Electronically Delivered

April 10, 2025

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

RE: Project Number(s) SL24431016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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 for widespread violations;
Level 3: a fine of $3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.
Level 4: a fine of $5,000 per incident, 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 - 0775 - 144g.45 Subd. 2 (a) - 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 $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

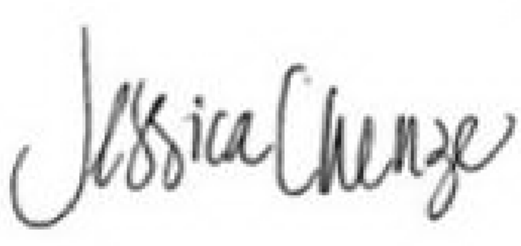
a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

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 Chenzie, 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
	24431	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL24431016-0 On March 11, 2025, through March 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 receiving services under the Assisted Living Facility with Dementia Care license.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated March 11, 2025, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
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 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 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).	0 550		

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0 550	Continued From page 4 The findings include: During the facility tour on March 11, 2025, at 11:18 a.m., the surveyor observed, and confirmed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the licensee's grievance procedure was not posted at the main entrance or within the facility. LALD/CNS-A stated the grievance procedure was normally posted on the wall at the main entrance and did not know why all the postings on the wall had been removed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
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 and interview, the licensee failed to post the required information related to	0 640		

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0 640	Continued From page 5 the reporting number for the Minnesota Adult Reporting Center (MAARC) and failed to post the 911 emergency number in common areas and near phones provided by the facility as required. 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 March 11, 2025, at 11:18 a.m., with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A, the 911 emergency number was not observed posted in common areas or near phones located in the facility or the information and reporting number for MAARC. LALD/CNS-A stated they were aware of the requirements and did not know why the postings had been taken down. LALD/CNS-A stated the information for MAARC was usually posted on the wall of the main entrance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment	0 775		

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0 775	Continued From page 6 Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to keep the facility in compliance with the Minnesota Fire Code. The deficient conditions have the ability to affect all staff and residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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). Findings include: On facility tour with the director of maintenance (DOM)-D on March 11, 2025, between 12:30 p.m. and 3:00 p.m. the following deficient conditions were observed: SMOKING: The surveyor observed that smoking is allowed outside the front door and on the back patio. They are utilizing a plastic container with sand in the bottom for the cigarette butts. An approved receptacle shall be provided at both locations and residents and employees shall be trained to use the receptacles. FIRE WALL:	0 775		

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0 775	Continued From page 7 The surveyor observed a hole in the required fire wall in the mechanical room. This hole shall be covered with the same rating required when the facility was built. SMOKE ALARMS: The surveyor observed the smoke alarms in the resident rooms were over 10 years old from date of manufacture. Smoke alarms over 10 years old from date of manufacture shall be replaced with like type alarms. CARBON MONOXIDE: The surveyor observed there was no carbon monoxide protection in the facility. Carbon monoxide protection shall be provided in the building to meet the Minnesota State Fire Code. The deficient conditions were visually verified by the DOM-D accompanying on the tour. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		
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	0 810		

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0 810	Continued From page 8 rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to document required fire safety evacuation training for residents as well as the required fire drills. This had the potential to directly affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 810		

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0 810	Continued From page 9 safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: A record review and interview were conducted on March 11, 2025, at approximately 2:30 p.m. with the regional director (RD)-B and director of maintenance (DOM)-D on the fire drills and training records for the residents. TRAINING: Record review indicated the licensee failed to complete and document training on the fire, safety and evacuation plan for the employees at new hire and twice a year there after and for the residents at least once a year. FIRE DRILLS: Record review indicated that one fire drill was completed and documented on 5/2/24. They are required to be completed two times per year on each shift and documented. TIME PERIOD FOR CORRECTION: Twenty-one (21) 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	01290		

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01290	Continued From page 10 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies (BGS) were submitted and a clearance received in affiliation with the assisted living licensee's current health facility identification (HFID) for five of 17 employees (regional director (RD)-B, director of maintenance (DOM)-D, licensed practical nurse (LPN)-I, unlicensed personnel (ULP)-J, ULP-K). This had the potential to affect all 10 residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to 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 11,	01290		

