Electronically Delivered

April 10, 2026

Licensee
Lakeside Manor
4831 London Road
Duluth, MN 55804

RE: Project Number(s) SL30409016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 18, 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 - $500.00
St - 0 - 0780 - 144g.45 Subd. 2 (a) (1) - Fire Protection And Physical Environment - $500.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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: SL30409016-0 On March 16, 2026, through March 18, 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 35 residents; 35 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 March 17, 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		
0 510 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 establish and maintain an effective infection control program to comply with accepted health care, medical, and nursing standards for infection control for seven of seven residents (R2, R6, R7, R8, R9, R10, R11) who received blood glucose monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 510		

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0 510	Continued From page 4 The findings include: During the entrance conference on March 16, 2026, at 11:06 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided blood glucose monitoring for the residents of the facility. CNS-B stated the resident's blood glucose meter and supplies were kept in the office, residents came into the office and were able to check their own blood glucose under staff supervision. The licensee's Current Resident Roster dated March 16, 2026, identified seven residents (R2, R6, R7, R8, R9, R10, R11) who received blood glucose monitoring. On March 17, 2026, at 7:17 a.m., the surveyor observed R2 enter the office and collect his blood glucose meter from the basket sitting on a table which was stored with along with other resident's blood glucose meters. R2 cleansed his finger with an alcohol prep pad then poked his finger with a lancet and obtained a blood sample onto the test strip. ULP-C recorded R2's blood glucose results of 111 milligrams per deciliter (mg/dl). R2 placed the blood glucose supplies back into basket (without sanitizing), then self-injected prescribed insulin into abdomen. R2 discarded insulin supplies and exited the office. The surveyor did not observe unlicensed personnel (ULP)-C or R2 disinfect the table before or after R2 checked his blood glucose and no disinfecting supplies were observed on the table or near the blood glucose supplies. ULP-C stated there were usually disinfecting wipes on the table and found the disinfecting wipes that fell behind the table where the resident's blood glucose supplies were stored. The disinfecting wipes used to disinfect surfaces after residents checked their blood glucose was a tub of	0 510		

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0 510	Continued From page 5 Members Mark Disinfecting Wipes, which indicated it killed 99.9% of bacteria including cold, flu and COVID-19 viruses; however, did not indicate the disinfecting wipes being used were appropriate to disinfect surfaces to reduce the risk of transmission of bloodborne pathogens. On March 17, 2026, 11:14 a.m., CNS-B stated staff should be disinfecting surfaces before and after residents checked own blood glucose. CNS-B further stated, each blood glucose meter case should be disinfected after use before storing with other resident blood glucose meters. CNS-B stated CNS-B was unaware what disinfecting wipes were being used to appropriately disinfect surfaces. The licensee's Disinfecting Reusable Equipment and Environmental Surfaces policy dated July 26, 2014, reusable equipment and environmental surfaces would be properly disinfected after use. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 630 SS=F	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	0 630		

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0 630	Continued From page 6 and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. 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 three of four residents (R2, R4, 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 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 March 16, 2026, at 11:06 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. R2 R2's diagnoses included diabetes, hypertension (HTN-high blood pressure), metabolic encephalopathy (brain has trouble working due to chemical or metabolic problem). R2's Service Plan (Waiver)-Addendum to Contract dated July 22, 2024, indicated R2's services included medication administration, blood glucose monitoring, safety checks,	0 630		

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0 630	Continued From page 7 behavior monitoring, housekeeping and laundry. On March 27, 2026, at 7:11 a.m., the surveyor observed unlicensed personnel (ULP)-C administering R2's scheduled morning medication. R2's 90 Day Assessment dated January 6, 2026, indicated R2 was not at risk to abuse other vulnerable adults or at risk of self abuse; however, did not include an assessment or review of R2's susceptibility to abuse by another individual. R4 R4's diagnoses included major depressive disorder, chronic pain and chronic obstructive pulmonary disease (COPD). R4's Service Plan (Waiver)- Addendum to Contract dated July 14, 2025, indicated R5's services included medication administration, blood pressure monitoring, housekeeping, laundry, and behavior monitoring. On March 17, 2026, at 7:10 a.m., the surveyor observed ULP-C administering R4's scheduled morning medications. R4's IAPP dated March 18, 2026, did not include an assessment of R4's risk to be abused, risk of abusing other vulnerable adults or risk of self-abuse. R5 R5's diagnoses included major depressive disorder, chronic pain and COPD. R5's Service Plan (Waiver)- Addendum to Contract dated July 14, 2025, indicated R5's	0 630		

