Electronically Delivered

May 4, 2026

Licensee
Westwood of Duluth
925 Kenwood Avenue
Duluth, MN 55811

RE: Project Number(s) SL30831016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 3, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

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

STATE CORRECTION ORDERS

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

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 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - $1,000.00

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
	30831	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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: SL30831016-0 On March 30, 2026, through April 3, 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 90 residents; 90 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on April 1, 2026, issued at a widespread scope and level three (I) for tag identification 2310; the licensee took mitigating action on April 2, 2026, however, the scope and level remain unchanged.	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480		

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

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated, March 31, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480		

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0 480	Continued From page 3 TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates.	0 480		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical, or nursing standards in regard to infection control during medication administration and assistance with personal cares for one of two employees (unlicensed personnel (ULP)-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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).	0 510		

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0 510	Continued From page 4 The findings include: ULP-E had hire date of March 6, 2023, to provide care and services to the residents of the licensee. ULP-E's employee record indicated ULP-E completed annual infection control training September 7, 2025. On March 31, 2026, at 6:52 a.m., the surveyor observed ULP-E assist R4 with morning cares and medication administration. ULP-E put on a pair of gloves and transferred R4 out of bed and into the wheelchair. ULP-E prepared and administered R4's morning medications. ULP-E escorted R4 into the bathroom onto the toilet. ULP-E assisted R4 into a standing position, provided peri cares, pulled up R4's underwear and transferred R4 back into the wheelchair. Wearing the same pair of gloves, ULP-E proceeded to assist R4 with dressing, applied tubi-grip stockings, clothes, shoes, hearing aid and glasses. ULP-E removed gloves and made R4's bed while R4 was in the bathroom completing grooming. Without performing hand hygiene, ULP-E exited R4's room and entered R8's room to check to see if R8 was ready to get up for the morning and R8 wanted to remain in bed. At 7:25 a.m., ULP-E entered R6's room, prepared and administered R6's morning medications, documented medications administered and exited R6's room. The surveyor did not observe ULP-E perform hand hygiene prior to entering resident rooms, after completing R4's morning/toileting cares, or in between or after assisting with resident's medication administration. Immediately following observations, ULP-E apologized and stated ULP-E realized after assisting with R4 and R8, ULP-E did not perform hand hygiene and should	0 510		

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0 510	Continued From page 5 have changed gloves after assisting R4 with toileting. ULP-E stated hand sanitizers were readily available for ULP-E to use in-between residents. On March 31, 2026, at 1:06 p.m., clinical nurse supervisor (CNS)-B stated staff should perform hand hygiene in-between residents and after the removal of gloves. CNS-B stated staff should have changed gloves and performed hand hygiene after assisting a resident with toileting needs before proceeding with dressing. The licensee's Hand Hygiene policy dated March 3, 2022, indicated hand washing shall be performed between client cares, and whenever direct physical contact with the client takes place. Use of gloves do not replace hand washing. Hands should be washed or decontaminated: -before and after direct contact with a client; -if moving from a contaminated-body site to a clean-body site during client care; -after contact with environmental surfaces or equipment in the immediate vicinity of the client; -after removing gloves or gown; and -before eating and after using a restroom. The licensee's Procedure for Using Gloves policy dated March 3, 2022, indicated gloves are to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, secretions, feces, or a contaminated item, such as soiled linens or wound dressings. Gloves will be removed carefully and disposed of in a proper container. After the use of and disposal of gloves, rewash hands. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7)	0 510		

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0 510	Continued From page 6 days	0 510		
0 650 SS=F	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 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 employee records contained the required content for two of two employees (clinical nurse supervisor (CNS)-B), unlicensed personnel (ULP-E). This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 650		

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0 650	Continued From page 7 safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 30, 2026 at 10:41 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of the required contents of employee records. CNS-B CNS-B was hired on January 19, 2026, through a contracted agency, to provide direct care services to residents and to provide staff supervision at the facility. During the course of the survey, March 30, 2026, through April 2, 2026, the surveyors observed CNS-B provide care and services to the residents at the facility. CNS-B's records lacked documented evidence CNS-B completed the following required orientation training: - a review of the provider's policies and procedures. ULP-E ULP-E was hired on March 6, 2023, to provide direct care services to residents at the facility. On March 31, 2026, at 6:52 a.m., the surveyor observed ULP-E assist R4 with morning cares and medication administration.	0 650		

