Electronically Delivered

June 24, 2026

Licensee
Wesley Residence of Duluth
5601 Grand Avenue
Duluth, MN 55807

RE: Project Number(s) SL30422016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on May 21, 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 - 0510 - 144g.41 Subd. 3 - Infection Control Program - $500.00
St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0800 - 144g.45 Subd. 2 (a) (4) - Fire Protection And Physical Environment - $1,000.00
St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - $1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $4,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

KKM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENT SL30422016-0 On May 19, 2026, through May 21, 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 32 residents; 32 receiving services under the Assisted Living Facility 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 May 19, 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		
0 490 SS=F	144G.41 Subdivision 1b Minimum requirements; other required services All assisted living facilities must offer to provide or make available the following services to residents: (1) weekly housekeeping; (2) weekly laundry service; (3) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation, and provide the name of or other identifying information about the persons responsible for providing this assistance; (4) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (5) provide culturally sensitive programs; and (6) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have daily programs of social and recreational activities based on individual and group interests, physical, mental,	0 490		

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0 490	Continued From page 4 and psychosocial needs. This had the potential to affect all 32 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 19, 2026, at 9:46 a.m. through 10:34 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated the licensee had not been offering or providing a daily program of social and recreational activities for residents since January 2026, and recently hired an activity staff that would be starting that week. CNS-B stated staff have not been providing daily activities for residents since the licensee lost their activity staff. During the facility tour on May 19, 2026, at 10:42 a.m., with CNS-B, the surveyor observed an activity calendar posted in the main hallway entrance of the facility; however, the activity calendar posted dated May 2026, was blank and did not have a daily activity scheduled. At 11:19 a.m., the surveyor observed the 2nd floor of the facility with CNS-B and observed an activity room that was locked. CNS-B stated residents did not have key access to the activities room. On May 21, 2026, at 10:50 a.m., R5 stated the licensee has not had a daily planned activity for	0 490		

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0 490	Continued From page 5 several months. R5 stated an activity calendar was posted monthly but it was blank and did not have daily activity listed. R5 stated the licensee hired a new activity staff that was starting that week. The licensee's Uniform Disclosure of Assisted Living Services and Amenities dated August 1, 2021, indicated the licensee provided supportive services to include required daily social and recreational services. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to	0 510		

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0 510	Continued From page 6 infection control during medication administration for one of two 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 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 May 19, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated the licensee provided required infection control training upon hire and at a minimum, annually. ULP-E was hired January 20, 2026, to provide direct care services to residents at the facility. ULP-E's employee record indicated ULP-E completed infection control and medication administration training on January 24, 2026. On May 20, 2026, at 1:13 p.m. through 1:20 p.m., the surveyor observed ULP-E prepare R6's medications, enter R6's room, administer R6's medications, exited the room and documented medications administered in EMR (electronic medical record). ULP-E prepared R7's medications, entered R7's room, administered medications, exited room and documented medications administered in EMR. ULP-E prepared R5's medications, entered R5's room, administered medications, exited room and	0 510		

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0 510	Continued From page 7 documented R5's medications administered in EMR. The surveyor did not observe ULP-E perform hand hygiene prior to preparing resident medications, in between administering resident medications or after administering medications. Immediately following the medication observations, ULP-E stated ULP-E did not realize ULP-E did not use hand sanitizer during the medication process and should have performed hand hygiene. On May 21, 2026, at 12:55 p.m., CNS-B stated staff should perform hand hygiene before preparing medications, in-between residents and after administration of medications. CNS-B stated hand sanitizer was available for use throughout the building and in the medication room. The licensee's Hand Hygiene policy dated January 2025, indicated hand hygiene should be performed between resident cares and whenever direct physical contact with a resident takes place. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact	0 550		

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0 550	Continued From page 8 information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post in a conspicuous place, the required information related to the grievance procedure. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the facility tour on May 19, 2026, at 10:42 a.m. through 11:37 a.m., with clinical nurse supervisor (CNS)-B, the licensee's grievance procedure was not observed posted within the facility. CNS-B stated the grievance procedure was located in a folder in the staff office and was available from staff if requested by a resident. CNS-B stated the grievance procedure was not posted within the facility. The surveyor reviewed	0 550		