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01290	Continued From page 11 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and regional director (RD)-B stated they were aware of the required content of the employee record. The licensee's Employee Roster printed March 11, 2025, listed RD-B, DOM-D, LPN-I, ULP-J, and ULP-K as current employees of the licensee. R2 and R3's March 2025, Medication Administration Record and Services Delivered included ULP-J's initials indicating ULP-J provided care and services to R2 and R3. RD-B was hired on December 6, 2021, to provide direct care to the residents of the licensee. DOM-D was hired on August 23, 2023, to provide maintenance services for the licensee. LPN-I was hired on July 31, 2023, to provide direct care to the residents of the licensee. ULP-J was hired on May 12, 2023, to provide direct care to the residents of the licensee. ULP-K was hired on October 9, 2024, to provide direct care to the residents of the licensee. The Department of Human Services (DHS) NetStudy employee roster dated March 12, 2025, did not include RD-B, DOM-D, LPN-I, ULP-J, and ULP-K as current employees of the licensee or indicate RD-B, DOM-D, LPN-I, ULP-J and ULP-K had been affiliated with the licensee's HFID 24431. On March 11, 2025, at 9:35 a.m., LALD/CNS-A and RD-B stated they do not complete employee	01290		

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01290	Continued From page 12 BGS and were not aware the employees noted above had not been affiliated with the licensee's HFID. LALD/CNS-A stated agent/owners of the licensee had multiple locations and sometimes employees were hired at one location and worked at different houses. 144.057 BACKGROUND STUDIES ON LICENSEES AND OTHER PERSONNEL. Subdivision 1. Background studies required. (a) Except as specified in paragraph (b), the commissioner of health shall contract with the commissioner of human services to conduct background studies of: (1) individuals providing services that have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; (2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime	01290		

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01290	Continued From page 13 Information Center database; (3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services; (4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities; (5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70; and (6) license applicants, owners, managerial officials, and controlling individuals who are required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a background study under chapter 245C, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual. (b) The commissioner of human services shall not conduct a background study on any individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from	01290		

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01290	Continued From page 14 the entity's roster for NETStudy 2.0. (c) If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs. §Subd. 2. Responsibilities of Department of Human Services. The Department of Human Services shall conduct the background studies required by subdivision 1 in compliance with the provisions of chapter 245C. For the purpose of this section, the term "residential program" shall include all facilities described in subdivision 1. The Department of Human Services shall provide necessary forms and instructions, shall conduct the necessary background studies of individuals, and shall provide notification of the results of the studies to the facilities, supplemental nursing services agencies, individuals, and the commissioner of health. Individuals shall be disqualified under the provisions of chapter 245C. If an individual is disqualified, the Department of Human Services shall notify the facility, the supplemental nursing services agency, and the individual and shall inform the individual of the right to request a reconsideration of the disqualification by submitting the request to the Department of Health. The licensee's Background Checks policy dated April 17, 2023, indicated 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. All employees must pass a background study and all contractors or volunteers with direct resident contact are required to have a background study. "Direct	01290		

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01290	Continued From page 15 contact" means providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the program. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01470 SS=D	144G.63 Subd. 2 Content of required orientation (a) The orientation must contain the following topics: (1) an overview of this chapter; (2) an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; (3) handling of emergencies and use of emergency services; (4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC); (5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person; (7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health Facility Complaints; (8) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care	01470		

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01470	Continued From page 16 Ombudsman at the Department of Human Services, county-managed care advocates, or other relevant advocacy services; and (9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure. (b) In addition to the topics in paragraph (a), orientation may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure orientation to assisted living statutes included all the required content for one of two employees (unlicensed personnel (ULP)-C). This practice resulted in a level two violation (a	01470		

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01470	Continued From page 17 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 11, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and regional director (RD)-B stated they were aware of the required content of the employee record. On March 11, 2025, at 9:21 a.m., the surveyor observed ULP-C administering R6's scheduled medications. ULP-C was hired on January 20, 2025, to provide direct care services to the residents of the licensee. ULP-C's employee record lacked evidence ULP-C completed the following required assisted living orientation: -overview of 144G assisted living statutes; -an introduction and review of the facility's policies and procedures related to the provision of assisted living services by the individual staff person; -consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county-managed care advocates, or	01470		