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0 650	Continued From page 8 ULP-E's employee record lacked documented evidence ULP-E completed annual review of the provider's policies and procedures. On April 1, 2026, at 2:50 p.m., LALD-A, and (regional director) RD-F, stated staff review the licensee's policies and procedures upon hire and annually; however, the licensee did not document the review of the licensee's policies and procedures in the employee record. The licensee's undated Personnel policy indicated the personnel record for each person would include: -record of all required training for unlicensed personnel. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650		
0 775 SS=E	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or	0 775		

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0 775	Continued From page 9 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Two (2) days	0 775		
0 780 SS=D	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	0 780		

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0 780	Continued From page 10 that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7)	0 780		

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0 780	Continued From page 11 days	0 780		
0 810 SS=E	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.	0 810		

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	30831	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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0 810	Continued From page 12 This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01060 SS=D	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the	01060		

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01060	Continued From page 13 facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide written notice with	01060		

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01060	Continued From page 14 required content to the resident, legal representative, and/or designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one residents (R1) reviewed for a hospitalization. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1's diagnoses included chronic obstructive pulmonary disease (COPD) and diabetes. R1's Service Plan dated January 1, 2025, indicated R1 received assistance with medication management, bathing, dressing, grooming, housekeeping, laundry, and shopping. R1's progress notes indicated the following: -On December 27, 2025, at 3:08 a.m., R1 had a fall and sustained an injury to the head and was transferred to the emergency room for evaluation. -On December 29, 2025, at 5:21 p.m., R1 was admitted to the Neuro Trauma unit. R1's record lacked evidence a written notice, including the following required content was provided to R1 or R1's representative: (1) the reason for the relocation; (2) the name and contact information for the	01060		

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01060	Continued From page 15 location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R1's record lacked notification was provided to the Office of Ombudsman for Long-Term Care for R1's hospitalization of four days or longer. On April 2, 2026, at 12:26 p.m., regional director (RD)-F stated they were unable find documentation in R1's record that R1 and/or R1's representative had been provided an emergency written notice or the OOLTC was notified of R1's hospitalization over four days. RD-F confirmed R1 was hospitalized from December 27, 2025, through January 3, 2026, then was discharged to a higher level of care March 25, 2026. The licensee's Emergency Relocation Checklist, undated, indicated when a facility takes any action that results in the resident leaving the facility (e.g. hospitalization or other inpatient admission), the facility must: -deliver a written notice to the resident, their legal representative and their designated representative. Also send the notice to the resident's case manager if they are receiving home and community-based waiver funds;	01060		

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01060	Continued From page 16 -deliver the notice to the Office of Ombudsman for Long Term Care if resident has not returned within four days as soon as possible and within 24 hours. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring	01620		

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01620	Continued From page 17 in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) conducted ongoing comprehensive nursing assessments not to exceed every 90 days for two of four residents (R4, R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the	01620		

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01620	Continued From page 18 situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 30, 2026, at 10:41 a.m., clinical nurse supervisor (CNS)-B stated, CNS-B completed comprehensive resident assessments on admission, 14 days after admission, every 90 days, or if a resident had a change in condition. R4 R4 was admitted to the facility December 2, 2024. R4's diagnoses included Parkinson's disease, muscle weakness and difficulty in walking. R4's Service Plan with Schedule dated December 5, 2025, indicated R4 received the following services: medication management, bathing, dressing, grooming, toileting, housekeeping and laundry. On March 31, 2026, at 6:52 a.m., the surveyor observed unlicensed personnel (ULP)-E assist R4 with morning personal cares, prepare and administer R4's medications. R4's 90-Day Assessments were completed on September 18, 2025, and January 19, 2026, however, R4's assessment was due by December 17, 2026 (33 days past due). R6 R6 was admitted to the facility April 30, 2024. R6's diagnoses included anxiety, heart failure, heart disease, and diabetes.	01620		

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01620	Continued From page 19 R6's unauthenticated Service Plan with Schedule dated March 31, 2026, indicated R6 received the following services: medication management, daily weight and blood glucose monitoring, housekeeping and laundry. On March 31, 2026, at 7:25 a.m., the surveyor observed ULP-E prepare and administered R6's scheduled morning medications. R6's 90-Day Assessments were completed on September 26, 2025, and January 21, 2026, however, R6's assessment was due by December 17, 2026 (36 days past due). R4 and R6's record lacked evidence of a 90-day reassessment was completed by an RN in the required time frame. On April 1, 2026, at 10:50 a.m., LALD-A and regional director (RD)-F stated they were aware R4 and R6's resident assessments were not completed within the required time frame and stated the licensee had a transition in nursing around that time period. The licensee's Initial and On-Going Assessment of Residents policy dated April 22, 2024, indicated the RN would determine the frequency of re-assessments based on the resident's needs, with the frequency between assessments not to exceed 90 days from the last date of the assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		

