Electronically Delivered

September 3, 2025

Licensee
Vitacare Living
102 North 58th Avenue West
Duluth, MN 55807

RE: Project Number(s) SL30495016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 16, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

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

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

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

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30495	A. BUILDING: _____ B. WING _____	07/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ***ATTENTION*** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30495016-0 On July 15, 2025, through July 16, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, July 15, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 775 SS=D	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 comply with the requirements of Minnesota State Fire Code Rules, Chapter 7511. 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: On July 16, 2025, at 10:15 a.m., the surveyor toured the facility with maintenance director (MD)-H. During the facility tour, the surveyor observed the following in occupied resident room 6: - The escutcheon was missing from the fire sprinkler in the bathroom closet. Fire sprinklers must be maintained as designed. - An extension cord was used to supply power, creating a fire hazard. During the facility tour interview, MD-H verified	0 775		

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0 775	Continued From page 4 the above listed observations. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 780 SS=E	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 5 by: Based on observation and interview, the licensee failed to provide smoke alarms that complied with fire protection requirements. 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: On July 16, 2025, at 10:15 a.m., the surveyor toured the facility with maintenance director (MD)-H. During the facility tour, the surveyor observed the following: - Smoke alarms were not installed outside and in the immediate vicinity of resident sleeping units. - When MD-H tested the smoke alarms installed in resident sleeping units, the smoke detector sounder bases installed outside of the sleeping units were not actuated. During the facility tour interview, MD-H verified the above listed smoke alarm observations. Smoke alarms are required to be installed outside and in the immediate vicinity of resident sleeping units. All dwelling unit smoke alarms must be interconnected throughout the facility so that actuation of one alarm causes all alarms to operate. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 780		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810		

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0 810	Continued From page 6 (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and maintain the fire safety and evacuation plan with	0 810		

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0 810	Continued From page 7 required content, and provide required training and drills. This had the potential to directly 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) 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: On July 16, 2025, maintenance director (MD)-H, regional director (RD)-B, and licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN On July 16, 2025, at 10:15 a.m., the surveyor toured the facility with MD-H. During the facility tour, the surveyor observed "you are here" labels were not accurate on the FSEP floor plans posted in resident rooms. During the facility tour interview, MD-H verified the FSEP floor plan observations. The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms. The FSEP	0 810		

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0 810	Continued From page 8 failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency, including individualized unique needs of residents. During an interview on July 16, 2025, at approximately 12:35 p.m., LALD/CNS-A stated in the event of a fire, all of the building occupants would immediately evacuate and that none of the current residents required assistance. Record review indicated the FSEP resident protection procedures were limited to putting a blankets over residents and moving them outside. Record review indicated a resident had been identified with an evacuation level 2 status and would require employee assistance. During an interview on July 16, 2025, at approximately 12:45 p.m., LALD/CNS-A verified electronically on the computer that there was a resident with an evacuation level 2 status and verified the FSEP was lacking. TRAINING Record review indicated the licensee failed to provide fire safety and evacuation training to residents at least once per year evident by a review of training documentation lacking the required frequency. The surveyor requested records for resident training on fire safety and evacuation completed between July 2024 and July 2025. Documentation for resident training on fire safety and evacuation completed in May 2024 was provided. No additional training records were provided. During an interview on July 16, 2025, at approximately 12:30 p.m., MD-H verified the resident training frequency was not met. DRILLS Record review indicated the licensee failed to conduct evacuation drills for employees twice per year, per shift with at least one evacuation drill every other month evident by a review of fire drill	0 810		

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0 810	Continued From page 9 reports lacking the required frequency. The surveyor requested records for evacuation drills completed between July 2024 and July 2025. Three fire drills were recorded in 2025, two completed in March and one in June. Two fire drills were recorded in 2024, completed in May and July. During an interview on July 16, 2025, at approximately 12:30 p.m., MD-H verified the evacuation drill frequency was not met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to	01060		

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01060	Continued From page 10 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with required content to the resident, legal representative, and/or designated representative for two of two residents (R2, R3) reviewed for a hospitalization. In addition, the licensee failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (R3) reviewed for a hospitalization. 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	01060		