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01470	Continued From page 18 other advocacy services. -a review of the types of assisted living services the employee will be providing and the facility's category of licensure; and -orientation to each specific resident and services provided. On March 13, 2025, LALD/CNS-A and RD-B stated the licensee assigned employee topics through CareAcademy (online based training program) and was assured the training program being used by the licensee met the assisted living orientation required content. RD-B was unable to provide evidence from the training syllabus the assigned training material met all the required content for assisted living orientation. The licensee's Assisted Living Orientation-ULP Staff policy dated April 17, 2023, indicated newly hired unlicensed personnel would receive orientation and training on topics required by Minnesota statues and rules for assisted living organizations. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01470		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;	01750		

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01750	Continued From page 19 (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R3) who received medication management 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 an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included pneumonia, acute respiratory failure and chronic obstructive pulmonary disease (COPD). R3's Service Plan-Modification dated February 2, 2025, directed to see R3's medication plan for medication services. R3's Medication Management Plan dated February 2, 2025, indicated R3 received assistance with medication administration. R3's Quarterly Assessment dated February 2,	01750		

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01750	Continued From page 20 2025, indicated R3 required assistance with medication administration and R3's self-administration of medications was not applicable. R3's hospital discharge orders dated December 10, 2024, included budesonide-formoterol (Symbicort) 160-4.6 micrograms (mcg) two puffs twice a day for COPD. R3's March 2025, electronic medication administration record (EMAR) indicated R3 was scheduled and received budesonide-formoterol fumarate (Symbicort) 160-4.5 mcg to inhale two puffs into the lungs two times a day; however, R3's record lacked instructions to rinse mouth after use of the inhaler and R3 was able to self-administer own inhaler. On March 12, 2025, at 9:29 a.m., the surveyor observed unlicensed personnel (ULP)-E administering R3's scheduled morning medications, then ULP-E handed R3 his inhaler to self-administer. R3 inhaled two consecutive puffs of the medication then handed the inhaler back to ULP-E. ULP-E did not remind R3 to rinse his mouth after the use of the inhaler. ULP-E documented medications administered in R3's EMAR. ULP-E stated there were no written instructions in R3's EMAR to direct R3 to rinse mouth after use of the inhaler or R3 was able to self-administer inhaler. On March 13, 2025, at 9:44 a.m., RN-G stated residents should be offered to rinse their mouth after the use of inhaler administration. RN-G further stated R3's EMAR did not indicate R3 was able to self-administer inhaler or provide written instructions to rinse mouth after use of the inhaler.	01750		

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01750	Continued From page 21 The manufacturer's instructions for Symbicort (steroid) inhaler dated August 2019, directed to rinse mouth with water and spit the out after each dose. use of the inhaler and spit the water out. The licensee's Medication Administration by Unlicensed Personnel -Minnesota (MN) Assisted Living (AL) policy, dated November 24, 2024, indicated the nurse may delegate to unlicensed staff the task of providing assistance with self-administration of medications or may delegate administration of medications if the nurse specifies in writing, specific instruction for administering medications for each resident, No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan.	01760		

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01760	Continued From page 22 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure medications were administered as prescribed for one of two residents (R2). 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 11, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the license provided medication administration services to the residents at the facility. R2's diagnoses included hypertension (high blood pressure), angina (chest pain) and coronary artery disease (narrowing of the arteries to the heart). R2's quarterly assessment dated February 5, 2025, indicated R2 required assistance with medication administration. R2's prescriber orders dated December 9, 2024, included losartan potassium (used to treat high blood pressure) 50 milligrams (mg) one time daily. Check blood pressure prior and do not administer if systolic blood pressure (SBP) (top	01760		

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01760	Continued From page 23 number) was below 130 millimeters of mercury (mmHg). If frequency not given due to low SBP, notify nursing. R2's recorded blood pressure readings indicated R2's SBP was below 130 mmHg on the following dates: -February 16, 2025, R2's BP was 118/65 mmHg; -March 2, 2025, R2's BP was 111/81 mmHg ; and -March 3, 2025, R2's BP was 112/93 mmHg. R2's February and March 2025 Medication Administration Summary included losartan potassium 50 mg daily. Check BP prior and do not administer if SBP was below 130 mmHg. R2's Medication Administration Summaries indicated R2 received losartan potassium 50 mg on the following dates noted above although R2's SBP was below 130 mmHg. On March 11, 2025, at 3:42 p.m., LALD/CNS-A stated staff should have held R2's losartan due to R2's SBP below 130 mmHg as directed. LALD/CNS-A stated if a medication was held, documentation in R2's record should indicate why that medication was held and stated there was no documentation on the days noted above, R2's losartan was held. LALD/CNS-A stated the instructions were clear on R2's Medication Administration Summary and did not understand why R2's losartan was administered, and it was considered a medication error. The Medication Administration by Unlicensed Personnel-Minnesota (MN)-Assisted Living (AL) policy dated November 4, 2024, indicated unlicensed staff that would provide assistance with self-administration of medication or medication administration would be trained and competency tested by the nurse on the following:	01760		