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0 630	Continued From page 8 services included medication administration, blood pressure monitoring, housekeeping, laundry, and behavior monitoring. On March 17, 2026, at 7:09 a.m., the surveyor observed ULP-C administering R5's scheduled morning medications. R5's IAPP dated October 1, 2025, indicated R5 was not at risk to abuse other vulnerable adults or risk of self-abuse; however, did not include an assessment or review of R5's susceptibility to abuse by another individual. On March 18, 2026, at 11:00 a.m., CNS-B stated she was not aware the licensee's IAPP assessments/evaluation did not include a review of a resident's susceptibility to abuse by another individual. CNS-B stated the licensee would have to contact Residex (electronic health record) to add question. The licensee's Vulnerable Adult Maltreatment policy dated August 1, 2021, indicated each resident receiving nursing services would have a written individualized abuse prevention plan. The plan would include: -resident's positional to abuse by another individual/vulnerable adult; -resident's risk of abusing other vulnerable adults; -interventions to minimize the risk of abuse to the resident and other vulnerable adults. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630		

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0 640	Continued From page 9	0 640		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content in common areas to include the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557 at the assisted living. 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 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:	0 640		

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0 640	Continued From page 10 During the entrance conference on March 16, 2026, at 11:06 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. During the facility tour on March 16, 2026, at 12:44 p.m., with LALD-A, the surveyor did not observe any posting with the emergency number for MAARC posted within the building. LALD-A stated LALD-A had thought all required postings were posted in the building. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 650 SS=D	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following 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	0 650		

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0 650	Continued From page 11 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 an employee record contained the required content for one of three employees (unlicensed personnel (ULP)-C). 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 March 16, 2026, at 11:06 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee was familiar with current minimum assisted living requirements. ULP-C was hired January 26, 2009, under the previous comprehensive license and began to provide assisted living services to residents at the facility August 1, 2021. ULP-C's employee record included a Performance Review dated July 31, 2024. ULP-C's employee record lacked evidence an annual performance review had been completed	0 650		

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0 650	Continued From page 12 for 2025. On March 17, 2026, at 2:12 p.m., LALD-A stated LALD-A was responsible for completing employee annual performance reviews and had not completed ULP-C's annual review for 2025. LALD-A stated LALD-A was aware of the requirement. The licensee's Personnel Records policy dated August 1, 2021, indicate personnel records would be kept up-to-date, well organized and confidential and would comply with the assisted living law and other relevant laws. The personnel recorded for each person would include: -performance evaluations which identify areas of improvement needed and training needs. Performance review must be conducted at least annually. 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;	0 680		

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0 680	Continued From page 13 (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 content. This had the potential to affect all 35 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 entrance conference on March 16, 2026, at 11:06 a.m., licensed assisted living director (LALD)-A stated they was responsible for managing and maintaining the licensee's emergency preparedness plan.	0 680		

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0 680	Continued From page 14 The licensee's Disaster Plan dated January 2026 lacked the following information: - a completed facility Hazard Vulnerability Assessment; -documentation of a quarterly review of the licensee's missing resident policy; - a communication plan that included: -written arrangement agreements with other facilities; -contact information for Minnesota office of Ombudsman; -emergency prep testing requirements to include: -participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of plan, facility is exempt from engaging in its next required full-scale exercise; -or an additional annual exercise that may include: a second full-scale exercise that is community-based or an individual, facility based functional 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. On March 18, 2026, at 10:25 a.m., LALD-A reviewed the licensee's emergency plan and confirmed the licensee did not have the following information noted above identified in the licensee's emergency preparedness plan. The licensee's Disaster Plan dated January 2026, indicated the purpose of the plan was to continue to provide quality care to residents of the licensee during times of major emergencies and/or disasters when such events are reasonably believed to be pending by maintaining close coordination and planning links with local	0 680		