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01060	Continued From page 11 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 July 15, 2025, from 9:27 a.m. to 10:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with the assisted living laws and regulations. The licensee's Resident Hold Days Report dated February 15, 2025, to July 15, 2025, indicated the following: -R2 was hospitalized from February 25, 2025, to March 17, 2025; and -R3 was hospitalized from May 2, 2025, to May 6, 2025. R2 R2's diagnoses included osteoarthritis, necrosis of bone of hips, carpel tunnel, spinal stenosis, asthma and anxiety. R2's Service Plan dated October 18, 2024, indicated to refer to R2's care plan for service needs. R2's Care Plan dated July 8, 2025, indicated R2 required assistance with medication administration, bathing, housekeeping, laundry and occasional assistance with mobility and transferring. R2's Resident Notes dated January 16, 2025, to July 16, 2025, indicated R2 was admitted to the hospital on February 25, 2025, for frequent falls and possible rib fracture and returned to the	01060		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01060	Continued From page 12 facility on March 17, 2025. R3 R3's diagnoses included macular degeneration, hypertension (high blood pressure), hypothyroidism (low thyroid levels) and history of right arm fracture. R3's Service Plan dated October 17, 2025, directed to see R3's care plan for service needs. R3's Care Plan dated June 10, 2025, indicated R3 required assistance with medication administration, dressing, bathing, housekeeping, laundry and supervision with mobility. R3's Resident Notes dated May 2, 2025, to July 16, 2025, indicated R3 was admitted to the hospital on May 2, 2025, for pneumonia, and returned to the facility on May 6, 2025. R2 and R3's record included a Notice of Emergency Relocation form dated February 25, 2025, and May 2, 2025, indicating R2 and R3 transferred to the hospital and return dates were unknown; however, R2 and R3's notification sections on the form had not been completed to indicate who had been provided the required Notification of Emergency Relocation information. In addition, R3's record lacked notification was provided to the Office of Ombudsman for Long-Term Care for R3's hospitalization of four days or longer. On July 16, 2025, at 3:35 p.m., LALD/CNS-A stated the licensee was aware of notifying the Ombudsman of Long-Term Care of hospitalizations four day stay or longer; however, R2 and R3 had not been provided a written notice that contained the required information for an	01060		

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	30495	A. BUILDING: _____ B. WING _____	07/16/2025

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VITACARE LIVING	102 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01060	Continued From page 13 emergency relocation. LALD/CNS-A stated they were unable to find documentation in R3's record indicating the Ombudsman of Long-Term Care had been notified of R3's hospitalization of four days or longer. The licensee's Emergency Relocation Notices policy dated August 12, 2024, indicated in the event of an emergency relocation, the licensee would promptly issue a written notice to the resident and required parties, in accordance the Minnesota Statutes that include the following information: -the reason for the relocation; -the name and contact information for the location and service provider; -contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; -estimated return date or statement that return date is unknown; -a statement of resident's right to appeal if housing or services are refused post-relocation, including agency contact information; -recipient notices include resident, legal representative, and designated representative, residents case manage, and Office of Ombudsman for Long-Term Care if not returned within four days; -residents retain the right to return unless a formal termination notice issued under 144G.52; -if the facility refuses to resume housing or services after relocation, it must initiate the termination process; -all emergency relocation and notices must be documented in the resident's record and retained per facility policy. No further information was provided.	01060		

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01060	Continued From page 14 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a background study (BGS) was submitted and a clearance was received in affiliation with the assisted living licensee's current health facility identification (HFID) for one of eight employees (unlicensed personnel (ULP)-G). This had the potential to affect all residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01290		