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01760	Continued From page 24 -the complete procedure for checking the medication record; -preparation of the medication for the resident; -administration to the resident; and -if the assistance or medication administration was not completed as ordered, the reason for that-and if a medication was not administered as ordered, whether the staff person must contact the registered nurse (RN) immediately. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01880 SS=F	144G.71 Subd. 19 Storage of medications An assisted living facility must store all 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 refrigerated medications were maintained at manufacturer recommended temperatures by failing to monitor and document medication refrigerator temperatures for one of one medication refrigerators. 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	01880		

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01880	Continued From page 25 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 11, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the license provided secured medication storage to the residents at the facility. The licensee's medication refrigerator temperature log dated January 1, 2025, through March 11, 2025, directed to document the medication fridge temperature nightly. The recorded temperature log indicated the licensee missed the following opportunities to record the medication refrigerator temperatures; -eight out of 31 opportunities in January 2025; -three out of 28 opportunities in February 2025; and -two out of 11 opportunities in March 2025. On March 11, 2025, at 3:02 p.m., LALD/CNS-A stated staff should be recording medication refrigerator temperatures daily and verified several days were blank where staff did not monitor and record the medication refrigerator temperature as assigned in Rtasks (electronic medical documentation system). On March 12, 2025, at 6:38 a.m., the surveyor observed the medication refrigerator with unlicensed personnel (ULP)-H and observed the following medications were being stored: -one unopened bottle of Latanoprost 0.005% eye drop; -one unopened box containing four single Trulicity pre-filled insulin pens; and	01880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01880	Continued From page 26 -one unopened Lantus Solostar prefilled insulin pen. The manufacturer's instructions for Latanoprost eye drop (used to treat glaucoma) dated August 2011, indicated to store unopened bottle(s) under refrigeration at 36 degrees Fahrenheit (F) to 46 F. The manufacturer's instructions for Trulicity insulin pen (used to treat diabetes) dated June 2021, directed to store the Trulicity insulin pen in the refrigerator between 36 F to 46 F. The manufacturer's instructions for Lantus Solostar insulin pen (long-acting insulin) dated June 2022, directed to keep new Lantus insulin pens in the refrigerator between 36 F to 46 F. The licensee's Storage of Medications policy, dated April 17, 2023, indicated medications would be handled and stored per acceptable standards. In the resident's individualized medication management plan, the registered nurse (RN) may identify the need for secured storage of the medications within the resident's private living space because of the resident's cognitive status, concerns about medication diversion or other concerns, when secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=E	144G.71 Subd. 20 Prescription drugs	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01890	Continued From page 27 A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure medications were maintained to include an original prescription label and information including the opened date and expiration date for time sensitive medications stored and managed 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 was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 11, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the license provided secured medication storage to the residents of the facility. On March 11, 2025, at 2:09 p.m., the surveyor reviewed the medication cart with unlicensed personnel (ULP)-C and observed the following:	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01890	Continued From page 28 -R2's opened glargine (Lantus) insulin pen (long-acting insulin) lacked the original packaging and 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 lacked the date the insulin had been opened and would expire; and -R5's opened bottle of Moxifloxacin 0.5% eye drop (used to treat infection) lacked the date the eye drop had been opened and when the eye drop would expire. On March 11, 2025, at 3:02 p.m., LALD/CNS-A stated staff were trained to write the date the insulins, eye drops and inhalers were opened. LALD/CNS-A stated all medications should either have a prescription label from the pharmacy or if purchased over the counter, at a minimum have the resident name. On March 12, 2025, between 7:08 a.m. and 7:22 a.m., the surveyor observed ULP-E administering R5's scheduled Moxifloxacin, Systane and prednisone eye drops. R5's eye drops lacked the date the eye drops had been opened and when the eye drops would expire. The manufacturer's instructions for glargine pre-filled injection pen dated December 1, 2021, directed to discard 28 days after opened. The manufacturer's instructions for Moxifloxacin eye drop dated September 2021, indicted to stop using eye drop four weeks after opened. The licensee's Storage of Medications policy, dated April 17, 2023, indicated medications would be handled and stored per acceptable standards.	01890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01890	Continued From page 29 In the resident's individualized medication management plan, the registered nurse (RN) may identify the need for secured storage of the medications within the resident's private living space because of the resident's cognitive status, concerns about medication diversion or other concerns, when secured storage of the medications is necessary, the RN will identify where the medications will be stored, how they will be secured or locked under proper temperature controls and who has access to the medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
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 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,	01910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01910	Continued From page 30 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 record all of the required content in the disposition of 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) 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: R1's diagnoses included hyperlipidemia, history of malignant neoplasm breast, history of colon cancer, and hypertension (high blood pressure). R1's January 2025 Medication Administration Summary indicated R1 was scheduled and received the following medications: -calcium 600 milligrams (mg) with vitamin D 20 micrograms (mcg) two tablets daily for supplementation; -clindamycin 300 mg one capsule three times a day for 10 days used to treat infections; -gabapentin 100 mg two capsules two times a day for nerve pain; -hydrochlorothiazide 25 mg daily for hypertension; -Omega 3-Fish Oil Softgel 500 mg one tablet	01910		