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0 680	Continued From page 15 emergency response organizations on an ongoing basis. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z-Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=F	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 two violation (a violation that did not harm a resident's health or	0 775		

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0 775	Continued From page 16 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) day	0 775		
0 780 SS=F	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	0 780		

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0 780	Continued From page 17 the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) day	0 780		

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0 790 SS=F	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota	0 790		

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0 790	Continued From page 19 Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) day	0 790		
0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 800		

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0 800	Continued From page 20 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) day	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive 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	0 810		

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0 810	Continued From page 21 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 two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 17, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all	01880		

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01880	Continued From page 22 prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained bearing the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. In addition, the licensee failed to ensure medications were maintained to include the opened date and expiration date for time sensitive medications stored by the licensee and failed to monitor for expired medications being managed and stored by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 16, 2026, at 11:06 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication storage for the residents at the facility. CNS-B stated nurses monitor medication carts with every pharmacy medication change over and all staff should be checking medications for expiration dates while preparing medications to be	01880		

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01880	Continued From page 23 administered. On March 16, 2026, at 1:04 p.m., the surveyor reviewed the medication cart and a shelf where resident medications were being stored with unlicensed personnel (ULP)-C and observed the following: NO ORIGINAL PRESCRIPTION LABEL -an unopened package of 30 ipratropium bromide (used to treat shortness of breath) three milliliter (ml) single vials lacked the original prescription label with information regarding the direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued; and -an opened Desitin (barrier cream) lacked the original prescription label with information regarding direction for use, medication name, medication dosage, resident's name, and the pharmacy in which it had been issued. TIME SENSITIVE MEDICATIONS -an opened Breztri inhaler (used to treat asthma symptoms) lacked the date the inhaler had been opened and when the inhaler would expire. EXPIRED MEDICATIONS -an opened bottle of simethicone (used for gas relief) expired February 2026; -an opened bottle of senna plus 8.6 mg (used for constipation) expired February 2026; -an opened bottle of Naproxen 220 mg (used for pain) expired February 2026; -an opened bottle of Tums (used for gastric upset) expired December 2025; -two opened bottles of GaviLAX powders (used for constipation) expired November 2025; and -an unopened Desitin tube (barrier cream) expired October 2025.	01880		

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01880	Continued From page 24 On March 17, 2026, at 11:17 a.m., CNS-B stated staff should be writing the date on the label when a medication is opened and if a medication does not have a prescription label, staff should be notifying the nurse. The manufacturer's instructions for use of Breztri inhaler dated January 2022, directed to throw away the inhaler three weeks after the inhaler had been removed from the foil pouch. The licensee's Central Storage of Medications policy dated July 14, 2014, indicated no unlabeled drugs or pharmaceutical substances would be allowed in the building. All Legend (prescription) medications that were centrally stored in the RN's office or med cart would be kept in their original containers bearing the original prescription label with legible information stating the prescription number, name of the drug, strength and quantity of the drug, expiration date of a time-dated drug, directions for use, the client's name, the prescriber's name, the date of issue, and the name and address of the dispensing pharmacy. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) day	01880		
01910 SS=F	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been	01910		