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0 550	Continued From page 9 the licensee's Resident Grievance policy/procedure located in the locked staff work room. The Grievance policy/procedure lacked the required content to indicate the name, telephone number, and e-mail contact information for the individual(s) who were responsible for handling resident grievances and the contact information to the Ombudsman of Long-Term Care. CNS-B stated CNS-B was unaware of the required content and was not aware the grievance procedure was required to be posted. The licensee's Resident Grievance policy dated February 2023, lacked the required content noted above and indicated the licensee would notify all recipients of service of this policy, and provide a copy, upon permission or within at leas five working days of service initiation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 630 SS=D	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.	0 630		

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0 630	Continued From page 10 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for one of three 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: During the entrance conference on May 19, 2026, at 9:53 a.m., clinical nurse supervisor (CNS)-B stated registered nurse (RN)-H completed resident assessments. R3's diagnoses included schizophrenia, anxiety, depression, chronic obstructive pulmonary disease, difficulty walking and dysphagia (difficulty swallowing). R3's Service Plan (Waiver)- Addendum to Contract dated April 8, 2026, indicated R3's services included medication administration, dressing, grooming, bathing, behavior monitoring, safety checks, housekeeping and laundry. On May 20, 2026, at 7:21 a.m., the surveyor observed CNS-B obtain R3's blood glucose (sugar) with results of 115 milligrams per deciliter	0 630		

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0 630	Continued From page 11 (mg/dl). R3's IAPP dated March 6, 2026, indicated R3 was at risk to be abused and had no history of risk of self-abuse; however, R3's assessment did not include an assessment of R3's risk of abusing other vulnerable adults. On May 21, 2026, at 12:49 p.m., CNS-B stated CNS-B was aware of the required content in an IAPP assessment. CNS-B reviewed R3's IAPP and stated CNS-B was unsure why R3's IAPP was missing the review of R3's risk of abusing others and would have to look more into it. The licensee's Individual Abuse Prevention Plan policy dated January 2025, indicated the licensee would develop an individual abuse prevention plan for each assisted living resident. The IAPP would include; -an individualized review or assessment of the resident's susceptibility to be abuse by another individual, including other vulnerable adults; -the person's risk of abusing other vulnerable adults; and -specific measures to minimize the risk of abuse to that person and other vulnerable adults; and -measure to minimize the risk of self-abuse, if applicable. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly	0 650		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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0 650	Continued From page 12 scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employees received orientation to assisted living requirements and regulations prior to providing services for one of one employee (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the	0 650		

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0 650	Continued From page 13 situation has occurred only occasionally). The findings include: During the entrance conference on May 19, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated the licensee was familiar with the current minimum assisted living requirements. ULP-E was hired January 20, 2026, to provide direct care services to residents at the facility. On May 20, 2026, at 1:13 p.m., through 1:20 p.m., the surveyor observed ULP-E prepare and administer resident medications. ULP-E's employee record lacked documented evidence of the following required orientation: -review of the provider's polices and procedures. On May 21, 2026, at 10:15 a.m., assisted living director in residency (ALDIR)-D stated the licensee did not have documentation for ULP-E's review of the licensee's policies and procedures at the time of hire. ALDIR-D stated the licensee would have to develop a process to ensure each new employee's record included documentation of review of the licensee's policies and procedures. The licensee's Personnel Records policy dated January 1, 2025, indicated personnel records would be kept up-to-date, will organized and confidential and would comply with the assisted living law and other relevant laws. The personnel record for each person would include a record of all required training for unlicensed personnel and competency evaluations.	0 650		

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0 650	Continued From page 14 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required	0 680		

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0 680	Continued From page 15 content. In addition, the licensee failed to post the EPP in a prominent area available to residents, staff and visitors. This had the potential to affect all residents, staff, and visitors of the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on May 19, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated licensed assisted living director (LALD)-I was responsible for developing and updating the licensee's EPP; however, LALD-I was currently on medical leave and to refer to executive director (ED)-A with any questions. During the facility tour on May 19, 2026, 10:42 a.m., to 11:37 a.m., with CNS-B the surveyor did not observe the licensee's emergency preparedness plan or signage indicated where the emergency plan was located. CNS-B stated CNS-B was unsure where the licensee's EPP was kept and stated the EPP could be located in the business office or staff office, which both are locked when no in use. The licensee's emergency plan last review date of August 29, 2025, lacked the following information: -documentation of a quarterly review of the licensee's missing resident policy; -documentation of participation in an annual	0 680		