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01910	Continued From page 31 twice a day for supplementation; -sodium chloride 1 gram (gm) give 0.5 tablet daily for low potassium; -valsartan 320 mg one tablet daily for hypertension; -vitamin B-12 1000 mcg one tablet daily for supplementation; -levothyroxine 25 mcg one tablet daily for low thyroid level; -simvastatin 20 mg one tablet every evening with supper for high cholesterol; and -seroquel 50 mg one tablet at bedtime for anxiety. R1's prescriber orders dated November 7, 2024, included the above noted medications. R1's Discharge Care Plan dated January 14, 2025, indicated R1 was admitted May 31, 2023, and discharged to a higher level of care on January 14, 2025. R1's discharge summary indicated R1 received medication management and R1's medications were sent with R1 at discharge. R1's Medication Disposition record dated January 14, 2025, included documentation for the disposition of the medications noted above of the medication's name, strength, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition; however, lacked documentation of the medication prescription number, as applicable. On March 12, 2025, at 11:57 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the paper form they had been using did not include an area to record the prescription number and had not been documenting the medication prescription	01910		

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01910	Continued From page 32 numbers separately. The licensee's Disposition or Disposal of Medication policy dated April 17, 2023, indicated documentation of the destruction, listing the date, quantity name of drug, prescription number, signature of person destroying the drugs and signature of witness to the destruction must be recorded and maintained in the resident's record for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 33 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 one of two residents (R2) 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 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 11, 2025, at 9:50 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the license provided treatment and therapy services to the residents at the facility. On March 11, 2025, at 11:57 a.m., the surveyor observed R2 monitor her own blood sugar at the dining table, document results in R2's record book and on a post-it note. R2 proceed and put R2's blood glucose meter and post it note on the medication cart. At 12:02 p.m., unlicensed personnel (ULP)-C returned to the medication cart, put R2's blood glucose meter in a drawer in the medication cart and documented R2's blood glucose results of 115 milligrams per deciliter (mg/dl). ULP-C stated they stored R2's blood glucose meter in the medication cart and gave it	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24431	A. BUILDING: _____ B. WING _____	03/13/2025

