Electronically Delivered

June 30, 2026

Licensee
McCarthy Manor Assisted Living
2221 North Arlington Avenue
Duluth, MN  55811

RE:  Project Number(s) SL30315017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on June 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 - 1290 - 144g.60 Subdivision 1 - Background Studies Required - $1,000.00**

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

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

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

factor.

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

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

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

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30315 | A. BUILDING: _____ B. WING _____ | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCCARTHY MANOR ASSISTED LIVING | 2221 NORTH ARLINGTON AVENUE DULUTH, MN 55811 |

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| 0 000 | Initial Comments<br><br>*****ATTENTION*****<br><br>ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S)<br><br>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey.<br><br>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.<br><br>INITIAL COMMENTS:<br><br>SL30315017-0<br><br>On June 1, 2026, through June 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 22 residents; 22 receiving services under the Assisted Living Facility license.<br><br>An immediate correction order was identified on June 2, 2026, for tag identification 1290, and was issued at a scope and level of three, widespread (I). The licensee took mitigating action immediately, 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.<br><br>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.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>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. | |
| 0 630 SS=F | 144G.42 Subd. 6 (b) Compliance with requirements for reporting ma | 0 630 | | |

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| 0 630 | Continued From page 1<br><br>(b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for two of three residents (R2, R3).<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on June 4, 2026, at 10:33 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.<br><br>R2 | 0 630 | | |

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| 0 630 | Continued From page 2<br><br>R2's diagnoses included history of childhood sexual abuse, depression, and anxiety disorder.<br><br>R2's vulnerability assessment/abuse prevention plan dated March 3, 2026, indicated R2, was not at risk of abusing other vulnerable adults; R2 was not at risk and had no history of attempted suicide or thoughts of suicide, however, R2's assessment lacked R2's susceptibility of being abused by other vulnerable adults.<br><br>R3<br>R3's diagnoses included major depressive disorder.<br><br>R4's vulnerability assessment/abuse prevention plan dated November 6, 2026, indicated R3 was not at risk to abuse other venerable adults, R3 was not at risk and had no history of attempted suicide or thoughts of suicide.; however, R3's assessment lacked R3's susceptibility to abuse by others.<br><br>On June 6, at 11:45 a.m., LALD-A and CNS-B stated they were aware of the required content in an IAPP assessment/evaluation. CNS-B reviewed R2 and R3's assessment and stated all the required content should be addressed in a resident's vulnerability assessment/abuse prevention plan since the licensee used Eldermark (electronic health record) and CNS-B would have to investigate it further. Upon further investigation CNS-B states that in the licensee's electronic medical record Residex, the assessment for the IAPP includes the question regarding abuse by other vulnerable adults, but does not flag to be addressed.<br><br>The licensee's undated INITIAL AND ON-GOING NURSING ASSESSMENT OF RESIDENTS | 0 630 | | |

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| 0 630 | Continued From page 3<br><br>UNDER THE COMPREHENSIVE LICENSED AGENCY policy, indicated the licensee would develop an individual abuse prevention plan for each resident, to be incorporated into the care plan including specific measures to minimize the risk of abuse for each resident including areas of vulnerability of being harmed or harming others.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 630 | | |
| 0 660 SS=E | 144G.42 Subd. 9 Tuberculosis prevention and control<br><br>(a) The facility must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. The program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The facility must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by | 0 660 | | |

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| 0 660 | Continued From page 4<br><br>the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including a history and symptoms screening for active TB for two of three employees (registered nurse (RN)-C, unlicensed personnel (ULP)-D).<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with the current minimum assisted living requirements.<br><br>The facility's TB risk assessment was completed November 21, 2025, and the facility was determined to be a low risk level.<br><br>RN-C<br>RN-C was hired August 27, 2025, to supervise and provide direct care services to residents at the facility.<br><br>Throughout the survey, RN-C was observed providing care and services to the licensee's residents.<br><br>RN-C's employee record included negative TB results on February 12, 2026, and February 19, | 0 660 | | |

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| 0 660 | Continued From page 5<br><br>2026; however, lacked evidence RN-C completed a history and symptom screening for active TB.<br><br>ULP-H<br>ULP-H was hired on August 5, 2025, to provide direct care services to the residents at the facility.<br><br>ULP-H's employee record included negative TB results on August 22, 2025 and September 5, 2025; however, lacked evidence ULP-H completed a history and symptom screening for active TB.<br><br>On June 3, 2026, at 11:32 a.m., (housing manager (HM)-I, stated HM-I was unable to find RN-C or ULP-H's history and screening questions and was unsure why either were not competed. HM-I stated the licensee completed employee history and screening questionnaires and should be in each employee record.<br><br>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. The second TST may be performed after the HCW (health care worker) starts working with patients. Baseline TB screening should be documented in the employee's record. In addition, the guidelines include, "TB training is required at time of hire for all HCWs."<br><br>The licensee's undated TB Prevention And Control Policy states that prior to contact with clients, all assisted living employees and all | 0 660 | | |