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0 680	Continued From page 16 full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise; or -an additional annual exercise that may include a second full-scale exercise or mock disaster drill or table-top exercise and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & revise plan as needed. During the exit survey on May 21, 2026, at 4:00 p.m., the surveyor informed ED-A and housing manager (HM)-C, if the missing emergency preparedness information noted above was located, the license could send the documents to the surveyor via email for review by the end the next day (May 22, 2026). On May 21, 2026, p.m., at 5:33 p.m., the surveyor received an email from HM-C that included a document titled AWAIR: Home Safety, Emergency Response, and Evacuation Plan revised April 2019; however, the information provided did not include missing EPP information noted above. The licensee's undated Essential Guide Assisted Living in Minnesota Volume 2: Clinical Polices and Procedures indicated the health care system's unified emergency preparedness program should be updated each time a facility leaves or enters the health care system's program. The integrated program should demonstrate that each separate facility included in the program actively participated in the program's development, and each facility should designate personnel to collaborate with the health care system to develop the plan. This participation should be documented. All components of the emergency preparedness	0 680		

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0 680	Continued From page 17 program that are reviewed annually should include all participating facilities, and each facility should be able to prove that it was involved in annual reviews and updates. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the	0 775		

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0 775	Continued From page 18 physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 775		
0 780 SS=I	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced	0 780		

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0 780	Continued From page 19 by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 780		
0 800 SS=I	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program.	0 800		

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0 800	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 800		
0 810 SS=I	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	0 810		

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0 810	Continued From page 21 or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. 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	0 810		

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0 810	Continued From page 22 issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated May 19, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 810		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview and record	01290		

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01290	Continued From page 23 review, the licensee failed to ensure the employee's current background study clearance was affiliated with the correct health care facility identification number (HFID) for two of five employees (cook (C)-F, maintenance (M)-G). This had the potential to affect all residents living within the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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 May 19, 2026, at 9:43 a.m., housing manager (HM)-C stated the license was familiar with the required contents in an employee record. C-F C-F was hired on November 23, 2022, to provide dietary services for the residents at the assisted living. During the course of the survey May 19, 2026, through May 21, 2026, the surveyor observed C-F prepare resident meals at the assisted living facility. C-F's employee record contained a Department of Human Services (DHS) Background Study Clearance letter dated November 30, 2022, under the licensee's main corporation and not the licensee's HFID 30422.	01290		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01290	Continued From page 24 M-G M-G was hired February 11, 2026, to provide facility maintenance duties at the assisted living facility. During the course of the survey, May 19, 2026, through May 21, 2026, M-G was observed performing maintenance duties at the assisted living facility. M-G's employee record contained a DHS Background Study Clearance letter dated February 12, 2026, under the licensee's main corporation and not the licensee's HFID 30422. On April May 20, 2026, at 3:30 p.m., assisted living direction in residency (ALDIR)-D stated the licensee was unaware maintenance staff background studies were required to be affiliated with each site performing maintenance duties. The licensee's Personnel Records policy dated January 2025, indicated the personnel record for each person would include a completed background study. The licensee's Employee Hire and Training Procedure policy dated January 2025, indicated upon hire, each employee would successfully pass a background study per Minnesota statute. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01550 SS=F	144G.64 (a) (4) Training in Dementia, Mental Illness, and De-	01550		