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01290	Continued From page 15 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 July 15, 2025, from 9:27 a.m. to 10:06 a.m., the surveyor requested a copy of the Minnesota Department of Human Services (MN DHS) NetStudy employee roster and a list of the licensee's current employees including hire dates and titles. Regional director (RD)-B stated the licensee staffed with one unlicensed personnel (ULP) from 7:00 a.m. to 7:00 p.m., and one ULP from 7 p.m. to 7 a.m. ULP-G was hired January 24, 2022, to provide direct care services to residents of the facility. On July 16, 2025, at 6:50 a.m., the surveyor observed ULP-G working at the facility, unsupervised. ULP-G stated he worked the 7 p.m. to 7 a.m. shift. ULP-G's BGS clearance letter dated January 17, 2022, was cleared; however, was affiliated through HFID 30617, a sister facility of the licensee. ULP-G's record lacked evidence ULP-G's BGS had been affiliated with the licensee's HFID 30495. The licensee's Employee Roster [name of facility] printed July 15, 2025, did not list ULP-G as an employee of the licensee. The licensee's DHS NetStudy employee roster provided by the licensee did not include ULP-G	01290		

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01290	Continued From page 16 as a current employee of the licensee or indicate ULP-G had been affiliated with the licensee's HFID 30495. On July 16, 2025, at 10:35 a.m., regional director (RD)-B stated ULP-G's name had not been added to the licensee's employee list because ULP-G was originally hired at a different location owned by the same company and ULP-G worked at several locations. Director of operations (DO)-E stated ULP-F should have been affiliated with all of their facilities since ULP-G worked at multiple locations. The licensee's Background Checks policy dated June 2, 2025, indicated all employees of the facility with direct resident contact would undergo a background study through the Minnesota Department of Human Services (DHS) using the NETStudy 2.0 System. Only individuals who receive a cleared study would be permitted to work at the facility of interact unsupervised with residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental	01530		

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01530	Continued From page 17 illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics	01530		

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01530	Continued From page 18 for three of three employees (licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, (unlicensed personnel (ULP)-C, (culinary director (CD)-D). This had the potential affect all residents and staff. 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: LALD/CNS-A was hired August 3, 2019, to supervise and provided direct care services to residents of the facility. During the course of the survey July 15, 2025, through July 16, 2025, the surveyor observed LALD/CNS-A provide care and services to the residents of the facility. ULP-C was hired October 30, 2024, to provide direct care services to residents of the facility. On July 15, 2025, at 11:45 a.m., the surveyor observed ULP-C administering R2's scheduled medications. CD-D was hired March 30, 2023, to provide direct care services to residents of the facility. LALD/RN-A, ULP-C, and CD-D's records lacked documentation LALD/CNS-A, ULP-C, and CD-D completed the required two hours of initial training	01530		

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01530	Continued From page 19 on mental illness and de-escalation topics which became effective July 1, 2025. On July 16, 2025, at 2:15 p.m., LALD/CNS-A and regional director (RD)-B stated they received an email from Educare (online training program) informing the release of the new mental illness and de-escalating trainings were available; however, they had not assigned staff the required trainings through Educare. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530		
01950 SS=D	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 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	01950		

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01950	Continued From page 20 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) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R2) receiving blood pressure monitoring. 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 July 15, 2025, from 9:27 a.m. to 10:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and therapy services to the licensee's residents. R2's diagnosis included hypertension (high blood pressure). On July 16, 2025, at 7:23 a.m., the surveyor observed unlicensed personnel (ULP)-F monitor R2's blood pressure with an automatic wrist blood pressure machine and obtained a blood pressure reading of 168/81 millimeters of mercury (mmHg) . ULP-F documented R2's blood pressure reading in RTasks (web-based software program). ULP-F stated there were no written directions in R2's record to indicate specific	01950		

