO *Priority Level: Priority 2 CFP#: 1*

MN Rule 4626.0030JKLMO The person in charge must be able to demonstrate their knowledge to the inspector of the food safety risks within their food operation and the relationship of the following factors to preventing foodborne disease: maintaining the food establishment and equipment in a clean condition and in good repair; procedures for cleaning and sanitizing utensils and food-contact surfaces of equipment; the importance of adequate food service equipment; responsibilities when a HACCP plan is required; proper use of toxic compounds in the establishment; and preventing contamination of the water supply from plumbing cross connections or backflow.

COMMENT: Food manager did not know which sanitizer they use, they do not have the proper test strips to measure the sanitizer and did not know the correct amount of tablets to add to the water for the correct reading.

ensure food manager knows which chemicals they use and how to use them

Comply By: Complied On Site Originally Issued On: 12/15/2025

New Order: 2-100 Supervision

2-102.12AMN *Priority Level: Priority 3 CFP#: 2*

MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.

COMMENT: NO CFPM on site, will send instructions.

Comply By: 1/30/2026 Originally Issued On: 12/15/2025

New Order: 3-500A Microbial Control: cooling

3-501.15A *Priority Level: Priority 2 CFP#: 33*

MN Rule 4626.0390A Cool food by: 1) placing the food in shallow pans; 2) separating the food into smaller portions 3) using rapid cooling equipment; 4) stirring the food in a container placed in an ice water bath; 5) using containers that facilitate heat transfer; 6) adding ice as an ingredient; or other effective methods.

COMMENT: cool food, uncovered, in the freezer or refrigerator. do not leave food out to cool on ice.

Comply By: Complied On Site Originally Issued On: 12/15/2025

New Order: 4-300 Equipment Numbers and Capacities

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

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

COMMENT: provide a test kit for quaternary ammonia

Comply By: 12/23/2025 Originally Issued On: 12/15/2025

New Order: 4-500 Equipment Maintenance and Operation

4-501.112A *Priority Level: Priority 2 CFP#: 16*

MN Rule 4626.0795A Maintain the temperature at the manifold of the hot water sanitizing rinse at a maximum temperature of 194 degrees F (90 degrees C) and no less than 165 degrees F (74 degrees C) for a single tank, stationary rack, single temperature machine or 180 degrees F (82 degrees C) for all other machines.

COMMENT: max dishwasher temp was 135 degrees. Service dishwasher. until serviced use the 3 compartment sink to sanitize dishes

Comply By: 12/30/2025 Originally Issued On: 12/15/2025

Food & Beverage General Comment

went over cooling, employee illness reporting and log, proper sanitation and testing of sanitizers.

dishwasher not functioning, can be used to wash and rinse dishes, but sanitation must be in the 3 compartment sink with approved sanitizer.

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 F1032251141 from 12/15/2025

Dorothy White
food 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	Inspection Info
VIRGINIA CAREFREE LIVING BY	Report Number: F1032251141
Virginia	Inspection Type: Full
County/Group: St Louis County	Date: 12/15/2025
	Time: 1:15PM

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

Location: Walk-in Cooler at 39 Degrees F.

Comment:

Violation Issued?: No

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

Location: Upright Cooler at 38 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

VIRGINIA CAREFREE LIVING BY
Virginia
County/Group: St Louis County

Inspection Info

Report Number: F1032251141
Inspection Type: Full
Date: 12/15/2025
Time: 1:15PM

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

Location: Dishwashing Area **Equal To** 135 Degrees F.

Comment: does not meet

Violation Issued?: No

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

Location: Dishwashing Area **Equal To** 400 PPM

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1032251141		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		3	Date: 12/15/2025	
		No. of Repeat Risk Factor/Intervention/Violations			Time: 1:15 PM	
		Score (optional)			Dur: min	
Establishment: VIRGINIA CAREFREE LIVING BY		Address: 421 10TH STREET SOUTH		City/State: Virginia, MN	Zip: 55792	Phone:
License/Permit #: HFID 33023		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	
Supervision						
1	OUT	Person in charge present, demonstrate knowledge and performs duties	X			
2	OUT	Certified Food Protection Manager				
Employee Health						
3	IN	knowledge, responsibilities, and reporting				
4	IN	Proper use of restriction and exclusion				
5	IN	Response to vomiting, diarrheal events				
Good Hygienic Practices						
6	IN	Proper eating, tasting, drinking, tobacco use				
7	IN	No discharge from eyes, nose, and mouth				
Preventing Contamination by Hands						
8	IN	Hands clean and properly washed				
9	IN	No bare hand contact with RTE foods, alternatives				
10	IN	Adequate handwashing sinks supplied and access				
Approved Source						
11	IN	Food obtained from approved source				
12	IN	Food Received at proper temperature				
13	IN	Food in good condition, safe & unadulterated				
14	N/A	Records available: shellstock tags, parasite dest.				
Protection From Contamination						
15	IN	Food separated and protected				
16	OUT	Food-contact surfaces; cleaned & sanitized				
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food				
GOOD RETAIL PRACTICES						
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.						
Mark "X" or OUT in box if numbered item is not in compliance				Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation		
COS				R		
Safe Food and Water						
30	IN	Pasteurized eggs used where required				
31		Water & ice from approved source				
32	N/A	Variance obtained for specialized processing methods				
Food Temperature Control						
33	X	Proper cooling methods used; adequate equipment for temperature control	X			
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:		
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						

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL33023016-0	Date: December 16, 2025
Facility Name: VIRGINIA CAREFREE LIVING BY OXFORD LIVING	
Facility Address: 421 10 TH STREET SOUTH, VIRGINIA, MN 55792	

☒ TAG IDENTIFICATION: 0775

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]
2. Controlled egress locking systems shall have the capability of being unlocked from the fire command center, a nursing station, or other approved location. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: A controlled egress locking system was installed on all emergency exit doors in the building. Director of maintenance (DM)-G stated a signal or switch was not installed that had the capability to break power to this egress locking system.

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

Comments: There was a controlled egress locking system installed on all exterior emergency exit doors and both interior doors out of the dementia care unit. To exit the building from the dementia care unit, occupants had to pass through two controlled egress doors.

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

Comments:

- Labeled 20 minute fire doors were propped open for resident rooms 18, 25, and 29.
- The labeled 20 minute fire doors were propped open for the wellness center and sunroom. These doors were closed by DM-G during the facility tour.

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

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

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 2; Pattern

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments: All smoke alarms did not actuate in occupied dwelling units 11, 36, and 37, when tested by director of maintenance (DM)-G. The smoke alarms in unit 11 were corrected and tested as interconnected while the surveyor was still onsite.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; Isolated

TIME PERIOD OF CORRECTION: Seven (7) days

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

Comments:

- There was a hole in the door for occupied resident room 36B.
- The window was broken in unoccupied resident room 41. Director of maintenance (DM)-G stated maintenance had already initiated the repair and delivery was pending.

☒ **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 procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

Comments: The fire safety and evacuation plan (FSEP) failed to include evacuation procedures for the individualized unique needs of residents.

☒ **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: A safety risk assessment with mitigation for the physical environment was requested by the surveyor but not provided. Director of maintenance (DM)-G stated a staff member recently left who had been responsible for maintaining this document, and a copy of the assessment could not be located.