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01550	Continued From page 25 (4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure two of two non-direct care employees (cook (C)-F) and (maintenance (M)-G) received the required amount of initial mental illness and de-escalation training in the required time frame. In addition, the licensee failed to ensure one of two employees (M-G) completed four hours of initial dementia training upon hire, and one of two employees (C-F) received annual dementia training for each 12 months of employment. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	01550		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01550	Continued From page 26 The findings include: During the entrance conference on May 19, 2026, at 9:43 a.m., housing manager (HM)-C stated the license was familiar with the required contents in an employee record. C-F C-F was hired on November 23, 2022, to provide dietary services for the residents at the assisted living. During the course of the survey May 19, 2026, through May 21, 2026, the surveyor observed C-F prepare resident meals at the assisted living facility. C-F's employee record indicated C-F completed 1.25 hours out of the required two hours of mental illness and de-escalation training. In addition, C-F's record lacked evidence C-F completed two hours of annual dementia training for each 12 months of employment. M-G M-G was hired February 11, 2026, to provide facility maintenance duties at the assisted living facility. During the course of the survey, May 19, 2026, through May 21, 2026, M-G was observed performing maintenance duties at the assisted living facility. M-G's employee record lacked evidence M-G completed two hours of initial training on mental illness and de-escalation. In addition, M-G's record lacked M-G completed initial four hours of dementia training within 160 hours of employment start date.	01550		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01550	Continued From page 27 On May 20, 2026, at 3:30 p.m., assisted living director in residency (ALDIR)-D stated the licensee was not aware maintenance staff were required to have training in mental illness, de-escalation, and dementia. ALDIR-D stated C-F's Educare transcript (online training program) did not indicate C-F completed two hours of annual dementia training in 2024 or 2025. The licensee's Assisted Living-Dementia Care Training policy dated January 2025, indicated non-direct care staff would complete minimum of four hours of initial training on dementia care topics upon orientation and a minimum 2 (two) hours of training on topics related to dementia care for each 12 months of employment thereafter. The policy did not address training on mental illness or de-escalation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01550		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and	01650		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01650	Continued From page 28 (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for one of two residents (R3). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 19, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B stated licensed assisted living director (LALD)-I	01650		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01650	Continued From page 29 who was currently out on medical leave, was the primary person responsible for maintaining resident services plans and CNS-B recently took over the responsibility. R3's diagnoses included type II diabetes, schizophrenia and chronic obstructive pulmonary disease. On May 20, 2026, at 7:21 a.m., the surveyor observed CNS-B monitoring R3's blood glucose (sugar) and obtain a reading of 115 milligrams per deciliter (mg/dl). R3's Provider Orders dated March 27, 2026, included blood glucose monitoring daily. R3's May 2025, indicated R3 was scheduled and received daily blood glucose monitoring. R3's Treatment and Therapy Plan Assessment as of May 20, 2026, did not indicate R3 received any treatment or therapy services. R3's Service Plan dated April 9, 2025, indicated R3 received assistance medication administration, activities of daily living, weekly vital signs monitoring, behavior monitoring, cigarette safety checks, housekeeping and laundry; however, R3's service plan did not include R3 received daily blood glucose monitoring. On May 21, 2026, at 1:55 p.m., CNS-B stated R3's service plan should include daily blood glucose monitoring and was unsure why it was missing from R3's service plan. The licensee's Contents of Service Plan policy dated January 2025, indicated all assisted living	01650		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01650	Continued From page 30 residents would have an up-to-date service plan identifying services to be provided based on the assessment by the RN and or other licensed health professional. The service plan would include: -a description of the services provided fees for services; -frequency of each service according to resident assessment and resident preferences; -schedule and methods of monitoring assessments Schedule and methods of monitoring staff providing services; and -a contingency plan. The service plan and revision would be entered into the resident record and residents would be notified of changes to fees for service when applicable. The licensee's policy on service plans was requested and not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and	01790		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01790	Continued From page 31 (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the	01790		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01790	Continued From page 32 completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to ensure unlicensed personnel (ULP) were trained and had demonstrated competency to prepare and give medications for residents having unplanned time away. 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 May 19, 2026, at 9:46 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated the licensee provided medication management to residents at the facility. ULP-E was hired January 20, 2026, to provide direct care services to residents at the assisted living facility.	01790		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01790	Continued From page 33 On May 20, 2026, at 1:13 p.m. through 1:20 p.m., the surveyor observed ULP-E prepare and administer resident medications. ULP-E's employee record lacked evidence to indicate ULP-E had been trained and demonstrated competency to provide medications to residents for unplanned time away from the facility. On May 21, 2026, at 12:22 p.m., CNS-B stated CNS-B would prepare resident medications for a residents planned time away from the facility if CNS-B was notified in advance. CNS-B stated the licensee did not have specific employee training on preparing medications to be sent with residents and would train at the time if needed. CNS-B stated the procedure for preparing and sending resident medications was set-up in Residex (electronic medical record) to guide staff. The licensee Training ULP for Medication, Treatment, and Therapy Administration policy dated January 2025, indicated before the RN delegated the task of administration, treatment and therapy, the RN would instruct the unlicensed personnel on performing these tasks and determine the unlicensed personnel as competent to perform the tasks. The RN would document the training and competency of unlicensed personnel to competently administer each type of service they are assigned in the staff's personnel record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01950	Continued From page 34	01950		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing, specific instructions for each resident and documented those instructions in the resident's record for two of three residents (R2, R3) who received treatment and therapy services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more	01950		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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01950	Continued From page 35 than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on May 19, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated the licensee provided treatment and therapy services to residents at the facility. R2 R2's diagnoses included hypoxia (low oxygen levels in the body), chronic obstructive pulmonary disease, sleep apnea and diabetes type II. On May 20, 2026, at 6:26 a.m., the surveyor observed R2 with oxygen on via nasal cannula (flexible tube with two prongs, which delivers oxygen through the nose) and observed CNS-B monitoring R2's blood glucose (sugar) with a reading of 233 milligrams per deciliter (mg/dl). R2's Provider Orders August 22, 2025, included continuous oxygen at 3.5 liters per minute (LPM) and monitor oxygen saturation level twice a day and if oxygen level is below 90 percent or less, to check the as needed (PRN) book for resident specific instructions and notify RN. R2's Planned Services dated May 21, 2026, indicated staff were to monitor R2's oxygen saturation level and instructions directed to place oximeter on finger until reading appears on the unit. If oxygen level is 90 percent or less, check in the PRN book for resident specific instructions and notify the RN. On May 21, 2026, at 11:29 a.m., unlicensed	01950		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 36 personnel (ULP)-J stated ULP-J was unaware of a PRN book with resident instructions. ULP-J reviewed information binders in the nurses office and was unable to find PRN instructions for R2's oxygen saturation instructions as indicated in R2's EMR (electronic medical record). On May 21, 2026, at 12:38 p.m., CNS-B reviewed R2's oxygen saturation instructions and stated she not aware of a PRN book for further instructions for staff to refer to if R2's oxygen saturation level was below 90 percent. CNS-B reviewed R2's oxygen saturation readings and verified several dates where R2's oxygen levels were below 90 percent and lacked documentation ULPs notified the RN. R3 R3's diagnoses included type II diabetes. On May 20, 2026, at 7:21 a.m., the surveyor observed CNS-B monitoring R3's blood glucose and obtain a reading of 115 mg/dl. R3's Provider Orders dated March 27, 2026, included blood glucose monitoring daily. R3's May 2025, indicated R3 was scheduled and received daily blood glucose monitoring. R3's Treatment and Therapy Plan Assessment as of May 20, 2026, did not indicate R3 received any treatment or therapy services. R3's Service Plan dated April 9, 2025, did not include R3 received daily blood glucose monitoring. On May 21, 2026, at 1:55 p.m., CNS-B stated R3's provider did not set blood glucose	01950		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01950	Continued From page 37 parameters for R3 and was taking oral medications to manage diabetes. CNS-B stated R3's EMR had instructions in place when R3's blood glucose level fell below 70 mg/dl; however, did not list parameters to notify the RN when R3's blood glucose level was high. The licensee's Administration of Medications Treatment, and Therapy by ULP policy dated January 2025, indicted unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: -documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR; and -the procedure for staff to notify the RN of any medications or dietary supplements that are being used by the resident and that are not included in the assessment for med management services. The licensee's Delegation of Nursing Tasks policy dated January 2025, indicated a registered nurse (RN) may delegate medication administration to unlicensed personnel only after the RN has developed specific written instructions for each resident and documented those instructions in the resident's medication record/MAR. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