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01880	Continued From page 20	01880		
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 two 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 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 30, 2026, at 11:41 a.m., licensed assisted living director (LALD)-A and clinical nurse supervisor (CNS)-B stated the licensee provided medication storage for the residents at the facility. CNS-B stated the licensee had one medication refrigerator which was in located on the unsecured unit in the unlicensed personnel's (ULPs) office.	01880		

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01880	Continued From page 21 On March 31, 2026, at 8:45 a.m., the surveyor reviewed the medication refrigerator located on secured unit with ULP-D and ULP-C and observed the internal thermometer temperature reading of 37 degrees Fahrenheit (F). ULP-C and ULP-D, stated staff had not been instructed to monitor the refrigerator temperatures and did keep a recorded temperature log of the medication refrigerator on the secured unit. On March 31, 2026, at 9:45 a.m., the surveyor reviewed the medication refrigerator content with ULP-C and observed the internal thermometer temperature reading of 37 degrees F and the following medications were being stored: - R2's opened bottle of liquid gabapentin (used for pain); and - an unopened bottle of latanoprost (Xalatan) eye drops (used to treat increased eye pressure). The manufacturer's instructions for gabapentin dated July 2010, directed to store Neurontin (gabapentin) oral solution in the refrigerator between 36-46 degrees F. The manufacturer's instructions for latanoprost eye drops dated December 2020, directed to store Latanoprost eye drops in the refrigerator between 36- 46 degrees F. The licensee's Medication Storage policy dated August 1, 2024, indicated medications managed by the licensee would be securely stored per manufacturer directions. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		

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02040	Continued From page 22	02040		
02040 SS=E	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care must meet the requirements of section 144G.45 and the following additional requirements: (1) an assessment of safety risks must be performed on and around the property. The safety risks identified by the facility on the assessment must be mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at 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:	02040		

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02040	Continued From page 23 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated April 2, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02040		
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. 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 two of three residents (R4, R6) who utilized bed rails. This resulted in an immediate order for correction on April 1, 2026. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include:	02310		

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02310	Continued From page 24 During entrance conference on November 17, 2025, at 10:25 a.m. through 11:36 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. R4 R4's diagnoses included Parkinson's Disease, muscle weakness and polyneuropathy (condition of the nervous system). R4's Service Plan dated December 2, 2024, indicated R4 required assistance with medication administration, dressing, bathing, housekeeping and laundry. R4's service plan did not indicate R4 had or required the use of a bed mobility device. On March 31, 2026, at 6:52 a.m., the surveyor observed unlicensed personnel (ULP)- E assist R4 with morning cares and medication administration. During the observation, the surveyor observed a consumer bed rail on R4's left side of R4's day bed. The consumer rail was a white U-shaped, double metal bars securely attached underneath R4's mattress and bed frame. The surveyor observed R4 used the consumer rail while ULP-E was assisting R4 to a standing position along side of R4's bed. R4's 90 Day assessment dated September 18, 2025, and R4's Change of Condition Assessment dated January 19, 2026, indicated R4 was independent with ambulation and used a walker for short distances; R4 did not require bed mobility devices such as a side rail, Halos, grab bars or other devices for when in bed. R4's Resident Progress dated March 31, 2026, indicated CNS-B was informed R4 had a bed rail	02310		