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VITACARE LIVING	101 NORTH 58TH AVENUE WEST DULUTH, MN 55807

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01950	Continued From page 34 to R2 at the scheduled times to check her own blood glucose. ULP-C reviewed R2's electronic medical administration record (EMAR) and stated there were parameters of when to notify the nurse if R2's blood glucose level was below 70 mg/dl or above 400 mg/dl; however, there were no specific instructions indicating R2 was able to monitor her own blood glucose. R2's diagnosis included diabetes type II with chronic kidney disease. R2's Quarterly Assessment dated February 5, 2025, indicated R2 performs own blood sugar checks and ULP draws up insulin and R2 self-injects. R2's Service Plan-Modification dated March 11, 2025, indicated R2's treatment services included blood glucose monitoring four times a day by unlicensed personnel (ULP). R2's March 2025 scheduled services indicated R2 received blood glucose monitoring four times a day. R2's electronic medical record lacked written instructions indicating R2 was able to check own blood glucose and report blood glucose results. On March 11, 2025, at 12:00 p.m., LALD/CNS-A stated staff should be monitoring R2 when checking own blood glucose to ensure appropriate procedure and accuracy of R2's blood glucose reading. LALD/CNS-A viewed R2's electronic medical record and stated there were no written instructions indicating R2 was able to monitor own blood glucose and staff were to monitor the process.	01950		

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01950	Continued From page 35 The licensee's Delegation of Nursing Tasks-Nursing Treatments and Therapy Services policy dated February 7, 2025, indicated prior to delegating administration of treatments and therapy the registered nurse (RN) or authorized Licensed Health Professional must: -develop and maintain a current individualized treatment or therapy management record for each resident that addresses the Statutes to the specific state; -instruct the unlicensed personnel in the proper methods to provide the treatment or perform the task with respect to each resident and determine that the unlicensed personnel have demonstrated the ability to competently follow the procedures; -develop written specific instructions for each resident and document those instructions in the resident's record; and -communicated with the unlicensed personnel about the individual needs of the resident. No further information provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Follow-Up
Date: *03/20/25*
Time: 10:30:00
Report: 8010251053

Food and Beverage Establishment Inspection Report

Location:
Scandia Capital Partners Llc
101 North 58th Avenue West
Duluth, MN55807
St. Louis County, 69

Establishment Info:
ID #: 0037767
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513351586
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-800 Highly Susceptible Populations

3-801.11B ***** Priority 1 *****

MN Rule 4626.0447B Discontinue using unpasteurized eggs or egg products in the preparation of Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, ice cream, and egg-fortified beverages when serving a highly susceptible population.

UNPASTEURIZED EGGS WERE USED IN POTATO SALAD MADE THE NIGHT BEFORE TO SERVE THE NEXT DAY TO MORE THAN ONE RESIDENT. POTATO SALAD WAS DISCARDED.

Corrected on Site

Surface and Equipment Sanitizers

Hot Water: = at 170 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK-AMANA KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: PREPACKAGE LETTUCE-AMANA KITCHEN
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 41 Degrees Fahrenheit - Location: RAW SHELL EGGS-AMANA KITCHEN
Violation Issued: No

Type: Follow-Up
Date: *03/20/25*
Time: 10:30:00
Report: 8010251053
Scandia Capital Partners Llc

Food and Beverage Establishment Inspection Report

Process/Item: Upright Cooler
Temperature: 38 Degrees Fahrenheit - Location: MILK-AMANA BACK
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-AMANA KITCHEN
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-AMANA BACK
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-FRIGIDAIRE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	1	0	0

COMMENTS:

THIS WAS A FOLLOW UP INSPECTION TO THE INSPECTION DONE 03/11/2025.

A NEW AMANA SIDE BY SIDE REFRIGERATOR WAS INSTALLED AND FOOD TEMPERATURES TAKEN WERE 41F OR BELOW.

ALL PREVIOUS ORDERS WERE CORRECTED.

RAW EGGS ARE ONLY TO BE USED IN ONE RESIDENT'S SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY SUCH AS AN OMELET OR SCRAMBLED AND COOKED TO 145F OR ABOVE OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

Type: Follow-Up
Date: *03/20/25*
Time: 10:30:00
Report: 8010251053
Scandia Capital Partners Llc

Food and Beverage Establishment Inspection Report

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8010251053 of 03/20/25.

Certified Food Protection Manager: Samantha M. Tabert

Certification Number: FM74713 Expires: 08/24/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Samantha Tabert
CFPM

Signed: Deborah R Kosiuk

8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010251053

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	1
No. of Repeat RF/PHI Categories Out	0
Legal Authority MN Rules Chapter 4626	