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	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01960	Continued From page 38	01960		
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 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 observation, interview, and record review, the registered nurse (RN) failed to ensure treatment services were documented as administered as prescribed, or to document the reason they were not provided for one of two residents (R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on May 19, 2026, at 9:43 a.m., clinical nurse supervisor (CNS)-B and housing manager (HM)-C stated the licensee provided treatment and therapy services to	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30422	A. BUILDING: _____ B. WING _____	05/21/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 39 residents at the facility. R2's diagnoses included hypoxia (low oxygen levels in the body), chronic obstructive pulmonary disease and sleep apnea. On May 20, 2026, at 6:26 a.m., the surveyor observed R2 with oxygen on via nasal cannula (flexible tube with two prongs, which delivers oxygen through the nose). CNS-B was observed monitoring R2's blood glucose (sugar) with a reading of 233 milligrams per deciliter (mg/dl). R2's Provider Orders August 22, 2025, included continuous oxygen at 3.5 liters per minute (LPM) and monitor oxygen saturation level twice a day and if oxygen level is below 90 percent or less, to check the as needed (PRN) book for resident specific instructions and notify RN. R2's Planned Services dated May 21, 2026, indicated staff were to monitor R2's oxygen saturation level and instructions directed to place oximeter on finger until reading appears on the unit. If oxygen level is 90 percent or less, check in the PRN book for resident specific instructions and notify the RN. R2's Vital Signs report dated April 1, 2026, through May 21, 2026, indicted R2's oxygen saturation levels were below 90 percent all the way down to 67 percent and R2's record lacked documentation the RN was notified as directed 17 times in April and 11 times in May. R2's resident notes dated December 1, 2025, through May 20, 2026, did not indicate the RN was notified of R2's oxygen saturation levels below 90 percent on the dates indicated above.	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01960	Continued From page 40 On May 21, 2026, at 11:29 a.m., ULP-J stated ULP-J was unaware of a PRN book with resident instructions. ULP-J reviewed information binders in the nurses office and was unable to find PRN instructions for R2's oxygen saturation instructions as indicated in R2's EMR (electronic medical record). On May 21, 2026, at May 21, 2026, at 12:38 p.m., CNS-B reviewed R2's oxygen saturation instructions and stated she not aware of a PRN book for further instructions for staff to follow if R2's oxygen saturation level was below 90 percent. CNS-B reviewed R2's oxygen saturation readings and verified several dates where R2's oxygen levels were below 90 percent and lacked documentation ULPs notified the RN. The licensee's Administration of Medications Treatment, and Therapy by ULP policy dated January 2025, indicted unlicensed personnel that would provide assistance with medication, treatment and therapy administration would be trained and competency tested by the RN on the following: -documentation, after assistance with self-administration of medications or medication, treatment and therapy administration, consistent with our facility's procedures for documenting the MAR; and -the procedure for staff to notify the RN of any medications or dietary supplements that are being used by the resident and that are not included in the assessment for med management services. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30422	A. BUILDING: _____ B. WING _____	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVENUE DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