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| 0 660 | Continued From page 6<br><br>volunteers will be screened for Tuberculosis. Prior to contact with clients, each staff person will be screened for tuberculosis. A two- step skin test or a single gamma release assay (IGRA) for M.Tuberculosis( e.g., Quantiferon TB Gold or TB Gold-InTube, TSPOT,) will be administered and reviewed by the RN. ULP-D's record lacked evidence of a two-step skin test.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 660 | | |
| 0 680 SS=F | 144G.42 Subd. 10 Disaster planning and emergency preparedness<br><br>(a) The facility must meet the following requirements:<br>(1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to all residents;<br>(4) post emergency exit diagrams on each floor; and<br>(5) have a written policy and procedure regarding missing residents.<br>(b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also | 0 680 | | |

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| 0 680 | Continued From page 7<br><br>working on site.<br>(c) The facility must meet any additional requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content. This had the potential to affect all 22 residents, staff and visitors.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated LALD-A was responsible for managing and maintaining the licensee's emergency preparedness plan.<br><br>The licensee's Disaster Plan dated January 23, 2026, lacked the following information:<br>-written arrangement agreements with other facilities receive residents in the event of limitations/cessation of operations to maintain the continuity of services to residents; and<br>-conduct exercises to test the EP at least twice per year, including unannounced staff drills using the emergency plan and analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events & | 0 680 | | |

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| 0 680 | Continued From page 8<br>revise plan as needed.<br><br>On June 6, 2026, at 12:44 p.m., the surveyor reviewed the licensee's EPP with LALD-A and confirmed the licensee did not have the following information noted above identified in the licensee's emergency preparedness plan.<br><br>The licensee's EPP plan dated January 23, 2026, indicated the purpose of the plan was to continue providing quality care to residents of the licensee during times of major emergencies and/or disasters or when such events are reasonably believed to be pending by maintaining close coordination and planning links with local emergency response organizations on an ongoing basis.<br><br>Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0100, sections A and B, effective October 2022, assisted living facilities shall comply with the federal emergency preparedness regulations for long-term care facilities under Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z-Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 0 680 | | |
| 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 9<br><br>Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and:<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G.<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days. | 0 775 | | |
| 0 810 SS=F | 144G.45 Subd. 2 (b-f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The | 0 810 | | |

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| 0 810 | Continued From page 10<br><br>plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) staff actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(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.<br>(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.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(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.<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in compliance with the requirements of Minnesota Statute 144G. | 0 810 | | |

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| | 30315 | A. BUILDING: _____ B. WING _____ | 06/03/2026 |

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| MCCARTHY MANOR ASSISTED LIVING | 2221 NORTH ARLINGTON AVENUE DULUTH, MN 55811 |

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| 0 810 | Continued From page 11<br><br>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).<br><br>The findings include:<br><br>Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated June 1, 2026, for the specific violations related the physical environment under Minnesota Statute 144G.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 0 810 | | |
| 01290 SS=G | 144G.60 Subdivision 1 Background studies required<br><br>(a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information.<br>(b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12.<br>(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. | 01290 | | |

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| 01290 | Continued From page 12<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure current employee records contained all the required content to include a current background study clearance letter for one of three employees (unlicensed personnel (ULP)-E). This had the potential to affect all residents living within the facility.<br><br>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 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).<br><br>The findings include:<br><br>This resulted in an immediate correction order on June 2, 2026.<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record.<br><br>ULP-E was hired on June 5, 2025, to provide direct care services to residents of the assisted living.<br><br>ULP-E's employee record included a background study dated July 17,2025, affiliated with the licensee's HFID; however, ULP-E's background study was no longer valid due to a previous inactive employment status report DHS by the | 01290 | | |