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01910	Continued From page 25 discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record the required content on disposition of the medications for one of one resident (R1) upon discharge. 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 16, 2026, at 11:06 a.m., clinical nurse supervisor (CNS)-B stated when destroying resident medications, CNS-B mixed the medications with	01910		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01910	Continued From page 26 water and kitty litter and only documented the destruction of narcotic medications (class of drugs to manage severe pain). The licensee's Discharged Resident/Client Roster dated January 1, 2025, to December 31, 2025, indicated R1 was admitted to the facility on October 15, 2024, and was discharged on August 19, 2025, to a higher level of care. R1's diagnosis included mild cognitive impairment. R1's Service Plan (Waiver)-Addendum to Contract dated November 18, 2024, indicated R1 received medication management services. R1's July 2025, Medication Administration Summary indicated R1 was administered the following medications: -atorvastatin 20 milligrams (mg) one tablet daily used to treat high cholesterol; -divalproex 125 mg one capsule three times a day used for cognitive impairment; -gabapentin 100 mg one capsule three times a day used to treat depression; -metformin 500 mg one tablet twice a day used to treat diabetes; -tamsulosin 0.4 mg one capsule every evening used to treat urinary urgency; -famotidine 40 mg one tablet daily used to treat gastric reflux; -paroxetine 20 mg one table every morning and take with 20 mg tablet for total of 50 mg used to treat depression; -quetiapine 50 mg one-half tablet twice daily used to treat mild cognitive impairment; and -trazodone 100 mg one tablet at bedtime used to treat sleep disorder.	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
01910	Continued From page 27 R1's prescriber orders dated July 15, 2025, included R1's medications noted above. R1's Discharge-Transfer Summary dated August 19, 2025, indicated R1 had a witnessed fall and obtained a left humorous fracture July 19, 2025. R1 was hospitalized then went to a short-term rehabilitation center. R1 was admitted to a higher level of care facility due to R1's increased needs and use of a wheelchair. R1's discharge summary indicated R1's medications were destroyed with water and kitty litter. R1's record included documentation R1's 12-oxycodone (narcotic pain medication) 5 mg tablets were given to [name of care center] on September 18, 2025; however, R1's record lacked documentation of the disposition of the above medications to include the medication name, strength, quantity, prescription numbers as applicable, to whom the medications were given, date of disposition, and names of staff or other individuals involved in the deposition. On March 17, 2026, at 2:12 p.m., CNS-B stated CNS-B was unaware of the required documentation for the disposition of resident medications managed by the licensee. CNS-B stated CNS-B had only been documenting the destruction of narcotic medications and the destructions of discontinued resident medications. The licensee's Disposition or Disposal of Medication policy date July 30, 2014, indicated the disposal of unused or discontinued prescription drugs would include documentation of the destruction, listing the date, quantity, name of drug, prescription number, signature of person destroying the drugs and signature of witness to	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
01910	Continued From page 28 the destruction and must be recorded in the client's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
02320 SS=E	144G.91 Subd. 4 (b) Appropriate care and services (b) Residents have the right to receive health care and other assisted living services with continuity from people who are properly trained and competent to perform their duties and in sufficient numbers to adequately provide the services agreed to in the assisted living contract and the service plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide care and services according to acceptable health care medical or nursing standards for medication administration by one of one employee unlicensed personnel (ULP)-C, not following the medication administration procedure. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive).	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
02320	Continued From page 29 The findings include: During the entrance conference on March 16, 2026, at 11:06 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided medication management services for the residents at the facility. ULP-C had a hire date of January 26, 2026, under the licensee's previous comprehensive license and began to provide assisted living services to the residents at the facility August 1, 2021. ULP-C's employee record indicated ULP-C passed medication administration skills test on April 10, and April 14, 2009. ULP-C's record included a Staff Supervision Summary dated October July 14, 2025, that indicated CNS-B observed ULP-C administering resident medications and ULP-C was educated on making sure ULP-C completed three checks prior to administering resident medications. On March 17, 2026, at 7:09 a.m., the surveyor observed ULP-C prepare R5's scheduled morning medications. ULP-C pulled up R5's profile in Residex (electronic medical record) with the list of R5's medications to be administered. Without reviewing R5's medication list, UP-C set up R5's medications from bubble packs and Dispill (pre-filled medication packs from the pharmacy) and administered to R5. ULP-C did not verify each medication in the Dispill packets against R5's electronic medication record (EMR) to ensure accuracy of medications administered. The following medications were administered: -vitamin D3 -tab-a-vite	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
02320	Continued From page 30 -escitalopram 10 milligrams (mg); -escitalopram 20 mg; -haloperidol 5 mg; -levothyroxine 100 mg; and -pantoprazole 40 mg. After ULP-C administered R5's medications, ULP-C clicked the verified box for each medication then clicked completed (confirmed medications were administered). -At 7:10 a.m., the surveyor observed ULP-C prepare and administer R4's scheduled morning medications. ULP-C obtained R4's bubble packs and Dispill packs and dispensed medications into a medication cup and administered to R4. ULP-C handed R4 Trelogy inhaler and R4 inhaled one puff of the medication. ULP-C pulled up R4's profile from the EMAR with the listed R4's medications to be administered and checked the verified box of each medication then checked complete. ULP-C did not have R4's list of medications at the time ULP-C prepared R4's medications. -At 7:25 a.m., the surveyor observed ULP-C prepare and administer R12's scheduled morning medications. ULP-C pulled up R12's list of medications in Residex and dispense medications from the Dispill pack into R12's hand. ULP-C did not review each medication in R12's EMAR to the list of medications on the Dispill pack before ULP-C administered R12's medications. Immediately following R12's medication administration, ULP-C checked the verified box for each medication and then complete. ULP-C stated she didn't always compare the medication list in Residex against the medications listed on the Dispill or bubble packs because she worked full-time, was a long term employee, was familiar with each resident's	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
02320	Continued From page 31 medications and resident medications seldom changed. On March 17, 2026, at 11:15 a.m., CNS-B stated staff should review the list of medications in Residex with the medications list on the Dispill and bubble packs, check verified at the time of preparing medications, and after medications were administered, check complete. The licensee's Medication Administration Employee Skills Test for Oral Medications from monthly Bubble Cards directed the following procedure: -wash hands; -check orders on MAR, med container label/dosage box (3 times) per 5 Right's: -Right resident; -Right medication; -Right time & day; -Right dosage; -Right route; -administer medications to resident per 5 R's; and -document administration per the 5 R's. The licensee's Administration of Medication by Unlicensed Personnel policy dated July 21, 2014, indicated unlicensed personnel that satisfy the training requirements, have been determined competent to follow the procedures and have been delegated the responsibility by the registered nurse (RN), may administer medications, orally, by suppository, through eye drops, through ear drops, by use of inhalant or nebulizer, gastric tube, insulin injection or topically by following the RN's written instructions for administering the medications to the client. Medications always need to be administered according to the "6 Rights": a Right person	02320		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30409	A. BUILDING: _____ B. WING _____	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MANOR	4831 LONDON ROAD DULUTH, MN 55804