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

WESLEY RESIDENCE OF DULUTH
5601 GRAND AVENUE
Duluth, MN 55807
St Louis County
Parcel:

Phone:

License Info

License: HFID 30422

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

Inspection Info

Report Number: F8010261074
Inspection Type: Full - Single
Date: 5/19/2026 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 2
Delivery: Emailed

New Order: 2-100 Supervision
2-102.12AMN *Priority Level: Priority 3 CFP#: 2*
MN Rule 4626.0033A Employ a certified food protection manager (CFPM) for the establishment.
COMMENT: ESTABLISHMENT DOES NOT HAVE A CURRENT CERTIFIED FOOD PROTECTION MANAGER.

STACY WADE HAD TAKEN A SERV SAFE CLASS 01/15/2024 HOWEVER AN APPLICATION FOR THE MINNESOTA CERTIFIED FOOD PROTECTION MANAGER HAD NOT BEEN COMPLETED WITHIN 6 MONTHS OF PASSING THE SERV SAFE EXAM.

ENROLL AN EMPLOYEE IN A FOOD SAFETY CLASS AND COMPLETE THE MINNESOTA CERTIFIED FOOD PROTECTION MANAGER APPLICATION ON LINE WITHIN 6 MONTHS OF PASSING THE FOOD SAFETY CLASS.

Comply By: 5/19/2026 Originally Issued On: 5/19/2026

New Order: 4-300 Equipment Numbers and Capacities
4-302.12B *Priority Level: Priority 2 CFP#: 36*
MN Rule 4626.0705B Provide a readily accessible food temperature measuring device with a small diameter probe to measure the temperature in thin foods such as meat patties and fish fillets.
COMMENT:
Comply By: 5/26/2026 Originally Issued On: 5/19/2026

New Order: 6-500 Physical Facility Maintenance/Operation and Pest Control
6-501.12A *Priority Level: Priority 3 CFP#: 55*
MN Rule 4626.1520A Clean and maintain all physical facilities clean.
COMMENT: THERE IS FOOD DEBRIS ON THE KITCHEN WALLS BEHIND SERVING AREA TABLE AND BEHIND DRY STORAGE SHELVING AND DUST ON THE WALL ABOVE THE STOVE. CLEAN AND MAINTAIN CLEAN.
Comply By: 6/1/2026 Originally Issued On: 5/19/2026

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.