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| 01290 | Continued From page 13<br>licensee.<br><br>On June 2, 2026, at 8:25 a.m., LALD-A provided ULP-E's Department of Human Services (DHS) background study clearance dated July 17, 2025. LALD-A stated ULP-E had been an employee of the licensee and worked up until August 3, 2025, then ULP-E moved and went to college out of state. LALD-A stated Owner (O)-F was responsible for employee background studies and O-F must have informed DHS ULP-E was no longer an employee of the licensee when ULP-E returned to college in August of 2025. LALD-A stated ULP-E came back to work for the licensee during winter break from college December 19, 2025, through January 9, 2026, and returned for the summer and recently worked May 13, 2026. LALD-A was unaware ULP-E's background study was no longer active, and the licensee needed to initiate a new background study for ULP-E.<br><br>On June 2, 2026, at 9:02 a.m., LALD-A provided an updated DHS Netstudy 2.0 Employee Roster that listed ULP-E's determination status as "In Process". LALD-A stated the licensee initiated a new background study for ULP-E's and ULP-E would need to be fingerprinted again. LALD-A stated ULP-E was not scheduled to work until June 5, 2026.<br><br>The licensee's undated background checks policy indicated employees, contractors, and regularly scheduled volunteer 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 contact" means providing face-to-face care, training, supervision, | 01290 | | |

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| 01290 | Continued From page 14<br><br>counseling, consultation, or medication assistance to person served by the program.<br><br>Continuous Direct Supervision defined in NETStudy 2.0 System User Manual Updated July 7, 2023, page 7: Continuous, Direct Supervision - An individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the people served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to people served by the entity.<br><br>Supervision defined in, NETStudy 2.0 System User Manual Updated July 7, 2023, page 53: Supervision Status Study subjects must be under continuous, direct supervision until the study subject is determined eligible until the entity is notified by DHS that the study subject may provide unsupervised services while the background study is being completed. The supervision status is shown in the "Supervision Required" column for convenience. However, programs are instructed to rely on background study notices for supervision status and other background study determination information.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Immediate | 01290 | | |
| 01440 SS=F | 144G.62 Subd. 4 Supervision of staff providing delegated nurs<br><br>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an | 01440 | | |

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| 01440 | Continued From page 15<br><br>appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.<br>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual had begun working for the licensee for two of two employees (unlicensed personnel (ULP)-D, ULP-H).<br><br>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 | 01440 | | |

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| 01440 | Continued From page 16<br>a large portion or all of the residents).<br><br>The findings include:<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with the current minimum assisted living requirements.<br><br>ULP-D<br>ULP-D was hired on May 16, 2023, to provide direct care services to the residents at the facility.<br><br>On June 3, 2026, at 11:15 a.m., ULP-D stated, registered nurses (RN), train staff on medication passes, skills, competencies, and direct care supervision. ULP-D states ULP-H has been working since May 16, 2023, and has not had an follow-up training, only annual training.<br><br>ULP-D's employee record lacked documentation of an appropriate licensed health professional or RN supervising ULP-D performing a delegated task within 30 days of providing a delegated task.<br><br>ULP-H<br>ULP-H was hired on August 5, 2025, to provide direct care services to the residents at the facility.<br><br>ULP-H's employee record lacked documentation of an appropriate licensed health professional or RN supervising ULP-H performing a delegated task within 30 days of providing a delegated task.<br><br>On June 3, 2026, at 11:32 a.m., housing manager (HM)-I stated ULP-D and ULP-H's employee records would not contain a 30-day supervision of a delegated task or treatment and was unaware of the requirement. | 01440 | | |

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| 01440 | Continued From page 17<br><br>The licensee's undated Supervision of Licensed and Unlicensed Personnel policy indicated supervision of unlicensed staff performing nursing or delegated nursing, delegated treatment or assigned therapy services an RN would supervise ULP's performing a delegated task(s) within 30 calendar days after the staff member begins working and first performs the delegated resident task.<br><br>No further information provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-One (21) days | 01440 | | |
| 01470 SS=D | 144G.63 Subd. 2 Content of required orientation<br><br>(a) The orientation must contain the following topics:<br>(1) an overview of this chapter;<br>(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;<br>(3) handling of emergencies and use of emergency services;<br>(4) compliance with and reporting of the maltreatment of vulnerable adults under section 626.557 to the Minnesota Adult Abuse Reporting Center (MAARC);<br>(5) the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights;<br>(6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person;<br>(7) handling of residents' complaints, reporting of complaints, and where to report complaints, including information on the Office of Health | 01470 | | |

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| 01470 | Continued From page 18<br><br>Facility Complaints;<br>(8) 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 other relevant advocacy services; and<br>(9) a review of the types of assisted living services the staff member will be providing and the facility's category of licensure.<br>(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:<br>(1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and the challenges it poses to communication;<br>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure employees | 01470 | | |