(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
02320	Continued From page 32 b. Right medication c. Right time d. Right route (by mouth, eye drops, to the skin, etc.) e. Right dose (how many milligrams, drops, etc) f. Right chart/record to document that the medication was taken No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02320		

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

Food & Beverage Inspection Report

Establishment Info

LAKESIDE MANOR
4831 London Rd

Duluth, MN 55804
St Louis County
Parcel:

Phone:

License Info

License: HFID 30409

Risk:
License:
Expires on:
CFPM: Daniel Thomas Pelfrey
CFPM #: 45344; Exp: 10/11/2028

Inspection Info

Report Number: F8010261056
Inspection Type: Follow-up - Single
Date: 4/1/2026 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS A FOLLOW-UP INSPECTION TO THE INSPECTION DONE ON 03/17/2026.

PREVIOUS ORDERS HAVE BEEN CLEARED.

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 F8010261056 from 4/1/2026

Deborah Kosiak

Bart Martinson

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

LAKESIDE MANOR
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261056
Inspection Type: Follow-up
Date: 4/1/2026
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: MILK/AURORA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 39 Degrees F.
Comment:
Violation Issued?: Yes

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

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

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

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

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

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

Minnesota (MDH) Version
EH Manager; RPT: F8010261056

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: 4/1/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
LAKESIDE MANOR	4831 London Rd	Duluth, MN	55804	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30409		Follow-up		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable — **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/O	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		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		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:

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

LAKESIDE MANOR
4831 London Rd

Duluth, MN 55804
St Louis County
Parcel:

Phone:

License Info

License: HFID 30409

Risk:
License:
Expires on:
CFPM: Daniel Thomas Pelfrey
CFPM #: 45344; Exp: 10/11/2028