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

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 F8010261074 from 5/19/2026

Deborah Kosiak

Stacy Wade

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

WESLEY RESIDENCE OF DULUTH
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261074
Inspection Type: Full
Date: 5/19/2026
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: PEAS**; Temperature Process:** Hot-Holding
Location: Stove at 203 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RED SAUCE**; Temperature Process:** Hot-Holding
Location: Stove at 187 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: NOODLES**; Temperature Process:** Hot-Holding
Location: Counter at 183 Degrees F.
Comment: JUST TAKEN OFF STOVE FOR SERVING
Violation Issued?: No

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

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

Food Temperature: Product/Item/Unit: MILK**; Temperature Process:** Cold-Holding
Location: Upright Cooler/5070 REFRIGERATOR at 41 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: ORANGE JUICE**; Temperature Process:** Cold-Holding
Location: Upright Cooler/ABC COMMERCIAL at 35 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: FOODS FROZEN**; Temperature Process:** Cold-Holding
Location: Upright Freezer/ADVANTCO 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

WESLEY RESIDENCE OF DULUTH
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261074
Inspection Type: Full
Date: 5/19/2026
Time: 10:30:00 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 100 PPM
Comment:
Violation Issued?: No

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

Minnesota (MDH) Version
EH Manager; RPT: F8010261074

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 5/19/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
WESLEY RESIDENCE OF DULUTH	5601 GRAND AVENUE	Duluth, MN	55807	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30422		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	OUT	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/O	Proper cooling time and temperature		
21	IN	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	IN	Approved thawing methods used		
36	X	Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
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	X	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:

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30422016	**Date:** 5/18/2026
Facility Name: Wesley Residence of Duluth	
Facility Address: 5601 Grand Avenue Duluth, MN 55807	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Lighted matches, cigarettes, cigars or other burning object shall not be discarded in such a manner that could cause ignition of other combustible material. [Minn. Stat. 144G.45 subd. 2; MSFC 310.7]

   Comments: *There was a designated smoking area in the back of the building for the residents with a cigarette butt receptacle provided, but the ground had several cigarette butts lying around. There was evidence of smoking in the breezeway on the second floor and at some of the other exits. These areas were not designated smoking areas, and residents would leave cigarette butts lying around on the ground. There also cigarette butt lying in the garbage can in resident room 225 and cigarette butts on the nightstand in resident room 216.*

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

   Comments: All of the smoke alarms in the resident bedrooms were outdated and older than 10 years.

☒ **TAG IDENTIFICATION: 0780**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments: Resident rooms 215, 216, 217, 218, 219, 220, 221 and 222 had adjoining rooms with shared bathrooms. The smoke alarms in these rooms were not interconnected with its adjoined room that it shared a bathroom with.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

   Comments:
   Resident rooms 108, 110, 213, 215 and 221 had severely soiled carpet.

   The bathroom across from resident room 223 had the light cover coming off. This same bathroom had paint coming off the ceiling.

   Resident rooms 224, 232 and 233 had garbage and personal belongings piled on the floor and were blocking the way of egress.

   Resident rooms 102, 214 and 218 had paint coming off the walls.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 3; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that are readily available at all times within the facility. [Minn. Stat. 144G.45 subd.2]

   Comments: The fire safety and evacuation plans were requested on May 18, 2026, but were not provided at the time of the survey. Housing manager (HM)-C emailed the FSEP documentation to the surveyor on May 21, 2026, three days after the onsite survey.

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

Comments: This FSEP that was provided by HM-C in the email had "AHL Healthcare Group" as the title, which represented all of the facilities that were under this company name. The FSEP was general and did not address specific actions that the employees at Wesley Residence would take in the event of a fire emergency. The policy referenced other resources such as a PAPP which was not provided for review.

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

   Comments: The FSEP did not identify specific fire protection actions for residents. There was no section in the policy that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency.

4. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. [Minn. Stat. 144G.45 subd.2]

   Comments: The FSEP failed to provide specific procedures for resident movement and evacuation or relocation during a fire or similar emergency including individualized unique needs of residents. The plan included instructions to evacuate residents but did not include any procedures for assisting residents during evacuation nor did it include instructions for staff to follow in case of relocation.

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

   Comments: The training documentation that was provided for employees did not cover site specific training. (HM)-C lacked documentation showing any training was completed or training was scheduled for a future date for staff on the FSEP.

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: HM-C failed to provide documentation showing any training was offered or training was scheduled for a future date for residents on the FSEP.