Electronically Delivered

May 7, 2026

Licensee
Heritage Haven Inc
3042 Morris Thomas Road
Duluth, MN  55811

RE:  Project Number(s) SL25455016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 22, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

**STATE CORRECTION ORDERS**

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

**IMPOSITION OF FINES**

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

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

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

pursuant to this survey:

**St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00**
**St - 0 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $2,000.00**. 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,

Kelly Thorson

Kelly Thorson, Supervisor
State Evaluation Team
Email: Kelly.Thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

CLN

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL25455016<br><br>On April 20, 2026, through April 22, 2026, 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 29 residents; 29 receiving services under the Assisted Living with Dementia Care Facility license.<br><br>An immediate correction order was identified on April 21, 2026, issued for SL25455016, tag identification 1290.<br><br>During the course of the survey, the licensee took action to mitigate the imminent risk. Noncompliance remained and the scope and level remain unchanged. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' findings is the Time Period for Correction.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>The letter in the left column is used for tracking purposes and reflects the scope and level issued pursuant to 144G.31 subd. 1, 2, and 3. | |

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| 0 480 | Continued From page 1 | 0 480 | | |
| 0 480 SS=F | 144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services<br><br>(a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626.<br>(b) For an assisted living facility with a licensed capacity of ten or fewer residents:<br>(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;<br>(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;<br>(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;<br>(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; | 0 480 | | |

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| 0 480 | Continued From page 2<br>(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;<br>(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<br>(7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated April 21, 2026, for the specific Minnesota Food Code violations. The Inspection | 0 480 | | |

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| 0 480 | Continued From page 3<br>Report was provided to the licensee within 24 hours of the inspection.<br><br>TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. | 0 480 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to develop a written | 0 680 | | |

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| 0 680 | Continued From page 4<br><br>emergency preparedness plan (EPP) with all the required content. This had the potential to affect all residents, staff, and visitors of the facility.<br><br>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 the residents).<br><br>The findings include:<br><br>The licensee's EPP dated February 27, 2026, lacked the following:<br>- subsistence needs for staff and residents during an emergency to include food and sewer and waste disposal<br>- the facilities role in providing care and treatment at alternative sites under a 1135 waiver<br><br>On April 21, 2026, at 10:20 a.m., owner/licensed assisted living director (O/LALD)-A stated they thought all the pieces were in the EPP, but if it is not in there, they don't have it.<br><br>The licensee's Emergency Preparedness-Emergency and Disaster Preparedness policy dated July 3, 2025, indicated this facility will be prepared to manage emergency and disaster situations, including missing residents through our hazard assessment and emergency planning.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |

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| 0 775 | Continued From page 5 | 0 775 | | |
| 0 775 SS=E | 144G.45 Subd. 2. (a) Fire protection and physical environment<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. | 0 775 | | |
| 0 780 SS=D | 144G.45 Subd. 2 (a) (1) Fire protection and physical environment<br><br>(a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter | 0 780 | | |

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| 0 780 | Continued From page 6<br><br>7511, and:<br>(1) for dwellings or sleeping units, as defined in the State Fire Code:<br>(i) provide smoke alarms in each room used for sleeping purposes;<br>(ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms;<br>(iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br>(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<br>(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;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and | 0 780 | | |

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| 0 780 | Continued From page 7<br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. | 0 780 | | |
| 0 790 SS=E | 144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment<br><br>(2) install and maintain portable fire extinguishers in accordance with the State Fire Code;<br>(3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or | 0 790 | | |

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| 0 790 | Continued From page 8<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. | 0 790 | | |
| 0 800 SS=D | 144G.45 Subd. 2 (a) (4) Fire protection and physical environment<br><br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. | 0 800 | | |

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| 0 800 | Continued From page 9<br><br>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).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. | 0 800 | | |
| 0 810 SS=I | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be | 0 810 | | |

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| 0 810 | Continued From page 10<br><br>readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01290 SS=I | 144G.60 Subdivision 1 Background studies required<br><br>(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.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure a background study was submitted and completed for the current health facility identification (HFID) number for one of one employee (maintenance (M-C).<br><br>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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 the residents).<br><br>This resulted in an immediate correction order issued on April 21, 2026. | 01290 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01290 | Continued From page 12<br><br>The findings include:<br><br>On April 20, 2026, at 11:30 a.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered one of the facility's employees was not listed as having a background study submitted with the licensee's HFID 25455.<br><br>M-C began employment on July 1, 1999. A current background study has not been completed for M-C.<br><br>On April 21, 2026, at 10:10 a.m. owner/licensed assisted living director (O/LALD) stated M-C has a background study from 2014, but has not had a background study run under this HFID. They have no idea how it was missed, they just didn't catch it.<br><br>The licensee's Employment-Background Studies policy dated June 11, 2025, indicated all employees, as well as contractors, and regularly scheduled volunteers of the facility with direct resident contact will undergo a background study through DHS.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: IMMEDIATE | 01290 | | |
| 01890 SS=F | 144G.71 Subd. 20 Prescription drugs<br><br>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 | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 13<br><br>label with legible information including the expiration or beyond-use date of a time-dated drug.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure time sensitive medications included the opened or expiration date for one of two residents (R4) and failed to keep a medication in its original container bearing the residents' name for two of two residents (R4 and R5).<br><br>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).<br><br>The findings include:<br><br>R4 was admitted to the licensee on September 21, 2021, to receive assisted living services including medication administration.<br><br>R5 was admitted to the licensee on June 4, 2025, to receive assisted living services including medication administration.<br><br>On April 21, 2026, at 2:35 p.m., the surveyor and unlicensed personnel (ULP)-F reviewed the contents of the locked medication refrigerator and found the following:<br><br>-R4's Metagenics, Omega Genic Fish Oil | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01890 | Continued From page 14<br><br>eicosapentaenoic acid (EPA)-docosahexaenoic acid (DHA) (supplement) lacked the resident name and an open or expiration date<br>-R5's AloeCure (digestive supplement) 16.7 fluid (fl) ounce (oz) lacked the resident name<br><br>On April 21, 2026, at 2:38 p.m., ULP-F stated she was trained to write resident names on over-the-counter medications provided by resident's family members. In addition, she stated she was trained to write the open date and the date the medication expires on the medication bottle.<br><br>On April 21, 2026, at 2:44 p.m., clinical nurse supervisor (CNS)-B stated staff are trained to write open dates and names on medications when needed.<br><br>The manufacturer's directions for Metagenics, Omega Genic Fish Oil EPA-DHA, indicated to discard medication 90 days after opening.<br><br>The licensee's Administration of Medication and Verification policy dated February 7, 2022, indicated an assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later administration. The facility must verify that the medications are up to date and stored as appropriate.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01890 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01940 | Continued From page 15 | 01940 | | |
| 01940 SS=D | 144G.72 Subd. 3 Individualized treatment or therapy managemen<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy administration;<br>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to include a written statement of a treatment service on the resident's service plan for one of one resident (R2). | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01940 | Continued From page 16<br><br>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).<br><br>The findings include:<br><br>R2 began receiving services on May 24, 2024.<br><br>R2's Individualized Treatment Assessment and Management Plan dated as of April 21, 2026, indicated R2 received assistance with compression stockings, oxygen management, blood glucose, and skin care.<br><br>R2's Service Plan dated May 30, 2024, lacked identification of treatment services related to R2's compression stockings.<br><br>On April 22, 2026, at 10:00 a.m., owner/licensed assisted living director (O/LALD)-A stated the compression stockings should be on the service plan. R2's power of attorney is out of state but is coming soon to sign new paperwork.<br><br>The licensee's Treatment and Therapy Plans policy dated June 11, 2025, indicated an assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures.<br><br>No further information provided. | 01940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (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 |
|---|---|---|---|---|
| 01940 | Continued From page 17<br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01940 | | |
| 02040 SS=E | 144G.81 Subdivision 1 Fire protection and physical environment<br><br>An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements:<br>(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<br>(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>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). | 02040 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 25455 | A. BUILDING: _____ B. WING _____ | 04/22/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HERITAGE HAVEN INC | 3042 MORRIS THOMAS ROAD DULUTH, MN 55811 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 02040 | Continued From page 18<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 20, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. | 02040 | | |

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

Heritage Haven Inc
3042 MORRIS THOMAS ROAD
Duluth, MN 55811
St Louis County
Parcel:

Phone:

## License Info

License: HFID 25455

Risk:
License:
Expires on:
CFPM: DIANE HOLMBERG
CFPM #: CFPM-57323; Exp: 2/24/2028

## Inspection Info

Report Number: F1016261076
Inspection Type: Full - Single
Date: 4/21/2026 Time: 12:30 PM
Duration: minutes
Announced Inspection:
Total Priority 1 Orders: 1
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery:

! **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: ITEMS INCLUDING COOKED HAM WERE BEING STORED ABOVE 41 DEGREES F. IN KITCHENS 1 AND 3. REPAIR OR REPLACE UPRIGHT COOLERS SO THAT THEY MAINTAIN TCS FOODS AT OR BELOW 41 DEGREES F AND INSTITUTE DAILY TEMP. LOGS ON ALL UPRIGHT COOLERS.
*Comply By: 4/21/2026 Originally Issued On: 4/21/2026*

**New Order: 4-300 Equipment Numbers and Capacities**
4-302.14 *Priority Level: Priority 2 CFP#: 48*
*MN Rule 4626.0715* Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT: TEST KIT NOT AVAILABLE FOR QUAT SANITIZER. OBTAIN TEST KIT FOR QUAT SANITIZER.
*Comply By: 4/24/2026 Originally Issued On: 4/21/2026*

# Food & Beverage General Comment

**COMMENTS:**

**DISCUSSED PROPER DISH WASHING (WASH, RINSE SANITIZE, AIR DRY)**

**DISCUSSED LIMITATIONS OF MENU FOR SUSCEPTIBLE POPULATIONS**

**RECOMMEND DAILY TEMP. LOG FOR UPRIGHT COOLERS**

**WEEKLY TEMP. LOG FOR DISH WASHERS COMPLETED**

DISCUSSED THE IMPORTANCE OF FREQUENT HAND WASHING BY ALL STAFF, AS WELL AS LIMITING BARE HAND CONTACT WITH ALL READY TO EAT FOODS. STAFF HAVE GLOVES AVAILABLE. USE GLOVES WITH ALL READY TO EAT FOODS AND CHANGE GLOVES FREQUENTLY AND ANY TIME TASKS ARE CHANGED.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL 24 HOURS AFTER THEIR LAST SYMPTOM.

CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH SALMONELLA, SHIGELLA, SHIGA TOXIN-PRODUCING E. COLI, HEPATITIS A. VIRUS, NOROVIRUS, OR ANOTHER BACTERIAL, VIRAL OR PARASITIC PATHOGEN OR IF THERE ARE ANY CUSTOMER ILLNESS COMPLAINTS.

**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 F1016261076 from 4/21/2026**

Establishment Representative

Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

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

# Temperature Observations/Recordings



## Establishment Info

Heritage Haven Inc
Duluth
County/Group: St Louis County

## Inspection Info

Report Number: F1016261076
Inspection Type: Full
Date: 4/21/2026
Time: 12:30 PM

**Food Temperature: Product/Item/Unit:** BELL PEPPER**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 44 Degrees F.
Comment:
*Violation Issued?: Yes*

**Food Temperature: Product/Item/Unit:** HAM**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 44 Degrees F.
Comment:
*Violation Issued?: Yes*

**Food Temperature: Product/Item/Unit:** BELL PEPPER**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 43 Degrees F.
Comment:
*Violation Issued?: Yes*

**Food Temperature: Product/Item/Unit:** HAM**; Temperature Process:** Cold-Holding
**Location:** Upright Cooler at 43 Degrees F.
Comment:
*Violation Issued?: Yes*

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

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

**Equipment Temperature: Product/Item/Unit:** ALL FOOD FROZEN X6**; Temperature Process:** Cold-Holding
**Location:** Upright Freezer 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

Heritage Haven Inc
Duluth
County/Group: St Louis County

## Inspection Info

Report Number: F1016261076
Inspection Type: Full
Date: 4/21/2026
Time: 12:30 PM

**Sanitizing Chemical:** **Product:** Quaternary Ammonia**; Sanitizing Process:** Spray Bottle
**Location:** Kitchen **Equal To** 400 PPM
Comment:
*Violation Issued?: No*

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

Heritage Haven Inc
3042 MORRIS THOMAS ROAD
Duluth, MN 55811
St Louis County
Parcel:

Phone:

## License Info

License: HFID 25455

Risk:
License:
Expires on:
CFPM: DIANE HOLMBERG
CFPM #: CFPM-57323; Exp: 2/24/2028

## Inspection Info

Report Number: F1016261081
Inspection Type: Follow-up - Single
Date: 4/28/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

# Food & Beverage General Comment

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION

ALL ORDERS HAVE BEEN CLEARED

CONTINUE WEEKLY MONITORING OF DISHWASHER TEMPS. AND DAILY MONITORING OF REFRIGERATOR TEMPS.

**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 F1016261081 from 4/28/2026**

DIANE
KITCHEN MANAGER

Clifford LaVigne,
Public Health Sanitarian 2
218-302-6181
clifford.lavigne@state.mn.us

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

# Temperature Observations/Recordings



## Establishment Info

Heritage Haven Inc
Duluth
County/Group: St Louis County

## Inspection Info

Report Number: F1016261081
Inspection Type: Follow-up
Date: 4/28/2026
Time: 11:00 AM

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

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

DEPARTMENT OF HEALTH

# Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

| | |
|---|---|
| **Project No:** SL25455016-0 | **Date:** April 20, 2026 |
| **Facility Name:** Heritage Haven Inc | |
| **Facility Address:** 3042 Morris Thomas Road, Duluth, MN 55811 | |

☒ **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. 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: In building 3042, the door closer was removed from the labeled one hour fire door for the laundry room. Fire doors shall be maintained to contain fire and smoke in the event of an emergency.*

3. A working space of not less than 30 inches in width, 36 inches in depth and 78 inches in height shall be provided in front of electrical service equipment. Where the equipment is wider than 30 inches, the working space shall be not less than the width of the equipment. Storage of materials shall not be located within the designated working space. [Minn. Stat. 144G.45 subd. 2; MSFC 604.3]

   *Comments: In building 3042, the area in front of the electrical panels was used for storage in the laundry room and storage closet at the end of the hall near resident rooms three and four. The minimum working space requirements in front of the panels were not met.*

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

*Comments: Carbon monoxide detectors were not installed within ten feet of resident bedrooms, identified as #10 in all three buildings. A carbon monoxide detector was not installed within ten feet of the bedroom in the house manager apartment. Carbon monoxide producing equipment and gas fireplaces were installed in all three buildings and these buildings did not have carbon monoxide detection systems.*

5. The emergency power system for means of egress illumination shall provide power for not less than 30 minutes and consist of storage batteries, unit equipment, or an on-site generator. [Minn. Stat. 144G.45 subd. 2; MSFC 1104.5.3]

   *Comments: In building 3042, at the end of the hall near the salon, the emergency light above the exit door did not work when tested by maintenance (M)-C. M-C stated monthly emergency light tested were not completed and explained these tests had been conducted quarterly. Emergency lighting systems shall be maintained to provide automatic illumination in the event of an emergency.*

6. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

   *Comments: Sprinkler heads were obstructed by storage less than 18 inches below the deflector in the following locations:*
   *<u>Building 3044</u>*
   *- Inside the employee office and laundry room closets.*
   *- On the top shelf in the tub room used to store paper towels.*
   *- Inside two hallway closets.*
   *Improper storage under a sprinkler head deflector would interfere with the spray pattern of water in the event of a fire.*

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☒ **TAG IDENTIFICATION: 0780**

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

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1. Smoke alarms shall be 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: In building 3044, when the smoke alarm outside the bedroom in the house manager apartment was tested by maintenance (M)-C, the bedroom smoke alarm was not actuated. The smoke alarms were not interconnected.*

☒ **TAG IDENTIFICATION: 0790**

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

1. Portable fire extinguishers installed and maintained to MN State Fire Code. [Minn. Stat. 144G.45 subd.2]

   *Comments:*
   *- The back of the tags attached to the portable fire extinguishers were blank. Monthly portable fire extinguisher inspections had not been completed. Maintenance (M)-C stated these inspections were conducted quarterly. Fire extinguisher inspections must be completed every month and documented to ensure each installed extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.*
   *- Portable fire extinguishers were installed inside the kitchen pantries, and the locations were not identified in buildings 3040 and 3044. A sign shall be displayed indicating the fire extinguisher's location if it is not visible.*

☒ **TAG IDENTIFICATION: 0800**

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

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

   *Comments:*
   *<u>Building 3040</u>*
   *- In the bathroom for resident room 6, the exhaust fan was not working and one light bulb in the fixture above the vanity was burnt out.*
   *- The weatherproof cover was missing from one exterior wall outlet.*
   *<u>Building 3042</u>*
   *- In resident room eight, the bathroom exhaust fan light was not working.*
   *- In resident room six, two light bulbs were not working in the fixture above the bathroom vanity, and the resident stated a ceiling fixture light bulb was burnt out in the living room.*
   *- The top part of one exterior light cover was missing on the side of the building.*
   *- The access panel was missing for the sprinkler valve in the closet at the end of the hall near resident rooms three and four.*
   *<u>Building 3044</u>*
   *- One section of soffit was missing from the front of the building.*

☒ **TAG IDENTIFICATION: 0810**

**SCOPE/ SEVERITY** Level 3; Widespread

**TIME PERIOD OF CORRECTION:** Twenty One (21) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) that include the location and number of resident rooms. [Minn. Stat. 144G.45 subd.2]

   *Comments: In building 3042, the door number for resident room four was covered by decorations. Resident room numbers need to be visible to provide efficient communication for exiting in the event of a fire or similar emergency.*

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

   *Comments:*
   *- The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the building's life safety systems. The same plan was used for all three buildings. The licensee stated the employee actions for the 3044 building, which was a R-4 occupancy, were different than for the 3040 and 3042 buildings, which were both I-2 occupancies.*
   *- The FSEP for the 3044 building inaccurately directed employees to use pull fire alarms. Pull fire alarms were not installed in this building.*

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

   *Comments: The evacuation instructions for residents failed to include procedures if the main exit door was not accessible.*

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans (FSEP) 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) in the emergency preparedness binders failed to include evacuation procedures for the individualized unique needs of residents. The licensee stated this information was maintained in the resident care plans and verified it was not included with the FSEP.*

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

   *Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed between April 2025 and April 2026, from the licensee. FSEP training records were not provided. Additionally, the surveyor requested FSEP training documentation for one new hire employee. An undated, unsigned, orientation checklist template was provided. Record review of the available documentation indicated employee training on the FSEP was not completed at the required frequency.*

6. Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. [Minn. Stat. 144G.45 subd.2]

   *Comments: The surveyor requested records for resident fire safety and evacuation training completed between April 2025 and April 2026, from the licensee. These training records were not provided. Record review of the available documentation indicated residents were not offered this training at the required frequency of at least once per year.*

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

   *Comments: The surveyor requested records for evacuation drills completed between April 2025 and April 2026, from the licensee. Fire drill schedules were provided, and record review indicated fire drills had been completed in all three buildings during February 2026. Evacuation drill records for 2025 were not provided. The licensee failed to meet the evacuation drill frequency as required by statute.*

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☒ **TAG IDENTIFICATION: 2040**

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

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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: The licensee provided safety assessments for each building, dated February 20, 2026. These assessments failed to include a mitigation strategy for each hazard identified.*