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| 01470 | Continued From page 19<br><br>received orientation to assisted living requirements and regulations prior to providing services for one of two employees (registered nurse (RN)-C).<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record.<br><br>RN-C was hired August 27, 2025, to supervise and provide direct care services to residents at the facility.<br><br>Throughout the survey, RN-C was observed providing care and services to the licensee's residents.<br><br>RN-C's employee record lacked documented evidence of the following required orientation:<br>-review of provider's policies and procedures;<br>-handling emergency and using emergency services;<br>-handling of resident complaints, reporting of complaints, and where to report;<br>-consumer advocacy services;<br>-review of types of Assisted Living services the employee will provide and provider's scope of | 01470 | | |

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| 01470 | Continued From page 20<br><br>license; and<br>principles of person-centered planning/service delivery.<br><br>On June 3, 2026, at 10:56 a.m., housing manager (HM)-I stated HM-I was responsible for assigning employee training. HM-I stated they were unaware RN-C was not assigned the required orientation training upon hire.<br><br>The licensee's undated Personnel Records policy, indicated the personnel record for each person must include a record of required in-service education for all staff providing services to clients.<br><br>The licensee's undated Assisted Living and Assisted Living with Memory Care Orientation-All Staff policy indicated all assisted living employees must complete an orientation to assisted living facility licensing requirements and regulations before providing services to residents. At a minimum, orientation must include the following topics:<br>-an overview of Minnesota's assisted living law;<br>-an introduction and review of agency policies and procedures related to the provision of assisted living services;<br>-emergency and disaster training;<br>-handling of emergencies and use of emergency services Emergency and disaster preparedness plan;<br>-procedures to use in handling various emergency situation;<br>-employee Right to Know;<br>-the assisted living bill of rights and staff responsibilities to ensuring the exercise and protection of those rights; and<br>-principles of person-centered planning and service delivery and how they apply to direct | 01470 | | |

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| 01470 | Continued From page 21<br>supportive services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01470 | | |
| 01530 SS=D | 144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De-<br><br>(a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements:<br>(1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br>(2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if | 01530 | | |

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| 01530 | Continued From page 22<br><br>issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter;<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure direct care staff received the required two hours of initial training on mental illness and de-escalation topics for one of two employees (registered nurse (RN)-C). In addition, the licensee failed to ensure one of two employees (RN-C) received the required amount of dementia care training in the required time frame.<br><br>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).<br><br>The findings include:<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record. | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30315 | A. BUILDING: _____ B. WING _____ | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCCARTHY MANOR ASSISTED LIVING | 2221 NORTH ARLINGTON 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 |
|---|---|---|---|---|
| 01530 | Continued From page 23<br><br>RN-C was hired August 27, 2025, to supervise and provide direct care services to residents at the facility.<br><br>Throughout the survey, RN-C was observed providing care and services to the licensee's residents.<br><br>RN-C's employee record lacked documentation the required two hours of initial training on mental illness and de-escalation topics were completed which became effective July 1, 2025. In addition, RN-C's record indicated RN-C completed only 4.25 hours of the required eight hours of dementia training topics within 120 working hours of start date.<br><br>On June 3, 2026, at 10:56 a.m., housing manager (HM)-I, was responsible for assigning employee training modules. HM-I was unaware RN-C was not assigned the required mental illness/de-escalation and dementia training's.<br><br>The licensee's undated Assisted Living Dementia Training policy indicated assisted living staff would receive required training on dementia care during orientation and annually. Supervisors of direct care staff would complete eight hours initial training on dementia care topics and would be completed within 120 working hours of the employment start date. The policy did not address mental illness or de-escalation employee training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01530 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30315 | A. BUILDING: _____ B. WING _____ | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCCARTHY MANOR ASSISTED LIVING | 2221 NORTH ARLINGTON 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 |
|---|---|---|---|---|
| 01550 | Continued From page 24 | 01550 | | |
| 01550 SS=D | 144G.64 (a) (4) Training in Dementia, Mental Illness, and De-<br><br>(4) staff who do not provide direct care, including maintenance, housekeeping, and food service staff, must have at least four hours of initial training on topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date, and must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; and<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure one of one non-direct care employee (cook (C)-G) received the required amount of dementia, mental illness, and de-escalation training in the required time frame.<br><br>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).<br><br>The findings include: | 01550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30315 | A. BUILDING: _____ B. WING _____ | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCCARTHY MANOR ASSISTED LIVING | 2221 NORTH ARLINGTON 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 |
|---|---|---|---|---|
| 01550 | Continued From page 25<br><br>During the entrance conference on June 1, 2026, at 10:35 a.m., licensed assisted living director (LALD)-A stated the licensee was aware of required contents in an employee record.<br><br>C-G was hired on September 11, 2025, to cook meals for residents at the assisted living facility.<br><br>During the course of the survey, C-G was observed preparing and serving resident meals.<br><br>C-G's employee record indicted C-G completed one of the required initial two hours of mental illness and de-escalation training; In addition, C-G's employee record indicted C-G completed three of the required four hours of dementia training within 120 hours of employment start date.<br><br>On June 3, 2026, at 10:56 a.m., housing manager (HM)-I assisted with onboarding new staff and was responsible for assigning training modules for employees. HM-I was not aware C-G was required to complete two hours of mental illness and de-escalation training and four hours of dementia training.<br><br>The licensee's undated Personnel Records policy indicated a personnel record for each employee would include record of all required training for unlicensed personnel.<br><br>The licensee's undated Assisted Living Dementia Training policy indicated assisted living staff would receive required training on dementia care during orientation and annually. Non direct care staff would complete four hours initial training on dementia care topics and would be completed within 120 working hours of the employment start | 01550 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 30315 | A. BUILDING: _____ B. WING _____ | 06/03/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MCCARTHY MANOR ASSISTED LIVING | 2221 NORTH ARLINGTON 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 |
|---|---|---|---|---|
| 01550 | Continued From page 26<br>date. The policy did not address mental illness or de-escalation employee training.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 01550 | | |

