Electronically Delivered

April 17, 2026

Licensee
Vitacare Living
23 Waterview Drive
Proctor, MN 55810

RE: Project Number(s) SL30617016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on March 26, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and may be imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement;
Level 2: a fine of $500 per violation, in addition to any enforcement mechanism authorized in § 144G.20;
Level 3: a fine of $1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 4: a fine of $3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
Level 5: a fine of $5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed

pursuant to this survey:

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $1,000.00
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 $2,000.00**. 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. 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, 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
	30617	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

(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: SL30617016-0 On March 23, 2026, through March 26, 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 30 residents; 30 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on March 25, 2026, issued for SL30617016-0, tag identification 1290. The licensee took action on March 26, 2026, to mitigate the risk; however, the scope and level remains at level 3/Widespread (I).	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 24, 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		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post required content in common areas and near telephones to include posting the 911 emergency number at the assisted living. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 640		

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0 640	Continued From page 4 The findings include: During the entrance conference on March 23, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On March 23, 2026, from 1:40 p.m. through 1:54 p.m., the surveyor completed a self-guided tour of the building. The surveyor did not observe any postings with the 911 emergency number in the commons area or near telephones provided by the assisted living with dementia care facility. On March 24, 2026, at 2:09 p.m., LALD/CNS-A stated the 911 emergency number used to be posted in the facility, however, the licensee had purchased new telephones and did not report the 911 emergency number. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640		
0 660 SS=D	144G.42 Subd. 9 Tuberculosis prevention and control (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,	0 660		

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0 660	Continued From page 5 contractors, students, and regularly scheduled volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines. (b) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain a tuberculosis (TB) prevention program based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) and Minnesota Department of Health (MDH), including completion of a TB screening and a two-step TST (tuberculin skin test) or other evidence of TB screening such as a blood test for one of two employees (registered nurse (RN)-B). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. The licensee's Facility TB Risk Assessment Worksheet for Health Care Settings Licensed by	0 660		

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0 660	Continued From page 6 MDH was completed on November 28, 2025, and the facility was determined to be a low risk level. RN-B was hired on November 17, 2025, to provide direct care services to residents and supervision to the staff at the assisted living facility. On March 24, 2026, at 10:13 a.m., the surveyor observed RN-B provide direct care to residents at the assisted living with dementia care facility. RN-B's employee record contained a negative QuantiFERON TB Gold blood test collected on July 29, 2025 (111 days prior to RN-B's employment start date). RN-B's employee record lacked evidence of a TB screen and a two-step TST or other evidence of a TB screening, such as a blood draw, within 90 days of employment or upon hire. On March 24, 2026, at 1:50 p.m., LALD/CNS-A stated the RN and executive director for the site were responsible for completing TB screens and testing during employee onboarding at hire. LALD/CNS-A further stated RN-B's employee record lacked a TB screen and RN-B's blood draw was over 90 days old from RN-B's employment start date. LALD/CNS-A stated the licensee accepted an employee's previous TST or blood draw if the documentation indicated the testing was completed within 90 days of employment start date. The licensee's TB Prevention and Control policy dated May 2, 2025, indicated upon hire staff will be screened for TB symptoms and tested for TB. In addition, if a staff member presents a two-step Mantoux (TST) with negative results or a negative	0 660		

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0 660	Continued From page 7 IGRA (Interferon-Gamma Release Assay- TB blood test) within 90-days of hire, this (documentation) will be used for proof of negative result and the staff member does not need further testing. The MDH TB Screening and Education Requirements for Assisted Living Facilities and Home Care Providers dated February 3, 2022, indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes assessing for current symptoms of active TB disease; assessing TB history; and testing for the presence of infection with Mycobacterium TB by administering either a two-step TB skin test or a single TB blood test. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last March 9, 2026, indicated a licensee could accept a TST or IGRA blood test dated within 90 days of hire for a new employee. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 660		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff	0 680		

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0 680	Continued From page 8 assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and post a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had the potential to affect residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and 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:	0 680		

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0 680	Continued From page 9 During the entrance conference on March 23, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On March 23, 2026, from 1:40 p.m. through 1:54 p.m., the surveyor completed a self-guided tour of the building. The surveyor did not observe the licensee's EPP or signage on where to locate the licensee's EPP. The licensee's EPP dated March 1, 2026, lacked the following required content: - quarterly review of the missing resident plan (last reviewed July 10, 2023); - exercises to test the EPP at least twice per year, including unannounced staff drills using the EPP to include: - participate in an annual full-scale exercise that is community based or conduct an annual, individual, facility-based functional exercise or if the facility experiences an actual emergency requiring activation of the plan, the facility is exempt from engaging in its next required full-scale exercise; - conduct an additional annual exercise that may include a second full-scale exercise that is community based or an individual, facility based functional exercise or mock disaster drill or table-top exercise; and - analyze the facility's response to and maintain documentation of all drills, tabletop exercises and emergency events and revise the plan as needed. On March 25, 2026, at 2:48 p.m., LALD/CNS-A stated the licensee kept the EPP in a cupboard and used to have a posting of the location for the	0 680		

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0 680	Continued From page 10 EPP, however, the posting must have been taken down. LALD/CNS-A further stated the licensee had completed at least two exercises for the EP, however, the licensee only documented fire drills and not full scale exercises. In addition, LALD/CNS-A stated the licensee did not document review of the missing resident policy quarterly. The licensee's Protocol: Elopement/Missing Resident policy dated July 10, 2023, indicated the assisted living director and CNS will review the missing resident plan at least quarterly and document any changes to the plan. The licensee's Emergency Preparedness policy dated June 2, 2023, indicated a fire drill or other emergency disaster drill is conducted at the residence at least every month. The licensee's Emergency and Disaster Preparedness policy dated June 1, 2023, indicated a written policy and procedure regarding missing residents is complete in compliance with MN Rule 4659.0110. In addition, the facility will post the emergency disaster plan (EPP) prominently and the facility conducts exercises to test the EPP at least twice per year. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0110, Subp. 4, effective October 2022, the assisted living director and CNS must review the missing person plan at least quarterly and document any changes to the plan. 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	0 680		