Date 03/20/25
Time In 10:30:00
Time Out

Scandia Capital Partners Llc	Address: 101 North 58th Avenue West	City/State: Duluth, MN	Zip Code: 55807	Telephone: 6513351586
License/Permit #: 0037767	Permit Holder	Purpose of Inspection: Follow-Up	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle 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) OUT	PIC knowledgeable; duties & oversight		
2	(IN) OUT N/A	Certified food protection manager, duties		
	Employee Health			
3	(IN) OUT	Mgmt/Staff;knowledge,responsibilities&reporting		
4	(IN) OUT	Proper use of reporting, restriction & exclusion		
5	(IN) OUT	Procedures for responding to vomiting & diarrheal events		
	Good Hygenic Practices			
6	(IN) OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	(IN) OUT N/O	No discharge from eyes, nose, & mouth		
	Preventing Contamination by Hands			
8	(IN) OUT N/O	Hands clean & properly washed		
9	(IN) OUT N/A N/O	No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed		
10	(IN) OUT	Adequate handwashing sinks supplied/accessible		
	Approved Source			
11	(IN) OUT	Food obtained from approved source		
12	IN OUT N/A (N/O)	Food received at proper temperature		
13	(IN) OUT	Food in good condition, safe, & unadulterated		
14	IN OUT (N/A) N/O	Required records available; shellstock tags, parasite destruction		
	Protection from Contamination			
15	(IN) OUT N/A N/O	Food separated and protected		
16	(IN) OUT N/A	Food contact surfaces: cleaned & sanitized		
17	(IN) OUT	Proper disposition of returned, previously served, reconditioned, & unsafe food		

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) 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" 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) OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT (N/A)	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A (N/O)	Plant food properly cooked for hot holding		
35	IN OUT N/A (N/O)	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
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 & used		
46		Gloves used properly		
		Utensil 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 & plan review		

Food Recalls:

Person in Charge (Signature) **Date:** 03/20/25

Inspector (Signature) Deborah R Kosiak

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *03/11/25*
Time: 10:30:00
Report: 8010251045

Food and Beverage Establishment Inspection Report

Location:
Scandia Capital Partners Llc
101 North 58th Avenue West
Duluth, MN55807
St. Louis County, 69

Establishment Info:
ID #: 0037767
Risk:
Announced Inspection: Yes

License Categories:

Expires on: / /

Operator:

Phone #: 6513351586
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ***** Priority 1 *****

MN Rule 4626.0395A2 Maintain all cold, TCS foods at 41 degrees F (5 degrees C) or below under mechanical refrigeration.

THE TEMPERATURE OF FOODS STORED IN THE GE REFRIGERATOR WERE ABOVE THE MAXIMUM TEMPERATURE OF 41F. MILK-49F, EGGS 46F, MEATBALLS 47F. FOODS WERE MOVED TO ANOTHER REFRIGERATOR OR DISCARDED.

Corrected on Site

4-700 Sanitizing Equipment and Utensils

4-703.11B ***** Priority 1 *****

MN Rule 4626.0905B Sanitize food contact surfaces of equipment and utensils after cleaning by using mechanical hot water operations that achieve a utensil surface temperature of 160 degrees F (71 degrees C) and are set up and maintained in accordance with the specifications of NSF International and the manufacturer's data plate.

SOME DISHWASHER TEMPERATURE TEST STRIPS DID REACH 160F, SOME DISHWASHER TEMPERATURE TEST STRIPS DID NOT REACH 160F. VERIFY DISHWASHER TEMPERATURE USING A DISHWASHER DIGITAL THERMOMETER.

Comply By: 03/13/25

4-200 Equipment Design and Construction

4-204.112A

MN Rule 4626.0620A Provide a temperature measuring device located in the warmest part of mechanically refrigerated units and coolest part of hot food storage units that are capable of measuring air temperature or a simulated product temperature.

Type: Full
Date: *03/11/25*
Time: 10:30:00
Report: 8010251045
Scandia Capital Partners Llc

Food and Beverage Establishment Inspection Report

AT THE TIME OF THE INSPECTION THERE WAS NO THERMOMETER INSIDE THE GE REFRIGERATOR.