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01950	Continued From page 21 parameters of when to notify the nurse. R2's Service Plan dated October 18, 2024, indicated to refer to R2's treatment plan for treatment and therapy service needs. R2's Treatment and Therapy Plan "as of" date, July 16, 2025, did not include monitoring R2's blood pressure daily. R2's July 2025, Medication Administration Summary indicated R2 was scheduled and received blood pressure monitoring daily and record results. R2's prescriber orders dated November 14, 2024, or May 8, 2025, did not include orders for monitoring R2's blood pressure daily. R2's blood pressure profile dated June 1, 2025, to July 16, 2025, included daily recorded blood pressure readings and indicated to monitor R2's blood pressure daily and record; however, lacked specific parameters of when to contact the RN. On July 16, 2025, at 1:20 p.m., LALD/CNS-A stated blood pressure parameters should be indicated in the resident's record in RTasks. LALD/RN-A stated when the task is being completed, the written directions and the blood pressure parameters would appear. LALD/RN-A confirmed, R2's record did not include specific blood pressure parameters. On July 16, 2025, at 2:39 p.m., licensed practical nurse (LPN)-I stated daily monitoring of R2's blood pressure was added to R2's Medication Administration Summary on February 19, 2025; however, blood pressures parameters were never added.	01950		

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01950	Continued From page 22 The licensee's Treatment & Therapy Management Plan dated August 12, 2024, indicated registered nurse was responsible for assessing and developing the treatment or therapy order/or therapy service plan for residents. The RN would prepare individualized treatment or therapy management plan for each client receiving ordered or prescribed or therapy services, which addresses: -type of services to be provided; -procedures for documenting treatments or therapies; -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to unlicensed personnel; and -procedures for notifying a registered nurse or appropriate licensed health professional when a problem arose with treatments or therapy services. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel policy dated August 12, 2024, the registered nurse (RN) may delegate to unlicensed personnel the task of providing administration of treatments and therapy services. The RN would develop a written, specific instruction for each resident and communicate with the unlicensed personnel about he individual needs of the resident. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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02320	Continued From page 23	02320		
02320 SS=D	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by unlicensed personnel (ULP)-F for one of one resident (R2) whose medications were not administered as directed. 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 July 15, 2025, from 9:27 a.m., to 10:06 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to the licensee's residents.	02320		

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02320	Continued From page 24 ULP-F was hired August 9, 2023, to provide direct care services to the residents of the facility. ULP-F's employee record indicated ULP-F completed skills competency in medication administration routes dated September 15, 2023, to include inhaler administration. R2's diagnoses included asthma. R2's prescriber orders dated May 8, 2025, included Advair inhaler (used to treat asthma) two puffs twice a day. R2's prescriber orders dated June 3, 2025, directed to continue to use Advair HFA inhaler with the spacer (device that attaches to the mouthpiece of the inhaler) and ensure proper technique. R2's July 2025, Medication Administration Summary indicated R2 was scheduled and received Advair HFA, inhale two puffs into the lungs two times a daily. Shake well, use with spacer and rinse mouth after use. On July 16, 2025, at 7:23 a.m., the surveyor observed ULP-F prepare R2's medications and inhaler and enter R2's room. ULP-F monitored R2's blood pressure, shook R2's Advair inhaler, attached the spacer to the inhaler and handed the inhaler to R2. ULP-F counted to three and R2 compressed the inhaler and inhaled the medication. R2 handed the inhaler back to ULP-F and ULP-F administered R2's medications. ULP-F did not instruct R2 to take two puffs of the inhaler or offer R2 to rinse mouth after use of the inhaler as directed. On July 16, 2025, at 1:20 p.m., LALD/CNS-B	02320		

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02320	Continued From page 25 stated staff should be following the directions on the resident's medication record and R2's record directed to administer two puff of Advair inhaler and to rinse mouth after use. The licensee's Administration of Medication, Treatment and Therapy by Unlicensed Personnel dated August 12, 2024, indicated unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: -the complete procedures for checking the resident's medication administration record; -preparation of the medication for the resident; -administration of the medication; and -documentation of administration. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

Vita Carefree
102 North 58th Avenue West
Duluth, MN 55807
St. Louis County
Parcel:

Phone:

License Info

License: HFID 30495

Risk:
License:
Expires on:
CFPM: Donna K Beck
CFPM #: 123374; Exp: 05/06/2027

Inspection Info

Report Number: F8010251043
Inspection Type: Full - Single
Date: 7/15/2025 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: THE TEMPERATURE OF THE CHICKEN PATTIES HELD IN THE KITCHEN AMANA UPRIGHT COOLER WERE 60F.
CHICKEN PATTIES WERE DISCARDED BY STAFF.
Comply By: Complied On Site Originally Issued On: 7/15/2025