Inspection Info

Report Number: F8010261043
Inspection Type: Full - Single
Date: 3/17/2026 Time: 10:30:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 3
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 2-300 Personal Cleanliness**
2-301.14A *Priority Level: Priority 1 CFP#: 8*
MN Rule 4626.0075A Food employees must wash their hands before: food preparation activities, including working with exposed food; touching clean equipment and utensils; touching unwrapped single-service and single-use articles.
COMMENT: OBSERVED AN EMPLOYEE EATING IN DINING AREA AND NOT WASHING HANDS WHEN ENTERING THE KITCHEN TO SERVE PLATED FOOD AND POURING MILK.
Comply By: 3/17/2026 Originally Issued On: 3/17/2026

! **New Order: 3-300B Protection from Contamination: cross-contamination, eggs**
3-302.11A(1) *Priority Level: Priority 1 CFP#: 15*
MN Rule 4626.0235A(1) Separate raw animal foods during storage, preparation, holding, and display from ready-to-eat foods to prevent cross-contamination.
COMMENT: RAW SHELL EGGS IN THE KITCHEN AURORA REFRIGERATOR WERE STORED ABOVE READY TO EAT FOODS AND FOOD CONTAINERS.

STORE RAW SHELL EGGS ON THE BOTTOM SHELF TO PREVENT CROSS-CONTAMINATION.
Comply By: 3/17/2026 Originally Issued On: 3/17/2026

New Order: 3-300C Protection from Contamination: equipment/utensils, consumers
3-304.12B *Priority Level: Priority 3 CFP#: 43*
MN Rule 4626.0275B Store the food preparation and dispensing utensil in a food that is not TCS food with the handles above the top of the food within containers or equipment that can be closed such as bins of sugar, flour or cinnamon.
COMMENT: A BOWL WAS USED FOR DISPENSING FLOUR.
PROVIDE A DISPENSING UTENSIL WITH A HANDLE.
Comply By: 3/17/2026 Originally Issued On: 3/17/2026

! **New Order: 3-500B Microbial Control: hot and cold holding**
3-501.16A2 *Priority Level: Priority 1 CFP#: 22*
MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.
COMMENT: THE TEMPERATURE OF MILK THAT HAD BEEN LEFT OUT AT ROOM TEMPERATURE DURING BREAKFAST WAS 42F.
MILK WAS DISCARDED.
Comply By: Complied On Site Originally Issued On: 3/17/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-305.11B *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1480B Provide lockers or other suitable facilities for the orderly storage of employees' clothing and other possessions.
COMMENT: AN EMPLOYEE'S JACKET AND OTHER PERSONAL ITEMS WERE STORED ON THE SAME SHELF THAT WAS USED FOR STORAGE OF CLEAN FOOD CONTAINERS.

PROVIDE ANOTHER PLACE FOR ORDERLY STORAGE OF PERSONAL CLOTHING AND OTHER PERSONAL ITEMS.

JACKET AND PERSONAL ITEMS WERE REMOVED.

DISCONTINUE STORING EMPLOYEES' PERSONAL FOOD ITEMS IN THE REFRIGERATOR USED TO STORE FOOD FOR THE ESTABLISHMENT.

PROVIDE A SEPARATE REFRIGERATOR FOR EMPLOYEES' FOODS ONLY.

Comply By: 3/27/2026 *Originally Issued On: 3/17/2026*

Food & Beverage General Comment

DISCUSSED THE EXCLUSION OF EMPLOYEE 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 AND AN ILLNESS LOG SHEET.

PASTEURIZED EGGS ARE USED WHEN MORE THAN ONE EGG IS BROKEN AND COMBINED SUCH AS FOR SCRAMBLED EGGS AND SERVED TO MORE THAN ONE PERSON.

DISTRIBUTED A HANDWASHING SIGN AND A VOMIT CLEANUP POSTER.

EMAILED A HANDWASHING FACT SHEET WITH THIS REPORT.