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02310	Continued From page 25 that day. CNS-B spoke with R4's and R4's family and discussed risk and benefits of bed rails and wanted to keep the current bed rail and agreed to be evaluated by physical therapy for the appropriate bed mobility device. R4's record lacked documentation R4 was assessed to have a consumer bed rail, the purpose of the bed rail, the bed rail was determined to not act as a restraint, the consumer bed rail was installed and maintained per manufacturer's guidelines, the risk versus benefits were discussed with R4/R4's representative on the use of the consumer bed rail, and the licensee reviewed the Consumer Product Safety Commission (CPSC) website to ensure R4's bed rail was not recalled prior to the start of the survey or request of documents by the surveyor. R6 R6's diagnoses included obesity, impaired mobility, right knee pain and dizziness. R6's Service Plan dated indicated R6 was independent with general mobility including bed mobility and did not have a bed mobility device. On March 31, 2026, at 7:25 a.m., the surveyor observed ULP-E administer R6's scheduled morning medications. During the observation, the surveyor observed two consumer bed rails attached to the right and left sides of R6's standard bed. The consumer rails were white, U-shaped metal bars. R6's stated the bed rails were helpful for R6 to maintain independence. R6's Resident Progress Note dated March 31, 2026, indicated CNS-B spoke with R6's power of attorney (POA) regarding R6's bed rails and POA	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30831	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
02310	Continued From page 26 provided and installed R6's bed rails. CNS-B re-educated on risk and benefits of bed rail use and R6's signed risk versus benefits statement. R6 continued to request the use of bed rail for transfers and bed mobility. R6's record included an Assistive Bed Devices Education and Acknowledgement Form dated April 26, 2024; however, lacked documentation R6 was assessed to have a consumer bed rail, the purpose of the bed rail, the bed rail was determined to not act as a restraint, the consumer bed rail was installed and maintained per manufacturer's guidelines, the licensee reviewed the CPSC website to ensure R6's bed rail was not recalled prior to the start of the licensee's survey or request of the documents by the surveyor. On April 1, 2026, from 10:04 a.m. to 11:04 a.m., regional director (RD)-F stated when the nurse completed a resident's comprehensive assessment and if the resident had a bed mobility device, the system would automatically 'trigger" a separate Assistive Bed Device Assessment to be completed. CNS-B stated CNS-B was not aware R4 or R6 had bed rails attached to their beds. CNS-B stated CNS-B reviewed R4 and R6's previous assessments and stated R4 and R6's records did not include evidence bed rail assessment had been completed. RD-F stated the organization had a list of preferred bed rails and on admission, bed rail information was reviewed and acknowledgement of education was signed. RD-F stated if residents and families requested to use bed rails, maintenance would only install bed rails on the licensee's preferred list and bed rail assessments would be completed every 90 days. RN-F stated R4 and R6's did not have consumer rails on the licensee's preferred	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30831	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

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02310	Continued From page 27 list of bed rails. CNS-B and RD-F stated R4 and R6 did not have bed rail assessments completed prior to surveyors request for documents. The FDA "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients. The FDA also identified; "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) last updated October 13, 2025 indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail;	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30831	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD OF DULUTH	925 KENWOOD AVENUE DULUTH, MN 55811

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02310	Continued From page 28 - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0140, Subp. 2, effective October 2022, a nursing assessment or reassessment under Minnesota Statutes, section 144G.70, subdivision 2, paragraphs (b) and (c), must be conducted on a prospective resident or resident receiving any of the assisted living services identified in Minnesota Statutes, section 144G.08, subdivision 9, clauses (6) to (12). B. The nursing assessment or reassessment under item A must: (1) address part 4659.0150, subpart 2, items A to N; (2) be conducted in person unless an exception under Minnesota Statues, section 144G.70, subdivision 2, paragraph (b), applies; (3) be conducted using a uniform assessment tool that complies with part 4659.0150; and (4) be in writing, dated, and signed by the registered nurse who conducted the assessment. The licensee Assistive Bed Devices policy dated April 30, 2023, indicated a nurse would fully	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30831	A. BUILDING: _____ B. WING _____	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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02310	Continued From page 29 complete the Assisi Bed Device Assessment in Matrix (or alternatively on paper, if necessary) (a) prior to installation of an assistive bed device and (b) following installation, with each 90-day assessment, upon a change in condition, and upon a change in the device. If the Assessment determination was that the device was not approved, alternative options would be discussed with the resident/responsible party to reach resolution and the unsafe device would not be installed (or would be removed if already installed) and alternative measures implemented. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	02310		

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

WESTWOOD OF DULUTH
925 KENWOOD AVENUE
Duluth, MN 55811
sSt Louis County
Parcel:

Phone:

License Info

License: HFID 30831

Risk:
License:
Expires on:
CFPM: SARAH WINGATE
CFPM #: CFPM 61920; Exp: 10/21/2028

Inspection Info

Report Number: F1016261064
Inspection Type: Full - Single
Date: 3/31/2026 Time: 11:00 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery:

New Order: 3-300B Protection from Contamination: cross-contamination, eggs
3-302.12 *Priority Level: Priority 3 CFP#: 37*
MN Rule 4626.0240 Properly label all working containers holding food or food ingredients that are removed from original packages with the common name of the food. Label the food in English and any other languages used by employees who handle food.
COMMENT: BULK SUGAR AND CORN MEAL WERE NOT LABELED.
Comply By: Complied On Site Originally Issued On: 3/31/2026

! **New Order: 3-500E Microbial Control: time as a control**
3-501.19B *Priority Level: Priority 1 CFP#: 24*
MN Rule 4626.0408B When using time only as a public health control for up to 4 hours, discard all TCS food that has been out of temperature control for more than 4 hours; was not at 41 degrees F (5 degrees C) or less when removed from temperature control; or is in unmarked containers.
COMMENT: CUT FRUIT UNDER TIME AS A CONTROL WAS NOT LABELED.
Comply By: Complied On Site Originally Issued On: 3/31/2026