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0 680	Continued From page 11 Code of Federal Regulations, title 42, section 483.73, or successor requirements. This part references documents, specifications, methods, and standards in "State Operations Manual Appendix Z - Emergency Preparedness for All Providers and Certified Supplier Types: Interpretive Guidance," which is incorporated by reference. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680		
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, 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 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:	0 775		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30617	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

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0 775	Continued From page 12 Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 24, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 775		
0 790 SS=C	144G.45 Subd. 2 (a) (2-3) Fire protection and physical environment (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation, 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 one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic	0 790		

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0 790	Continued From page 13 failure that has affected or has potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated March 24, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 790		
0 800 SS=E	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, 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	0 800		

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0 800	Continued From page 14 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 March 24, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days	0 800		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.	0 810		

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0 810	Continued From page 15 (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, 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 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, Physical Environment Inspection Report (PEIR) dated March 24, 2026, for the specific violations related	0 810		

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0 810	Continued From page 16 the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
01290 SS=I	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on observation, interview, and record 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 13 employees (information technologist (IT)-L). This had the potential to affect all residents living within the facility. This practice resulted in a level three violation (a violation that harmed a resident's health or safety,	01290		

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01290	Continued From page 17 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: This resulted in an immediate correction order on March 25, 2026. During the entrance conference on March 23, 2026, at 12:55 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was aware of required contents in an employee record. Assisted living director in residency (ALDIR)-J stated ALDIR-J was responsible for completing employee background studies upon hire. IT-L was hired on February 5, 2025, to provide IT services at the facility. On March 24, 2026, during the later morning hours, IT-L was observed providing a tour for the Minnesota Department of Health (MDH) engineer surveyor. IT-L's employee record lacked a cleared background study through the Minnesota Department of Human Services (MN DHS) NETStudy website. On March 24, 2026, at 2:04 p.m., LALD/CNS-A stated IT-L was not listed on the licensee's NETStudy 2.0 Background Study Roster, however, LALD/CNS-A had thought IT-L had a cleared background study at a sister facility location.	01290		

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01290	Continued From page 18 On March 25, 2026, at 8:48 a.m., office manager (OM)-D stated IT-L was now affiliated with the licensee's NETStudy 2.0 Roster. The surveyor requested to see IT-L's original background study issued through the sister facility location, however, the background study was never provided. On March 25, 2026, at 2:43 p.m., OM-D stated the licensee's previous sensitive information person (SIP) had a background check ran for IT-L under a sister location, however, the previous SIP employee was no longer employed at the facility, and there was not an employee record with a background study for IT-L at the sister facility location. OM-D further stated no other employees had access to the NETStudy 2.0 Roster when the previous SIP employee left and OM-D would not be notified if IT-L's employee background study were to become ineligible. IT-L stated IT-L provided IT services, including computer updates and camera access for the licensee and was not onsite "99.9 percent of the time." On March 25, 2026, at 2:58 p.m., unlicensed personnel (ULP)-E stated ULP-E had seen IT-L in the building working. On March 25, 2026, at 2:59 p.m., ULP-M stated IT-L had been onsite working on IT issues for the licensee approximately once per week and worked alone or unsupervised. On March 25, 2026, at 3:28 p.m., ALDIR-J stated ALDIR-J could not guarantee ALDIR-J had direct supervision of IT-L the entire time IT-L was onsite yesterday (March 24, 2026). The licensee's Background Checks policy dated	01290		

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01290	Continued From page 19 June 2, 2025, indicated all employees, contractors, and regularly scheduled volunteers are subject to background studies. 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 persons served by the program. Direct Contact Services - Providing face-to-face care, training, supervision, counseling, consultation, or medication assistance to persons served by the entity. 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. No further information was provided. TIME PERIOD FOR CORRECTION: Immediate	01290		
01620 SS=E	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620		

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01620	Continued From page 20 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 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	01620		

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01620	Continued From page 21 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 three residents (R2, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 23, 2026, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the registered nurse (RN) completed a comprehensive preadmission assessment, admission assessment, 14 days after admission, and then at least every 90 days unless the resident had a change of condition.	01620		

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01620	Continued From page 22 R2 R2 was admitted to the facility on August 27, 2024. R2's diagnoses included cardiomyopathy (enlarged heart), congestive heart failure (CHF), and hypertension (HTN- high blood pressure). R2's Medication Management Plan: Addendum to Service Plan (service plan) dated August 27, 2024, indicated R2's services included medication administration five times per day. On March 24, 2026, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-G bring R2's scheduled morning medication to R2 to self-administer. R2's record included a Q4 (quarter 4) Assessment dated October 29, 2025, completed by an RN. R2's Quarterly Assessment dated February 12, 2026 (106 days after the previous assessment), was completed by RN-B. R2's record lacked evidence of a 90-day reassessment completed by an RN in the required time frame. On March 25, 2026, at 12:58 p.m., LALD/CNS-A stated R2's assessments were completed over 90 days a part, and LALD/CNS-A stated LALD/CNS-A was unsure why R2's 90-day assessment was completed late. R7 R7 was admitted to the facility on March 4, 2024. R7's diagnoses included diabetes, CHF, end	01620		

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01620	Continued From page 23 stage renal (kidney) disease on dialysis, and HTN. R7's Medication Management Plan: Addendum to Service Plan and Treatment Plan: Addendum to Service Plan (service plan) dated August 10, 2023, indicated R7's services included medication administration four times per day, blood glucose checks four times per day, and fluid restriction daily. On March 24, 2026, at 8:38 a.m., the surveyor observed ULP-F administer R7's scheduled morning medication. R7's record included a Q2 (quarter 2) Assessment dated November 4, 2025, completed by an RN. R7's Quarterly Assessment dated February 18, 2026 (106 days after the previous assessment), was completed by RN-B. R7's record lacked evidence of a 90-day reassessment completed by an RN in the required time frame. On March 25, 2026, at 2:13 p.m., LALD/CNS-A stated the licensee used electronic medical records for residents, which prompted the RNs to know when assessments were due to be completed. LALD/CNS-A further stated R7's 90-day assessment was not completed within 90 days and LALD/CNS-A was unsure why. The licensee's Initial and On-Going Nursing Assessment of Residents policy dated May 2, 2025, indicated ongoing comprehensive nursing assessments are completed periodically but no less than every 90-days.	01620		

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01620	Continued From page 24 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced	01650		

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01650	Continued From page 25 by: Based on observation, interview, and record review, the licensee failed to ensure service plans were revised to include the required content for two of three residents (R2, R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on March 23, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. R2 R2 was admitted to the facility on August 27, 2024. R2's diagnoses included cardiomyopathy (enlarged heart), congestive heart failure (CHF), and hypertension (HTN- high blood pressure). R2's Service Plan: Part 2 (two) (service plan) dated August 27, 2024, indicated R2's code status was full resuscitation. R2's Quarterly Assessment dated February 12, 2026, indicated under the finance/care decisions section: R2's code status and advance directives	01650		

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01650	Continued From page 26 were DNR (do not resuscitate). On March 24, 2026, at 7:15 a.m., the surveyor observed unlicensed personnel (ULP)-G bring R2's scheduled morning medication to R2 to self-administer. R2's service plan lacked revision when R2's code status was revised from full resuscitation to DNR. R7 R7 was admitted to the facility on March 4, 2024. R7's diagnoses included diabetes, CHF, end stage renal (kidney) disease on dialysis, and HTN. R7's Service Plan: Part 2 (two) (service plan) dated August 10, 2023, indicated R7's code status was DNR. On March 24, 2026, at 8:38 a.m., the surveyor observed ULP-F administer R7's scheduled morning medication. R7's Quarterly Assessment dated February 18, 2026, indicated under the finance/care decisions section: R7's code status and advance directives were CPR (cardiopulmonary resuscitation). On March 24, 2026, at 8:38 a.m., the surveyor observed ULP-F administer R7's scheduled morning medication. R7's service plan lacked revision when R7's code status was revised from DNR to full resuscitation. On March 25, 2026, at 1:02 p.m., LALD/CNS-A and registered nurse (RN)-B stated resident service plans were to be revised to reflect current	01650		

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01650	Continued From page 27 resident's code status, however, LALD/CNS-A and RN-B had thought R2 and R7's code status listed on the service plans had errors and were not revised to reflect each resident's code status. The licensee's Contents of Service Plans policy dated May 2, 2025, indicated service plans are reviewed and revised as needed based upon on-going resident assessment. In addition, the service plan content included circumstances in which emergency medical services are not to be summoned. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the registered nurse (RN) failed to reassess a resident for appropriate medication management services when resident's status changed for one of two residents (R2) who received medication management services.	01710		

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01710	Continued From page 28 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:43 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management to residents at the facility. R2 was admitted to the facility on August 27, 2024. R2's diagnoses included cardiomyopathy (enlarged heart), congestive heart failure (CHF), and hypertension (HTN- high blood pressure). R2's Medication Management Plan: Addendum to Service Plan (service plan) dated August 27, 2024, indicated R2's services included medication administration five times per day. R2's Med (medication) Admin (administration) Summary- Actual- Month dated February 2026, and March 2026, respectively indicated unlicensed personnel (ULPs) administered R2's medications. R2's prescriber orders dated June 25, 2025, August 4, 2025, August 29, 2025, September 8, 2025, October 27, 2025, November 3, 2025, and	01710		

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01710	Continued From page 29 March 16, 2026, respectively, included all medications listed on R2's electronic medication administration record (EMAR). On March 24, 2026, at 7:15 a.m., the surveyor observed ULP-G bring R2's scheduled morning medication to R2 to self-administer. R2's Quarterly Assessment dated February 12, 2026, indicated R2 was unable to self-administer medications, unlicensed personnel trained by nurse provide medication administration [sic]. In addition, R2 was deemed not able to self-administer medications safely. R2's record lacked evidence, R2 was assessed for self-administration of medications. On March 25, 2026, at 1:03 p.m., RN-B stated ULPs were trained to administer all resident medications unless the EMAR indicated the resident was assessed for self-administration. RN-B further stated R2 had not been assessed to self-administer any medications. The licensee's Medication Management Program policy dated May 2, 2025, indicated at the time of assessment, the RN determines with the client (resident)/caregiver what medication management services will be provided. In addition, the assessment includes client (resident)/caregiver ability in medication self-management. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01710		

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01760	Continued From page 30	01760		
01760 SS=D	144G.71 Subd. 8 Documentation of administration of medication Each medication administered by the assisted living facility staff must be documented in the resident's record. The documentation must include the signature and title of the person who administered the medication. The documentation must include the medication name, dosage, date and time administered, and method and route of administration. The staff must document the reason why medication administration was not completed as prescribed and document any follow-up procedures that were provided to meet the resident's needs when medication was not administered as prescribed and in compliance with the resident's medication management plan. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of the administration of medications included all required content for one of two residents (R7). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:43 p.m., licensed assisted living	01760		

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01760	Continued From page 31 director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management to residents at the facility. R7's diagnoses included diabetes, congestive heart failure (CHF), end stage renal (kidney) disease on dialysis, and hypertension (HTN- high blood pressure). R7's Medication Management Plan: Addendum to Service Plan and Treatment Plan: Addendum to Service Plan (service plan) dated August 10, 2023, indicated R7's services included medication administration four times per day, blood glucose checks four times per day, and fluid restriction daily. R7's prescriber orders March 24, 2026, included an order for Insulin aspart (Novolog Flexpen) insulin 100 units/milliliter (mL)- four (4) units to be administered three times daily at 8:00 a.m., 12:00 p.m., and 6:00 p.m., and additional units per the below sliding scale (a scale directing the amount of insulin that should be administered based off the blood glucose (sugar) result) on non-dialysis days (Sunday, Tuesday, Thursday, Saturday): - less than 199 or R7 is not eating the meal= administer 0 units; - 200 - 259 = administer 1 unit; - 260 - 319 = administer 2 units; - 320 - 379 = administer 3 units; - 380 - 439 = administer 4 units; - 440 - 499 = administer 5 units; and - 500 - 559= administer 6 units. On March 24, 2026, at 8:38 a.m., the surveyor observed unlicensed personnel (ULP)-F administer a total of five (5) units of Novolog insulin to R7 per the sliding scale from R7's blood glucose reading of 221. ULP-F documented on	01760		

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01760	Continued From page 32 R7's electronic medication administration record (EMAR) R7 was administered four (4) units plus an additional one (1) unit (from the sliding scale) of Novolog Flexpen insulin. ULP-F stated ULP-F was trained to document how many additional Novolog insulin units were administered to R7 based on the blood glucose sliding scale results. R7's Med (medication) Admin (administration) Summary- Month dated March 2025, indicated the following: -March 3, 2026, at 12:00 p.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -March 7, 2026, at 12:00 p.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -March 8, 2026, at 12:00 p.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -March 10, 2026, at 8:00 a.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -March 12, 2026, at 8:00 a.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; -March 19, 2026, at 6:00 p.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results; and -March 19, 2026, at 12:00 p.m., lacked how many units of Novolog Flexpen insulin were administered based on the sliding scale blood glucose results.	01760		

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01760	Continued From page 33 On March 26, 2026, at 1:47 p.m., LALD/CNS-A stated R7's documentation for Novolog insulin administered based on the sliding blood glucose scale was supposed to have the actual amount of insulin units documented with each entry under the notes section on the EMAR. LALD/CNS-A further stated R7 confirmed the additional units administered based on the sliding scale prior to the ULP administering the Novolog insulin. The licensee's Documentation of Medication, Treatment and Therapy Management Services policy dated May 2, 2025, indicated RNs (registered nurses), LPNs (licensed practical nurses), and ULPs will appropriately document all medications. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01890 SS=F	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to monitor expired medications in three of three locked medication carts (one, two, three).	01890		

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01890	Continued From page 34 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on March 23, 2026, at 12:43 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management to residents at the facility. MEDICATION CART ONE On March 25, 2026, at 1:35 p.m., the surveyor and unlicensed personnel (ULP)-M observed an opened stock tube of lubricating jelly expired August 24, 2026. MEDICATION CART TWO On March 25, 2026, at 1:47 p.m., the surveyor and ULP-M observed the following expired medications: -opened stock ketoconazole shampoo expired August 2025; and -unopened stock barrier cream expired August 24, 2023. MEDICATION CART THREE On March 25, 2026, at 2:05 p.m., the surveyor and ULP-M observed the following expired medications: -unopened stock lubricating jelly expired August 24, 2023; -opened stock lancets expired November 2025;	01890		

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01890	Continued From page 35 and - opened stock Dulcolax expired December 2025. On March 25, 2026, at 2:17 p.m., LALD/CNS- A stated nurses completed weekly audits of the three locked medication carts and monitored for expired medications, however, all staff were expected to check expiration dates of medications prior to medication administration. The licensee's Storage of Medications policy dated May 2, 2025, indicated the registered nurse (RN) will provide education to the resident/resident's representative on the proper storge of medications in the home including the need to be refrigerated, or stored in a cool, dry area, and according to manufacturer's recommendations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of	01910		

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01910	Continued From page 36 medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:43 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management to residents at the facility. The licensee's Discharged Resident/Client Roster Evaluations dated December 1, 2025, through March 23, 2026, indicated R1 was admitted to the facility on September 24, 2025, and discharged on February 7, 2026.	01910		

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01910	Continued From page 37 R1's diagnoses included epilepsy, chronic pain syndrome, and major depressive disorder. R1's Medication Management Plan: Addendum to Service Plan (service plan) dated September 24, 2025, indicated R1's services included mediation administration. R1's Med (medication) Admin (Administration) Summary dated January 2025, and February 2025, respectively, indicated R1 received the following medications: -Abilify (antidepressant) 2 milligrams (mg) daily -buspirone HCl (antianxiety) 22.5 mg twice daily -Depakote DR (for seizures) 750 mg three times daily -Desvenlafaxine ER (antidepressant) 100 mg daily -lacosamide (for epilepsy) 200 mg twice daily -Lamotrigine (for epilepsy) 20 mg twice daily -Ozempic (for weight loss) 2 mg/3 milliliters (mL) once weekly -Testosterone Transdermal gel (replacement supplement) 20.25 mg/1.25 grams (gm) two pumps daily -lorazepam (antianxiety) 0.5 mg twice daily as needed -Zofran (antinausea) 4 mg every 8 hours as needed R1's prescriber orders dated September 29, 2025, included the above noted medications. R1's Discharge Care Plan dated February 7, 2026, indicated R1 moved to a different assisted living facility to be closer to family. R1's Medication Disposition- Resident dated September 1, 2025, through September 30, 2025,	01910		

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01910	Continued From page 38 included all medications noted above, however, lacked the prescription numbers for Ability, buspirone HCl, Depakote DR, Desvenlafaxine ER, Lamotrigine, Ozempic, Testosterone Transdermal gel, and Zofran. On March 24, 2025, at 1:59 p.m., LALD/CNS-A stated the licensee was aware prescription numbers were required, if applicable, to be documented with medication disposition. LALD/CNS-A further stated R1 had come to the facility with some medications from home and the prescription numbers were not entered into the licensee's electronic medical record system. The licensee's Disposition or Disposal of Medication policy dated May 2, 2025, indicated documentation of the medication destruction would include the prescription number. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01910		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be	01940		

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01940	Continued From page 39 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for one of two residents (R7) who had treatments or therapies managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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:	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30617	A. BUILDING: _____ B. WING _____	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VITACARE LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

(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
01940	Continued From page 40 During the entrance conference on March 23, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and therapy services to residents at the facility. R7's diagnoses included diabetes, congestive heart failure (CHF), end stage renal (kidney) disease on dialysis, and hypertension (HTN- high blood pressure). R7's Medication Management Plan: Addendum to Service Plan and Treatment Plan: Addendum to Service Plan (service plan) dated August 10, 2023, indicated R7's services included a 1,200 milliliters (mL) fluid restriction daily to preserve remaining kidney function. R7's prescriber orders lacked an order for 1,200 mL fluid restriction daily. R7's Quarterly Assessment dated February 18, 2026, indicated R7 went to dialysis three times per week. Give R7 eight (8) to 16 ounces of fluids with each meal. Encouraged to drink water throughout the day to prevent dehydration. On March 24, 2026, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R7. R7's record lacked a treatment plan including the following required content: -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy task that would be delegated to ULPs; -procedures for notifying a registered nurse (RN)	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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VITACARE LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

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01940	Continued From page 41 when a problem arose; and -and resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On March 25, 2026, at 1:16 p.m., LALD/CNS-A stated treatments provided to residents should have a treatment plan. LALD/CNS-A further stated LALD/CNS-A would look for R7's treatment plan and provide to the surveyor. On March 27, 2026, at 12:28 p.m., LALD/CNS-A emailed (electronic mail) the surveyor, which indicated LALD/CNS-A and RN-B were looking into R7's fluid restriction, LALD/CNS-A was waiting to hear back on the fluid restriction, and LALD/CNS-A will send supporting documentation over to the surveyor. No additional documentation was emailed to the surveyor. The licensee's Treatment and Therapy Management policy dated May 2, 2025, indicated the RN will prepare an individualized treatment or therapy management plan for each client (resident) receiving ordered or prescribed treatments or therapy services which addresses the following: -procedures for documenting treatments or therapies; -procedures for monitoring treatments or therapies to prevent possible complications or adverse reactions; -identification of treatment or therapy tasks delegated to ULPs; and -procedures for notifying the RN when a problem arises related to the treatment or therapy service.	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30617	A. BUILDING: _____ B. WING _____	03/26/2026

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VITACARE LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

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01940	Continued From page 42 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for one of two residents (R7) receiving treatment management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 43 resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and therapy services to residents at the facility. R7's diagnoses included diabetes, congestive heart failure (CHF), end stage renal (kidney) disease on dialysis, and hypertension (HTN- high blood pressure). R7's Medication Management Plan: Addendum to Service Plan and Treatment Plan: Addendum to Service Plan (service plan) dated August 10, 2023, indicated R7's services included a 1,200 milliliters (mL) fluid restriction daily to preserve remaining kidney function. R7's prescriber orders lacked an order for 1,200 mL fluid restriction daily. R7's Quarterly Assessment dated February 18, 2026, indicated R7 went to dialysis three times per week. Give R7 eight (8) to 16 ounces of fluids with each meal. Encouraged to drink water throughout the day to prevent dehydration. On March 24, 2026, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R7.	01950		

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VITACARE LIVING	23 WATERVIEW DRIVE PROCTOR, MN 55810

(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
01950	Continued From page 44 R7's record lacked documentation of R7's fluid intake. R7's record lacked specific instructions for when ULPs should notify the RN when a problem arises regarding the 1,200 mL fluid restriction and communicated with the ULP about the individual needs of R7. On March 25, 2026, at 1:16 p.m., LALD/CNS-A stated treatments provided to residents should have a treatment plan. LALD/CNS-A further stated LALD/CNS-A would look for R7's treatment plan and provide to the surveyor. On March 27, 2026, at 12:28 p.m., LALD/CNS-A emailed (electronic mail) the surveyor, which indicated LALD/CNS-A and RN-B were looking into R7's fluid restriction, LALD/CNS-A was waiting to hear back on the fluid restriction, and LALD/CNS-A will send supporting documentation over to the surveyor. No additional documentation was emailed to the surveyor. The licensee's Treatment and Therapy Management policy dated May 2, 2025, indicated the RN will provide education to the client (resident)/responsible party regarding the treatment or therapy and may, as appropriate, instruct other team members, including paraprofessionals (ULPs), to provide on-going teaching based on the written client (resident) education instructions prepared by the RN. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		

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01960	Continued From page 45	01960		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented as administered as prescribed, or to document the reason they were not provided for one of two residents (R7) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and	01960		

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01960	Continued From page 46 therapy services to residents at the facility. R7's diagnoses included diabetes, congestive heart failure (CHF), end stage renal (kidney) disease on dialysis, and hypertension (HTN- high blood pressure). R7's Medication Management Plan: Addendum to Service Plan and Treatment Plan: Addendum to Service Plan (service plan) dated August 10, 2023, indicated R7's services included a 1,200 milliliters (mL) fluid restriction daily to preserve remaining kidney function. R7's prescriber orders lacked an order for 1,200 mL fluid restriction daily. R7's Quarterly Assessment dated February 18, 2026, indicated R7 went to dialysis three times per week. Give R7 eight (8) to 16 ounces of fluids with each meal. Encouraged to drink water throughout the day to prevent dehydration. On March 24, 2026, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R7. R7's record lacked documentation of R7's fluid intake to remain under 1,200 mL per day. On March 25, 2026, at 1:16 p.m., LALD/CNS-A stated treatments provided to residents should have a treatment plan. LALD/CNS-A further stated LALD/CNS-A would look for R7's treatment plan and provide to the surveyor. On March 27, 2026, at 12:28 p.m., LALD/CNS-A emailed (electronic mail) the surveyor, which indicated LALD/CNS-A and registered nurse (RN)-B were looking into R7's fluid restriction,	01960		

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01960	Continued From page 47 LALD/CNS-A was waiting to hear back on the fluid restriction, and LALD/CNS-A will send supporting documentation over to the surveyor. No additional documentation was emailed to the surveyor. The licensee's Treatment and Therapy Management policy dated May 2, 2025, indicated each staff member who administers a treatment or therapy is responsible for documenting this in the clinical record. In addition, when a treatment or therapy is not administered as ordered or prescribed, staff will document the reason why it was not administered and any follow-up procedures provided to meet the client's (resident's) needs. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure up-to-date written or electronically recorded orders were	01970		

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01970	Continued From page 48 maintained for one of two residents (R7) who received treatments managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on March 23, 2026, at 12:53 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided treatment and therapy services to residents at the facility. R7's diagnoses included diabetes, congestive heart failure (CHF), end stage renal (kidney) disease on dialysis, and hypertension (HTN- high blood pressure). R7's Medication Management Plan: Addendum to Service Plan and Treatment Plan: Addendum to Service Plan (service plan) dated August 10, 2023, indicated R7's services included a 1,200 milliliters (mL) fluid restriction daily to preserve remaining kidney function, and CPAP (continuous positive airway pressure machine used to treat sleep apnea) applied every night. R7's Quarterly Assessment dated February 18, 2026, indicated R7 went to dialysis three times per week. Give R7 eight (8) to 16 ounces of fluids with each meal. Encouraged to drink water throughout the day to prevent dehydration. In	01970		

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01970	Continued From page 49 addition, R7 had a CPAP and R7 reported to the registered nurse (RN), R7 stopped using the CPAP in the fall of 2025. R7's record lacked documentation of R7's fluid intake. R7's Service Recap- By Resident- By Service dated March 1, 2026, to March 24, 2026, indicated to assist R7 with CPAP at bedtime. The daily documentation indicated R7 had assistance with CPAP, was left blank, or was documented R7 did not use the CPAP. On March 24, 2026, at 8:13 a.m., the surveyor observed unlicensed personnel (ULP)-F complete a blood glucose check for R7. R7's record lacked a prescriber order for R7's restricted fluid intake and CPAP. On March 25, 2026, at 1:16 p.m., LALD/CNS-A stated treatments provided to residents should have a treatment plan, which included a treatment order. LALD/CNS-A further stated LALD/CNS-A would look for R7's treatment plan and provide to the surveyor. On March 27, 2026, at 12:28 p.m., LALD/CNS-A emailed (electronic mail) the surveyor, which indicated LALD/CNS-A and RN-B were looking into R7's fluid restriction and CPAP, LALD/CNS-A was waiting to hear back on the fluid restriction and CPAP, and LALD/CNS-A will send supporting documentation over to the surveyor. No additional documentation was emailed to the surveyor. The licensee's Treatment and Therapy Management policy dated May 2, 2025, indicated the RN will obtain orders or prescriptions for all	01970		

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01970	Continued From page 50 treatments and therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02310 SS=F	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 ensure the care and services were appropriate based on the needs of residents who reside in the secured (required a keypad code to exit) unit at the facility with regards to safely storing chemicals. This had the potential to affect all 30 residents, staff, and visitors of the secured unit. 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:	02310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02310	Continued From page 51 The licensee held an assisted living with dementia care license. During the entrance conference on March 23, 2026, at 12:39 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On March 24, 2026, at 5:55 a.m., the surveyor observed an unlocked cabinet, under the sink, in the shared resident's dining room, which included the following opened bottles: -Member's Mark disinfectant wipes; -Sprayway all-purpose cleaner; and -Febreze odor spray. On March 24, 2026, at 6:32 a.m., unlicensed personnel (ULP)-H stated chemicals were supposed to be stored in the licensee's kitchen or in the locked storage closets. On March 24, 2026, at 1:56 p.m., LALD/CNS-A stated LALD/CNS-A was not aware of chemicals stored under the sink in the resident dining room. LALD/CNS-A further stated all cleaning chemicals were expected to be placed in the locked utility room in the back storage area and not accessible to residents. The Member's Mark Disinfecting Wipes Safety Data Sheet dated August 29, 2016, indicated may cause irritation to the eyes and skin. The Sprayway All Purpose Cleaner Safety Data Sheet dated April 22, 2022, indicated the cleaner solution could cause serious eye irritation and skin irritation. The Febreze Air Effects Safety Data Sheet dated	02310		

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02310	Continued From page 52 February 24, 2015, indicated to not get Febreze in eyes, on skin, or on clothing. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	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

VITACARE LIVING
23 WATERVIEW DRIVE
Proctor, MN 55810
St Louis County
Parcel:

Phone:

License Info

License: HFID 30617

Risk:
License:
Expires on:
CFPM: Braxton R. Lawrence
CFPM #: 65669; Exp: 03/09/2029

Inspection Info

Report Number: F1006261032
Inspection Type: Full - Single
Date: 3/24/2026 Time: 10:30 AM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 1
Total Priority 2 Orders: 0
Total Priority 3 Orders: 2
Delivery: Emailed

! **New Order: 4-500 Equipment Maintenance and Operation**
4-501.114C3 *Priority Level: Priority 1 CFP#: 16*
MN Rule 4626.0805C3 Provide and maintain an approved quaternary ammonium compound sanitizing solution in water with 500 ppm hardness or less, a minimum temperature of 75 degrees F (24 degrees C) and a concentration specified in 21CFR.178.1010 and as indicated by the manufacturer's use directions and label.
COMMENT: THE QUAT SANITIZER DISPENSING SYSTEM WAS READING OVER 500 PPM ON BOTH THE FACILITIES AND INSPECTOR'S QUAT TEST STRIPS. DISPENSER LIKELY NEEDS TO BE ADJUSTED. UPPER LAKES SERVICE DEPARTMENT WAS CALLED IMMEDIATELY AND THEY WILL BE COMING OUT TO LOOK AT THE SYSTEM. SANITIZER BUCKET WAS DILUTED TO 400 PPM FOR LUNCH SERVICE. STAFF DO ALSO HAVE BLEACH ON HAND IF THEY WOULD PREFER TO MAKE A BLEACH WATER SOLUTION BETWEEN 50-100 PPM UNTIL DISPENSER CAN BE ADJUSTED/REPAIRED. REMINDER DO NOT MIX BLEACH WITH THE QUAT AMMONIA.
Comply By: Complied On Site Originally Issued On: 3/24/2026

New Order: 4-600 Cleaning Equipment and Utensils
4-601.11C *Priority Level: Priority 3 CFP#: 49*
MN Rule 4626.0840C Clean non-food contact surfaces of equipment and maintain free of accumulations of dust, dirt, food residue, and other debris.
COMMENT: DISCUSSED WITH STAFF THAT THE BAFFLES ARE TYPICALLY CLEANED ONCE A WEEK, BUT BAFFLES DID HAVE A SLIGHT BUILD-UP OF GREASE AND DUST. DISCUSSED CLEANING THEM AND KEEPING UP WITH THE ROUTINE CLEANING SCHEDULE.
Comply By: 3/31/2026 Originally Issued On: 3/24/2026

New Order: 6-200 Physical Facility Design and Construction
6-202.11A *Priority Level: Priority 3 CFP#: 56*
MN Rule 4626.1375A Provide effective shielding, coated or shatter-resistant light bulbs for all light fixtures where there is exposed food, clean equipment, utensils and linens, or unwrapped single-service or single-use articles.
COMMENT: THE LIGHT GLOBE SHIELD IN THE WALK-IN FREEZER IS BROKEN/MISSING AND STAFF WERE NOT SURE IF THE LIGHT BULB WAS A SHATTER-RESISTANT LIGHT BULB. EITHER REPLACE THE GLOBE COVER OR REPLACE LIGHT BULB WITH A SHATTER RESISTANT LIGHT BULB.
Comply By: 4/10/2026 Originally Issued On: 3/24/2026

Food & Beverage General Comment

COMMENTS:

INSPECTION ACCOMPANIED BY SAMANTHA TABERT.

OBSERVED GOOD HAND WASHING AND GLOVE USE DURING INSPECTION. DISCUSSED THE IMPORTANCE OF PROPER HAND WASHING AND NO BARE HAND CONTACT WITH ALL READY TO EAT FOODS.

DISCUSSED THE EMPLOYEE ILLNESS POLICY AND THE EXCLUSION OF EMPLOYEES SICK WITH SYMPTOMS OF VOMITING AND/OR DIARRHEA UNTIL THEY HAVE BEEN SYMPTOM FREE FOR AT LEAST 24 HOURS. ALSO, CONTACT THE DEPARTMENT OF HEALTH IF ANY EMPLOYEES ARE DIAGNOSED WITH HEPATITIS A., SHIGA TOXIN-PRODUCING E. COLI, SALMONELLA, SHIGELLA, OR NOROVIRUS OR IF THERE ARE ANY FOODBORNE ILLNESS COMPLAINTS.

NOTE ON SANITIZER DISPENSER: SAMANTHA EMAILED AT 1:04 P.M. SAME DAY AS INSPECTION THAT UPPER LAKES WAS OUT AND ADJUSTED THE SANITIZER DISPENSER TO DISPENSE AT APPROPRIATE LEVELS.

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 F1006261032 from 3/24/2026

Callie Harrison

Samantha Tabert
Regional Culinary Director

Callie Harrison,
Public Health Sanitarian 3
218-302-6173
callie.harrison@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

VITACARE LIVING
Proctor
County/Group: St Louis County

Inspection Info

Report Number: F1006261032
Inspection Type: Full
Date: 3/24/2026
Time: 10:30 AM

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

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

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

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

Food Temperature: Product/Item/Unit: SPAGHETTI NOODLES**; Temperature Process:** Cooking
Location: Stove at 178 Degrees F.
Comment:
Violation Issued?: No

Food Temperature: Product/Item/Unit: HAMBURGER**; Temperature Process:** Cooking
Location: Stove at 193 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

VITACARE LIVING
Proctor
County/Group: St Louis County

Inspection Info

Report Number: F1006261032
Inspection Type: Full
Date: 3/24/2026
Time: 10:30 AM

Sanitizing Chemical: **Product:** Quaternary Ammonia**; Sanitizing Process:** Dispenser
Location: Kitchen **Greater Than** 500 PPM
Comment:
Violation Issued?: Yes

Sanitizing Chemical: **Product:** Chlorine**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 50 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1006261032

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	1	Date: 3/24/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 10:30 AM
Score (optional)		Dur: min

Establishment:	Address:	City/State:	Zip:	Phone:
VITACARE LIVING	23 WATERVIEW DRIVE	Proctor, MN	55810	
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 30617		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

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

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	OUT	Food-contact surfaces; cleaned & sanitized	X	
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

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

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	N/A	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	IN	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48		Warewashing facilities: installed, maintained, used; test strips		
49	X	Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) [redacted]

Follow-up: Follow-up Date:

DEPARTMENT OF HEALTH

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL30617016-0	**Date:** MARCH 24, 2026
Facility Name: VITACARE LIVING	
Facility Address: 23 WATERVIEW DRIVE, PROCTOR, MN 55810	

☒ **TAG IDENTIFICATION: 0775**

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

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

2. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. The 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:
   - A keypad lock that required entry of a code to unlock was installed on the marked exit door leading from the secure dementia care unit to the main entrance. During the building tour, information technology (IT)-L stated this exit door lock was not fail safe and would not unlock with activation of the fire alarm system, fire sprinkler system, or loss of power.
   - During the building tour, the surveyor asked office manager (OM)-D if a remote button or switch was installed that would disengage the controlled egress locking system for the building. OM-D stated no and explained the licensee was already working with a company to evaluate the controlled egress locking system for this building.
   - Unlocking procedures for the controlled egress locking system were not included in the fire safety and evacuation plan.

3. Gates used as a component in a means of egress shall meet the same requirements for doors. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.2]

Comments: Illuminated exit signs were installed above two doors exiting into the dementia care courtyard. This courtyard was enclosed by a fence with two gates leading to the public way. Locks were installed on both fence gates that were not tied into the building fire alarm system.

4. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: The surveyor requested the most recent copy of the sprinkler inspection report. The five year internal pipe inspection was listed as a deficiency on the provided sprinkler report dated May 5, 2025.

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

   Comments:
   - The exterior courtyard was the designated smoking area for residents. Burnt cigarettes had been discarded along the foundation of the building, on the ground, and inside a planter containing potting soil.
   - In non-designated smoking areas at the front and north side of the building, burnt cigarettes had been discarded along the foundation of the building and on the ground.

6. Storage shall be maintained 2 feet (610 mm) or more below the ceiling in nonsprinklered areas of buildings or a minimum of 18 inches (457 mm) below sprinkler head deflectors in sprinklered areas of buildings. [Minn. Stat. 144G.45 subd. 2; MSFC 315.3.1]

   Comments: In resident occupied pod three, room 11/12, the sprinkler inside the closet was obstructed by the storage of personal items on a shelf under the sprinkler head.

☒ **TAG IDENTIFICATION: 0790**

SCOPE/ SEVERITY: Level 1; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

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

Comments: Inspections were not recorded every month on the back of the tags attached to the portable fire extinguishers. Fire extinguisher inspections must be conducted and documented every month to ensure each extinguisher is in its designated place, it has not been tampered with, and there is no obvious physical damage or condition that would interfere with its use or operation.

☒ **TAG IDENTIFICATION: 0800**

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

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

   Comments:
   - The courtyard sidewalk was cracked in two locations, creating a trip/fall hazard.
   - In resident occupied pod one, room 4/5, there was exposed pink fiberglass insulation between the sash and casing.
   - One ceiling tile was cracked above the nurse station.
   - One ceiling tile was cracked and taped outside the southeast storage/mechanical rooms.

☒ **TAG IDENTIFICATION: 0810**

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

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

   Comments: Numbers were posted at the doors for each resident sleeping room. The posted evacuation floor plans were lacking these resident room number labels. Resident room numbers are required to be included on the FSEP floor plan and correspond with the numbers installed at the resident room doors to provide efficient communication for exiting in the event of a fire or similar emergency.

2. 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 facility's building

layout and environmental risks. The employee actions were limited to the RACE (Remove, Alarm, Confine, Extinguish/Evacuate) and PASS (Pull, Aim, Squeeze, Sweep) acronyms and were created using a template.

3. 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 management plan binder failed to include evacuation procedures for the individualized unique needs of residents and lacked instructions on where this information was maintained. The surveyor requested these procedures from assisted living director in residency (ALDIR)-J and they stated that the surveyor would need to ask the office manager as they did not know how to locate these procedures.

4. 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 training completed between March 2025 and March 2026, from the licensee. Record review of the available documentation indicated employees were trained on the FSEP in October 2025. Documentation was not provided to support employee training on the FSEP was completed at the required frequency of twice per year. Additionally, employee training had been incorrectly recorded on the same forms used for resident emergency preparedness training.

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

   Comments: The surveyor requested records for evacuation drills completed between March 2025 and March 2026, from the licensee. Record review of the provided fire drill reports indicated drills were not conducted in July, August, or September 2025. Additionally, the licensee had inappropriately combined first and second shift employees for the February 19, 2026, fire drill.