Comply By: 03/11/25

Surface and Equipment Sanitizers

Chlorine: = 100 PPM at Degrees Fahrenheit
Location: WIPING CLOTH BUCKET
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Cooking
Temperature: 170 Degrees Fahrenheit - Location: STEAK,MUSHROOM IN BROTH
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 46 Degrees Fahrenheit - Location: EGGS-GE
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 49 Degrees Fahrenheit - Location: MILK-GE
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 47 Degrees Fahrenheit - Location: MEATBALLS
Violation Issued: Yes

Process/Item: Upright Cooler
Temperature: 39 Degrees Fahrenheit - Location: MILK-AMANA
Violation Issued: No

Process/Item: Upright Cooler
Temperature: 40 Degrees Fahrenheit - Location: PREPACKAGED LETTUCE
Violation Issued: No

Process/Item: Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-GE BOTTOM
Violation Issued: No

Process/Item: Upright Freezer
Temperature: Degrees Fahrenheit - Location: FOODS FROZEN-FRIGIDAIRE
Violation Issued: No

Total Orders In This Report	Priority 1	Priority 2	Priority 3
	2	0	1

COMMENTS:

DISCUSSED THE USED OF RAW EGGS AND THAT RAW EGGS ARE ONLY TO BE USED IN ONE RESIDENT'S SERVING AT A SINGLE MEAL IF THE EGGS ARE COMBINED, COOKED AND SERVED IMMEDIATELY SUCH AS AN OMELET OR SCRAMBLED AND COOKED TO 145F OR ABOVE OR IN BAKED GOODS THAT ARE THOROUGHLY COOKED IF EGGS ARE COMBINED AS AN INGREDIENT IMMEDIATELY BEFORE BAKING.

PASTEURIZED EGGS OR EGG PRODUCTS MUST BE SUBSTITUTED FOR RAW EGGS WHEN MORE THAN ONE IS BROKEN, COMBINED AND NOT COOKED, BAKED, OR USED IMMEDIATELY.

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

DISCUSSED CLEANING AND SANITIZING ONE OF THE TWO COMPARTMENT SINKS BEFORE WASHING AND RINSING OF FRUITS AND VEGETABLES.

ESTABLISHMENT WILL BE REPLACING THE GE REFRIGERATOR.

NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Minnesota Department of Health inspection report number 8010251045 of 03/11/25.

Certified Food Protection Manager: Samantha M. Tabert

Certification Number: FM74713 Expires: 08/24/26

Inspection report reviewed with person in charge and emailed.

Signed: _____
Samantha M. Tabert
CFPM

Signed: Deborah R Koenig
8010

651-201-4500
health.foodlodging@state.mn.us

Report #: 8010251045

Food Establishment Inspection Report

Minnesota Department of Health
Minnesota Department of Health
PO Box 64975
St. Paul, MN 55164-0975

No. of RF/PHI Categories Out	2	Date	03/11/25
No. of Repeat RF/PHI Categories Out	0	Time In	10:30:00
Legal Authority MN Rules Chapter 4626		Time Out	

Scandia Capital Partners Llc	Address: 101 North 58th Avenue West	City/State: Duluth, MN	Zip Code: 55807	Telephone: 6513351586
License/Permit #: 0037767	Permit Holder	Purpose of Inspection: Full	Est Type	Risk Category

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle 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 OUT		
PIC knowledgeable; duties & oversight			
2	IN OUT N/A		
Certified food protection manager, duties			
Employee Health			
3	IN OUT		
Mgmt/Staff;knowledge,responsibilities&reporting			
4	IN OUT		
Proper use of reporting, restriction & exclusion			
5	IN OUT		
Procedures for responding to vomiting & diarrheal events			
Good Hygenic Practices			
6	IN OUT N/O		
Proper eating, tasting, drinking, or tobacco use			
7	IN OUT N/O		
No discharge from eyes, nose, & mouth			
Preventing Contamination by Hands			
8	IN OUT N/O		
Hands clean & properly washed			
9	IN OUT N/A N/O		
No bare hand contact with RTE foods or pre-approved alternate pprocedure properly followed			
10	IN OUT		
Adequate handwashing sinks supplied/accessible			
Approved Source			
11	IN OUT		
Food obtained from approved source			
12	IN OUT N/A N/O		
Food received at proper temperature			
13	IN OUT		
Food in good condition, safe, & unadulterated			
14	IN OUT N/A N/O		
Required records available; shellstock tags, parasite destruction			
Protection from Contamination			
15	IN OUT N/A N/O		
Food separated and protected			
16	IN OUT N/A		
Food contact surfaces: cleaned & sanitized			
17	IN OUT		
Proper disposition of returned, previously served, reconditioned, & unsafe food			

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

Person in Charge (Signature) **Date:** 03/12/25

Inspector (Signature) Deborah R Kosiak