New Order: 4-100 Equipment Construction Materials
4-101.11BCDE *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0450BCDE Remove all multi-use equipment, utensils, and food storage containers that are not durable, corrosion-resistant, nonabsorbent, smooth, easily cleanable, resistant to pitting, chipping, scratching or not able to withstand repeated warewashing.
COMMENT: REMOVE THE FRY PAN THAT IS WORN AND NO LONGER EASILY CLEANABLE. FRY PAN WAS DISCARDED BY STAFF.
Comply By: Complied On Site Originally Issued On: 7/15/2025

New Order: 4-200 Equipment Design and Construction
4-201.11GMN *Priority Level: Priority 3 CFP#: 47*
MN Rule 4626.0506G Discontinue serving TCS foods that are held for more than same-day service in an adult or child care center or boarding establishment or provide equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.
COMMENT: CHICKEN PATTIES STORED IN THE UPRIGHT COOLER WERE COOKED AND PREPARED IN ADVANCE AND WOULD HAVE HAD TO BE REHEATED (PASSING THROUGH THE DANGER ZONE MORE THAN ONE TIME) TO BE SERVED LATER IN THE DAY.

THIS FACILITY IS ONLY ALLOWED TO PREPARE TCS FOODS FOR SAME-DAY SERVICE. TCS FOODS ARE NOT TO BE COOKED IN ADVANCE AND COOLED FOR LATER USE. HOT FOODS ARE TO BE KEPT HOT AND COLD FOODS COLD BEFORE SERVING.

CHICKEN PATTIES WERE DISCARDED BY STAFF.
Comply By: Complied On Site Originally Issued On: 7/15/2025

Food & Beverage General Comment

COMMENTS:

DISCUSSED THE EXCLUSION OF EMPLOYEES ILL WITH VOMITING OR DIARRHEA FROM THE FOOD ESTABLISHMENT FOR 24 HOURS AFTER SYMPTOMS ARE GONE.

PASTEURIZED EGGS ARE USED IN THE ESTABLISHMENT.

NO LEFTOVER FOODS ARE SERVED TO THE RESIDENTS.

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 F8010251043 from 7/15/2025

Deborah Kosiak

Samantha Tabert

Deb Kosiak,
Public Health Sanitarian 3
218-302-6176
deb.kosiak@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

Vita Carefree
Duluth
County/Group: St. Louis County

Inspection Info

Report Number: F8010251043
Inspection Type: Full
Date: 7/15/2025
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: COOKED CHICKEN PATTIES**; Temperature Process:** Cold-Holding
Location: Upright Cooler/AMANA at 60 Degrees F.
Comment: CHICKEN PATTIES WERE DISCARDED BY STAFF
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler/AMANA at 34 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler/AMANA BACK ROOM at 37 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FOODS FROZEN**; Temperature Process:** Cold-Holding
Location: Upright Freezer/FRIGIDAIRE at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FOODS FROZEN**; Temperature Process:** Cold-Holding
Location: AMANA TOP/BACK ROOM at Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FOODS FROZEN**; Temperature Process:** Cold-Holding
Location: AMANA SIDE/KITCHEN at 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

Establishment Info

Vita Carefree
Duluth
County/Group: St. Louis County

Inspection Info

Report Number: F8010251043
Inspection Type: Full
Date: 7/15/2025
Time: 10:30:00 AM

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 160 Degrees F.
Comment: TEMPERATURE TAPE CHANGED FROM BLUE TO ORANGE.
Violation Issued?: No

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen/UNDERCOUNTER **Equal To** 200 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F8010251043

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 7/15/2025
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
Vita Carefree	102 North 58th Avenue West	Duluth, MN	55807	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30495		Full		

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

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

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

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	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		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Person in Charge (signature)

Inspector (signature) Deborah Kosiak

Follow-up: Follow-up Date: