Electronically Delivered

April 17, 2026

Licensee
Vitacare Living
126 98th Avenue West
Duluth, MN 55808

RE: Project Number(s) SL30577016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 2, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jess Schoenecker, Supervisor
State Evaluation Team
Email: Jess.Schoenecker@state.mn.us
Telephone: 651-201-3789 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
	30577	A. BUILDING: _____ B. WING _____	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	126 98TH AVENUE WEST DULUTH, MN 55808

(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: SL30577016-0 On March 30, 2026, through April 2, 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 eleven (11) residents; 11 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 March 31, 2026, 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, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		

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0 810	Continued From page 4	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans 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, record review, and	0 810		

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0 810	Continued From page 5 interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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, Physical Environment Inspection Report (PEIR) dated April 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	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	01060		

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01060	Continued From page 6 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 provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with the required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care (OOLTC) of the emergency relocation lasting more than four days for one of	01060		

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01060	Continued From page 7 four residents (R5). 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: R5 was admitted on February 17, 2026, and began receiving assisted living services. R5's Service Plan signed on February 20, 2026, indicated R5's services included assistance with areas identified on care plan and medication administration. R5's record included a progress note dated March 25, 2026, indicating resident had fallen and was transferred to the hospital. On March 30, 2026, at 10:33 a.m. during a facility tour, R5 stated they had just returned from the hospital. On March 30, 2026, at 11:31 a.m., ULP-C stated R5 had returned from the hospital that morning. R5's record lacked evidence of a written notice provided to the resident, the resident's legal representative, designated representative, and OOLTC (for relocations where the resident did not return within four days) that contained, at a minimum: - the reason for the relocation;	01060		

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01060	Continued From page 8 - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the OOLTC; - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. On March 31, 2025, at 12:34 p.m., director (D)-G presented the surveyor with an emergency relocation form dated March 31, 2026. D-G stated she had provided the emergency relocation notice to R5 today. D-G stated they file emergency relocation forms for each hospitalized resident and this one "just got missed". The licensee's Emergency Relocation Notices policy dated August 12, 2024, indicated that in the event of an emergency relocation, the licensee would promptly issue a written notice to the residents and other required parties. The relocation notice would include the following content: -the reason for relocation; -the name and contact information of the new location and service provider; -contact information for the OOLTC; -the estimated return date or a statement that the return date is unknown; and -a statement of the residents' right to appeal if housing or services are refused post-relocation, including agency contact information. No further information was provided.	01060		

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01060	Continued From page 9 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01290 SS=D	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 interview and record review, the licensee failed to ensure a background study was affiliated with the assisted living facility license for one of three employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or	01290		

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01290	Continued From page 10 a limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-E was hired on November 10, 2025, and began providing assisted living services. ULP-E's record included a background study dated November 11, 2025, and was affiliated with [another licensee] under same ownership. A person search on NETStudy conducted on March 31, 2026, at 10:48 a.m., indicated the licensee had initiated a background study for ULP-E on March 30, 2026, at 8:22 a.m. (during the survey). On March 31, 2026, at 12:34 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they had recently learned how to affiliate employees that had a previous background clearance and they had initiated her affiliation on March 30, 2026. The licensee's Background Checks policy dated April 17, 2023, indicated all employees of the facility with direct resident contact would undergo a background study through DHS. The policy also indicated only those with satisfactory results would continue to work with the facility and its residents. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		

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01620	Continued From page 11	01620		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be	01620		

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01620	Continued From page 12 completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a registered nurse (RN) conducted ongoing assessments not to exceed 90 calendar days from the last date of assessment for one of five residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted to the licensee on August 2, 2022, and was discharged on February 12, 2026. R3's Service Plan signed on August 2, 2022, indicated R3's services included assistance with medication administration, compression stockings, and blood glucose management.	01620		

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	30577	A. BUILDING: _____ B. WING _____	04/02/2026

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01620	Continued From page 13 R3's record included 90-day assessments dated July 30, 2025, and October 31, 2025, indicating 93 days had passed between assessments. On March 31, 2026, at 2:15 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were unaware assessments had been late. LALD/CNS-C did not indicate why the assessment was late. The licensee's Resident Pre-Admission Assessment and Monitoring Process policy updated on May 2, 2025, lacked indication of the frequency of ongoing assessments. No additional information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of four residents (R1). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 was admitted on January 12, 2026, and began receiving assisted living services. R1's Service Plan, undated, indicated R1 received services including assistance with medication administration and blood glucose management. R1's record included a prescriber order dated January 12, 2026, for Lantus insulin 20 units to be given subcutaneously at bedtime. R1's Service Recap Summary dated March 2026, and Blood Glucose Log dated March 2026, included notes for the following dates: -March 4, 2026, at 8:00 p.m. - BG-239, U-6; -March 5, 2026, at 8:00 p.m. - BG 193, U-5; -March 6, 2026, at 8:00 p.m., - BG 158, U-4; -March 7, 2026, at 8:00 p.m., - BG 202, U-5; -March 11, 2026, at 8:00 p.m. - BG 198, U-5; -March 12, 2026, at 8:00 p.m. - BG 208, U-5;	01760		

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01760	Continued From page 15 -March 13, 2026, at 8:00 p.m. - BG 222, U-5; and -March 18, 2026, at 8:00 p.m. - BG 225, U-5. On March 31, 2026, at 11:31 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated the notes indicated that the ULP checking the blood glucose had administered additional insulin. LALD/CNS-C stated R1 did not have an order for sliding scale insulin and that this was a medication error. LALD/CNS-C stated the physician had been notified at the time the error was discovered. R1's progress notes dated January 1, 2026, through March 31, 2026, lacked documentation of a medication error or provider notification. On March 31, 2026, at 2:15 p.m., LALD/CNS-C stated they would be providing additional education to the unlicensed personnel (ULP) involved in the medication error. The licensee's Reporting, Documenting and Reviewing Incidents Involving Residents policy updated May 2, 2025, indicated the RN would complete an assessment of the resident following an incident and would document in the resident's chart the details of any incident involving the resident including the follow up actions that were taken. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen	01940		

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01940	Continued From page 16 For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current individualized treatment management record included the required content for one of three residents (R6). This practice resulted in a level two violation (a violation that did not harm a client's health or	01940		

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01940	Continued From page 17 safety but had the potential to have harmed a client'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: R6 was admitted to the licensee on February 17, 2026. R6's assessment completed by a registered nurse (RN) on March 17, 2026, indicated R6 had a right heel wound. R6's physician orders dated February 10, 2026, included an order for a dressing change to R6's right foot three times weekly. R6's Service Plan signed on February 20, 2026, referred to the treatment plan for treatment details. R6's Treatment Plan signed on February 20, 2026, lacked documentation of wound care for R6's right heel wound, including the following required content: -a statement of the service to be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; and -any resident specific requirements related 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.	01940		

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01940	Continued From page 18 On March 31, 2026, at 12:34 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were providing wound care for R6 three times weekly. LALD/CNS-C stated they were unaware the treatment was not listed on the treatment plan. LALD/CNS-C further stated they were transitioning from an all-paper format to an electronic medical record. The licensee's Treatment and Therapy Management policy reviewed on May 5, 2025, indicated the RN would prepare an individualized treatment management plan for each client receiving ordered or prescribed treatments or therapy services. The treatment plan would address: -the type of service to be provided; -procedures for documenting treatments or therapies; -procedures doe monitoring treatments or therapies to prevent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to unlicensed providers; and -procedures for notifying the RN when a problem arises related to the treatment or therapy service. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who	01960		

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01960	Continued From page 19 administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document treatment administration for one of three residents (R6). 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: R6 was admitted to the licensee on February 17, 2026. R6's assessment completed by a registered nurse (RN) on March 17, 2026, indicated R6 had a right heel wound. R6's physician orders dated February 10, 2026, included an order for a dressing change to R6's right foot three times weekly. R6's Service Plan signed on February 20, 2026, referred to the treatment plan for treatment details.	01960		

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01960	Continued From page 20 R6's Service Recap Summary log dated March 2026, lacked documentation that wound care was being performed. On March 31, 2026, at 12:24 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they were providing wound care for R6 three times weekly. LALD/CNS-C stated they were unaware the service was not being documented and thought the oversight was related to the transition from a paper process to an electronic documentation system. The licensee's Treatment and Therapy Management policy reviewed on May 5, 2025, indicated each staff member administering a treatment or therapy would be responsible for documenting this in the clinical record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02140 SS=F	144G.83 Subd. 3 Supervising staff training Persons providing or overseeing staff training must have experience and knowledge in the care of individuals with dementia, including: (1) two years of work experience related to Alzheimer's disease or other dementias, or in health care, gerontology, or another related field; and(2) completion of training equivalent to the requirements in this section and successfully passing a skills competency or knowledge test required by the commissioner. This MN Requirement is not met as evidenced	02140		

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02140	Continued From page 21 by: Based on interview and record review, the licensee failed to ensure the designated person to oversee staff training in the care of individuals with dementia completed the required skills competency or knowledge test required by the commissioner. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 30, 2026, at 10:30 a.m., regional director (RD)-A identified licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C as the person providing dementia care training and oversight. LALD/CNS-C's record included certificates of completion for Educare's 5-part dementia education series (online education) dated March 6, and March 7, 2026. LALD/CNS-C's record lacked evidence of completion of Educare's dementia care test and completion of a skills competency or knowledge test required by the commissioner. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQ's) updated March 9, 2026,	02140		

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02140	Continued From page 22 identified Educare's 5-part Dementia Series and test would meet the requirement of statute 144G.83, Subd 3; however, it further identified the essentiALZ® Exam from the Alzheimer's Association as the skills competency or knowledge test required by the commissioner to meet the requirement of statute 144G.83, Subd 3. On March 31, 2026, at 12:36 p.m., RD-A and LALD/CNS-C stated they thought they had met the requirements of the statute as this was not cited at another facility, under the same ownership, that was recently surveyed. The licensee's Assisted Living with Dementia Care: Dementia Training policy dated April 17, 2023, indicated people providing or overseeing staff training would complete training related to Alzheimer's disease or other dementia, and successfully pass a skills competency or knowledge test required by the commissioner. No further information was provided. TIME PERIOD TO CORRECT: Twenty-one (21) days	02140		
02170 SS=F	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to	02170		

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02170	Continued From page 23 participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure each resident was evaluated for activities and an individualized activity plan contained all required content for two of two residents (R1, R4) with a dementia related diagnosis. 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	02170		

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02170	Continued From page 24 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: The licensee held an Assisted Living Facility with Dementia Care license effective May 1, 2025, through April 30, 2026. R1 was admitted to the licensee on January 12, 2026, with a diagnosis of vascular dementia. R4 was admitted to the licensee on August 8, 2024, with a diagnosis of unspecified dementia. R1 and R4's records lacked an activities evaluation to include the following content: -past and current interests; -current abilities and skills; -emotional and social needs and patterns; -physical abilities and limitations; -adaptations necessary for the residents to participate; and -identification of activities for behavioral interventions. R1 and R4's records lacked individualized activity plan based on activity evaluations, preferences, and needs. On March 31, 2026, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-C stated they did not have individualized activity plans for their residents and there would be no additional information beyond what is in the resident assessments and care	02170		

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02170	Continued From page 25 plans. The licensee's Description of Life Enrichment Programs and how Activities are Implemented in ALDC policy dated March 16, 2023, indicated each resident would have an evaluation with all required content and an individualized activity plan would be developed for each resident. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02170		

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

VITACARE LIVING
126 98TH AVENUE WEST

Duluth, MN 55808
St Louis County
Parcel:

Phone:

License Info

License: HFID 30577

Risk:
License:
Expires on:
CFPM: Bryce J Huffman
CFPM #: 123282; Exp: 05/06/2027

Inspection Info

Report Number: F8010261055
Inspection Type: Full - Single
Date: 3/31/2026 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

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 BAKING SHEET THAT IS WORN AND NO LONGER EASILY CLEANABLE.

BAKING SHEET WAS DISCARDED.
Comply By: Complied On Site Originally Issued On: 3/31/2026

New Order: 4-200 Equipment Design and Construction
4-204.112A *Priority Level: Priority 3 CFP#: 36*
MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.
COMMENT: THERE WAS NOT A THERMOMETER IN THE KITCHEN KENMORE REFRIGERATOR.

A THERMOMETER WAS PROVIDED AND MORE THERMOMETERS WERE ORDERED.
Comply By: Complied On Site Originally Issued On: 3/31/2026

Food & Beverage General Comment

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

ESTABLISHMENT IS USING PASTEURIZED EGGS.

FOOD IS PREPARED FOR SAME DAY SERVICE. NO LEFTOVER FOODS ARE SERVED TO THE RESIDENTS.

DISTRIBUTED AN EMPLOYEE ILLNESS LOG SHEET, HANDWASHING SIGN, VOMIT CLEANUP POSTER AND FACT SHEETS ON HIGHLY SUSCEPTIBLE POPULATION AND FOOD TEMPERATURE REQUIREMENTS.

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 F8010261055 from 3/31/2026

Deborah Kosiak

Tawni Huffman

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

VITACARE LIVING
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261055
Inspection Type: Full
Date: 3/31/2026
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler/KENMORE at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HOT DOGS**; Temperature Process:** Cold-Holding
Location: Upright Cooler/KENMORE at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler/WHIRLPOOL at 39 Degrees F.
Comment:
Violation Issued?: No

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

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

Food Temperature: Product/Item/Unit: FOODS FROZEN**; Temperature Process:** Cold-Holding
Location: Upright Cooler/KENMOORE BOTTOM 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

VITACARE LIVING
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261055
Inspection Type: Full
Date: 3/31/2026
Time: 10:30:00 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

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

Minnesota (MDH) Version
EH Manager; RPT: F8010261055

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	0	Date: 3/31/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
VITACARE LIVING	126 98TH AVENUE WEST	Duluth, MN	55808	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30577		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/O	Proper reheating procedures for hot holding		
20	N/A	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	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	X	Thermometers provided & accurate	X	
		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:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30577016-0	**Date:** APRIL 1, 2026
Facility Name: VITACARE LIVING	
Facility Address: 126 98TH AVENUE WEST, DULUTH, MN 55808	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Isolated **TIME PERIOD OF CORRECTION:** Two (2) 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. Where used in Group I-2 (ALFDC) and ambulatory care facilities, portable, electric space heaters shall be limited to those having a heating element that cannot exceed a temperature of 212°F (100°C), and such heaters shall only be used in nonsleeping staff and employee areas. [Minn. Stat. 144G.45 subd. 2; MSFC 604.10.5]

   Comments: In occupied resident sleeping room four, there was a space heater plugged into an electrical outlet. Maintenance (M)-G stated during the building tour that they were not aware this resident had a space heater in their room.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: Resident room numbers were not legible on all copies of the emergency evacuation floor plans displayed in the common areas of the building. Resident rooms shall be clearly labeled on the emergency floor plans 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 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 and were created using a template.