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 F8010261043 from 3/17/2026

Deborah Kosiak

Bart Martinson

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

LAKESIDE MANOR
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261043
Inspection Type: Full
Date: 3/17/2026
Time: 10:30:00 AM

Food Temperature: Product/Item/Unit: MILK/AURORA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 42 Degrees F.
Comment: MILK HAD BEEN SITTING OUT DURING BREAKFAST- MILK DISCARDED
Violation Issued?: Yes

Food Temperature: Product/Item/Unit: CHICKEN NUGGETS/TENDERS**; Temperature Process:** Cooking
Location: Oven at 203 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MAC & CHEESE**; Temperature Process:** Cooking
Location: Oven at 167 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MIXED VEGETABLES**; Temperature Process:** Cooking
Location: Stove at 207 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: MILK/AURORA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: CHICKEN NOODLE HOTDISH/AURORA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: RAW SHELL EGG**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HEAD LETTUCE/AMANA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 32 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: PREPACKAGED UNSLICED HAM/AMANA**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment:
Violation Issued?: No

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

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

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

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

Sanitizer Observations/Recordings

Establishment Info

LAKESIDE MANOR
Duluth
County/Group: St Louis County

Inspection Info

Report Number: F8010261043
Inspection Type: Full
Date: 3/17/2026
Time: 10:30:00 AM

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** WIPING CLOTH SINK
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 BLACK
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F8010261043

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	3	Date: 3/17/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
LAKESIDE MANOR	4831 London Rd	Duluth, MN	55804	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30409		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	OUT	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	OUT	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	IN	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	OUT	Proper cold holding temperatures	X	
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	IN	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43	X	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		Physical facilities installed, maintained & clean		
56	X	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: SL30409016	**Date:** 3/17/2026
Facility Name: Lakeside Manor	
Facility Address: 4831 London Rd. Duluth, MN 55804	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; 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. The means of egress shall be maintained free of obstructions or impediments to full instant use in case of fire or other emergency. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.2]

   Comments: The emergency exit doors going out the north and west exits on the second floor, did not have the snow removed so that there was a clear pathway leading to a public way.

3. Lighted matches, cigarettes, cigars or other burning objects 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: The wrap around porch had various designated smoking areas with cigarette butt receptacles provided at each site. There were cigarette butts and ashes lying on the wooden deck. There were also signs of cigarette burns on the wooden deck boards and on the cushion of the chairs.

☒ **TAG IDENTIFICATION: 0780**

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

1. Smoke alarms are provided in each room used for sleeping purposes. [Minn. Stat. 144G.45 subd.2]

   Comments: Resident room 104 smoke alarm was not working.

2. 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: The smoke alarms in the bedrooms and outside of the bedrooms were not interconnected with the other smoke alarms in the facility. There was a smoke alarm system in the common areas of the facility that was not connected to the bedroom smoke alarms.

☒ **TAG IDENTIFICATION: 0790**

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

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

   Comments: There was no documentation of the required monthly visual inspections of the fire extinguishers. Licensed assisted living director (LALD)-A stated that he did not know the requirements for staff doing monthly checks on the fire extinguishers.

☒ **TAG IDENTIFICATION: 0800**

SCOPE/ SEVERITY: Level 2; 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: The carpet in resident rooms 202, 206 and 207 had significant staining. The carpet in room 202 was torn. Resident room 205 had dark stains on the wall behind the radiator and the paint and sheet rock were missing.

☒ **TAG IDENTIFICATION: 0810**

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

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1. 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: 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 plan addressed staff as a whole with no specific directions on what staff should be doing when a fire safety emergency happens and that staff will take orders and direction from the fire department once they arrive.

2. 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 licensee failed to develop the fire safety and evacuation plan (FSEP) with unique or unusual needs for movement or evacuation for staff to assist residents in the event of a fire or similar emergency. LALD-A stated that they did not have this type of plan in place.

3. 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: LALD-A stated that staff get training on the fire and safety plan upon hire once per year. Training for staff is required to be completed upon hire and twice per year.

4. 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: LALD-A stated that residents get training on the fire and safety plan once per year but did not provide any documentation to support their statement.

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

   Comments: Evacuation drill documentation provided by LALD-A indicated that drills were being completed only twice a year. The fire drill log showed the drills being done on June 14, 2025, and September 11, 2025. LALD-A stated that he was not aware of the requirements for these drills.