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

Mccarthy Manor Inc
2221 North Arlington Avenue
Duluth, MN 55811
St Louis County
Parcel:

Phone:

## License Info

License: HFID 30315

Risk:
License:
Expires on:
CFPM: BART T MARTINSON
CFPM #: CFPM 11206; Exp: 10/25/2028

## Inspection Info

Report Number: F1016261108
Inspection Type: Full - Single
Date: 6/2/2026 Time: 11:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery:

No orders were issued for this inspection report.

# 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 F1016261108 from 6/2/2026**

BART
DIRECTOR

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

Mccarthy Manor Inc
Duluth
County/Group: St Louis County

## Inspection Info

Report Number: F1016261108
Inspection Type: Full
Date: 6/2/2026
Time: 11:30 AM

**Food Temperature: Product/Item/Unit:** CORN DOG**; Temperature Process:** Heating
**Location:** Steam Table at 167 Degrees F.
Comment:
*Violation Issued?: No*

**Food Temperature: Product/Item/Unit:** FRENCH FRIES**; Temperature Process:** Heating
**Location:** Steam Table at 152 Degrees F.
Comment:
*Violation Issued?: No*

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

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

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

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

# Sanitizer Observations/Recordings



## Establishment Info

Mccarthy Manor Inc
Duluth
County/Group: St Louis County

## Inspection Info

Report Number: F1016261108
Inspection Type: Full
Date: 6/2/2026
Time: 11:30 AM

**Sanitizing Equipment**: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
**Location:** Dishwashing Area **Equal To** 165 Degrees F.
Comment:
*Violation Issued?: No*

**Sanitizing Chemical**: **Product:** Quaternary Ammonia**; Sanitizing Process:** Wiping Cloth Bucket
**Location:** Kitchen **Greater Than** 200 PPM
Comment:
*Violation Issued?: No*

# Physical Environment Inspection Report

ASSISTED LIVING | ASSISTED LIVING WITH DEMENTIA CARE

| | |
|---|---|
| **Project No:** SL30315017-0 | **Date:** 6/1/2026 |
| **Facility Name:** MCCARTHY MANOR ASSISTED LIVING | |
| **Facility Address:** 2221 NORTH ARLINGTON AVENUE; DULUTH, MN 55811 | |

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Interior vertical shafts, including stairways, elevator hoistways, and service and utility shafts, that connect two of more stories of a building, shall be enclosed or protected. When openings are required to be protected, opening protectives shall be maintained self-closing. [Minn. Stat. 144G.45 subd. 2; MSFC 1103.4, 1103.4.1]

   *Comments: Inside the basement laundry room surveyor observed a vertical utility shaft that connected the basement to the other levels of the facility. The opening was not enclosed or protected and was being used as a utility shaft for wires to additional levels.*

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   *Comments: Levels 2 and 3 vestibules on the north side of the building leading to the exterior stairwell were being used as storage for housekeeping equipment and resident wheelchairs. Licensed assisted living director (LALD)-A removed equipment while surveyor was on site.*

☒ **TAG IDENTIFICATION: 0810**

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

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

   *Comments: Licensee failed to provide evacuation map with number of resident rooms.*

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

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

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: Licensee failed to provide documentation on training for staff on the FSEP.*