New Order: 6-300 Physical Facility Numbers and Capacities
6-301.14A *Priority Level: Priority 3 CFP#: 10*
MN Rule 4626.1457 Provide a sign or poster at all handwashing sinks used by food employees that notifies them to wash their hands.
COMMENT: HAND WASHING SINKS DID NOT HAVE HAND WASHING REMINDER SIGNS.
Comply By: Complied On Site Originally Issued On: 3/31/2026

Food & Beverage General Comment

COMMENTS:

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

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

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

NOTE: All new food equipment must meet the applicable standards of the American National Standards Institute (ANSI). Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.

I acknowledge receipt of the Duluth District Office inspection report number F1016261064 from 3/31/2026

SARAH WINGATE
KITCHEN MANAGER

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

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

Temperature Observations/Recordings

Establishment Info

WESTWOOD OF DULUTH
Duluth
County/Group: sSt Louis County

Inspection Info

Report Number: F1016261064
Inspection Type: Full
Date: 3/31/2026
Time: 11:00 AM

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

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

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

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

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

Equipment Temperature: Product/Item/Unit: ALL FOOD FROZEN**; Temperature Process:** Cold-Holding
Location: Walk-in Freezer at Degrees F.
Comment:
Violation Issued?: No

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

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

Food Temperature: Product/Item/Unit: SOUP**; Temperature Process:** Hot-Holding
Location: WARMER at 166 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

WESTWOOD OF DULUTH
Duluth
County/Group: sSt Louis County

Inspection Info

Report Number: F1016261064
Inspection Type: Full
Date: 3/31/2026
Time: 11:00 AM

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Kitchen **Equal To** 700 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Dishwashing Area **Equal To** 170 Degrees F.
Comment:
Violation Issued?: No

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30831016-0	**Date:** April 2, 2026
Facility Name: Westwood of Duluth	
Facility Address: 925 Kenwood Avenue, Duluth, MN 55811	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Fire doors shall be maintained to be self-closing and latch as designed. Fire doors shall not be blocked, obstructed, or otherwise made inoperable. [Minn. Stat. 144G.45 subd. 2; MSFC 705]

   Comments: Three labeled fire doors were held open with wedges in the following locations:
   - Temporary main entrance
   - Elevator room
   - Resident assistant office room 1141
   Licensed assisted living director (LALD)-A explained there was an active remodeling project in the building and stated these doors were not normally propped open. Fire doors shall be maintained to contain fire and smoke in the event of an emergency.

3. Controlled egress locking system procedures for operation of the unlocking system shall be described as part of the fire safety and evacuation plan. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

   Comments: The operation and unlocking procedures for the controlled egress locking system were not included with the fire safety and evacuation plans.

☒ **TAG IDENTIFICATION: 0780**

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

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

   Comments:
   - Resident room 2169, was a two bedroom dwelling unit, with three smoke alarms. When licensed assisted living director (LALD)-A tested the smoke alarms, these alarms indicated two devices were detected but none of the alarms sounded.
   - Resident room 2147, was a one bedroom dwelling unit, with two sets of hardwired smoke alarms. When LALD-A tested the smoke alarms, two alarms tested as interconnected. The smoke alarms were not all interconnected.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Pattern **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 (FSEP) that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific employee actions to take in the event of a fire or similar emergency relative to the assisted living building layout and environmental risks. The plan was from a third party template. The plan directed employees to evacuate the building immediately if the fire cannot be extinguished with a portable fire extinguisher, and was not consistent with the resident instructions to shelter in place.

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

   Comments: The provided fire safety and evacuation plan (FSEP) in the emergency operations plan binder failed to include evacuation procedures for the individualized unique needs of residents or instructions on where this information was maintained.

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

   Comments: The surveyor requested records for employee fire safety and evacuation plan (FSEP) training completed between April 2025 and April 2026, from the licensee. Record review of the available

documentation indicated employees completed training from an online third party. Documentation was not provided to support employee training on the site specific FSEP was completed at the required frequency.

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: The surveyor requested records for resident fire safety and evacuation training completed between April 2025 and April 2026, from the licensee. Record review of the available documentation indicated residents were offered this training on February 20, 2025.

☒ **TAG IDENTIFICATION: 2040**

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

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1. An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and have a safety risk assessment performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm. [Minn. Stat. 144G.81 subd.1]

   Comments: The hazard vulnerability assessment for the property and grounds, dated March 10, 2025, failed to include a mitigation strategy for each hazard identified.