



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 28, 2022

Administrator
Long Lake Loon Lodge
7747 Loon Lodge Lane Northeast
Bemidji, MN 56601

RE: Project Number(s) SL20285015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on December 23, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health 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.

The enclosed State Form documents the state licensing orders. The Department of Health 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 imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572, Subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

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

St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program = \$500.00

The total amount you are assessed is \$500.00. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 the Department of Health within 15 calendar days of the correction order receipt date.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:

Free from Maltreatment reconsideration requests should addressed to:

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

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. Requests for hearing may be emailed to

Health.HRD.Appeals@state.mn.us.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "Casey DeVries". The signature is fluid and cursive, with the first name "Casey" written in a larger, more prominent script than the last name "DeVries".

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Telephone: 651-201-5917 Fax: 651-215-9697

pmb

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/23/2021
NAME OF PROVIDER OR SUPPLIER LONG LAKE LOON LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7747 LOON LODGE LANE NE BEMIDJI, MN 56601		
(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 Initial comments *****ATTENTION***** ASSISTED LIVING 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: SL20285015 On December 21, 2021 through December 23, 2021, the Minnesota Department of Health conducted a survey at the above provider, and the following correction orders are issued. At the time of the survey, there were nine (9) residents receiving services under the provider's Assisted Living license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2 and 3	
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours	0 460		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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0 460	Continued From page 1 per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to provide a means for two of two residents (R1 and R3) to request assistance for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect all nine (9) residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 460		

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0 460	Continued From page 2 The findings include: The licensee held an assisted living facility license and was licensed for a bed capacity of ten (10) residents. The current census at the facility was nine (9) residents. During the entrance conference on December 21, 2021, at approximately 10:25 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the facility did not have a call system in place for residents to request assistance when needed. R1 R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). On December 22, 2021, at approximately 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with dressing, grooming and toileting. At approximately 7:49 a.m., ULP-C administered R1's morning medications. R1 was unable to articulate to the surveyor how he would call for assistance, if needed. R3 R3's diagnoses included diabetes, hypertension (high blood pressure) and cognitive decline. On December 21, 2021, at approximately 1:35 p.m., the surveyor observed R3 seated at the dining room table. When the surveyor asked R3 how he requested staff assistance when he needed it, R3 stated he hollered out for help. The licensee's 24-Hour Emergency Response policy dated August 1, 2021, indicated residents living at the facility would have access to 24-hour	0 460		

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0 460	Continued From page 3 emergency response by staff. All residents would be given instructions on the use of the emergency response system upon move in and ongoing, as needed. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 460		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that: (i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; (ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and (iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility; (12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be: (i) awake; (ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time; (iii) capable of communicating with residents; (iv) capable of providing or summoning the appropriate assistance; and	0 470		

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0 470	Continued From page 4 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure a written staffing plan was developed. This had the potential to affect all nine (9) residents living at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license. The licensee failed to develop and implement a staffing plan for determining its staffing level that: - included an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility; - ensured sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and - ensured that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility. During the entrance conference on December 21,	0 470		

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0 470	Continued From page 5 2021, at approximately 10:35 a.m., the surveyor requested a copy of the facility's staffing plan from registered nurse (RN)-B. During a facility tour on December 21, 2021, at approximately 11:15 a.m., with licensed assisted living director (LALD)-A the surveyor observed the main common area, which lacked a posting of the daily staffing schedule. On December 22, 2021, at approximately 3:45 p.m., RN-B confirmed she had not developed a written staffing plan to include the above noted required content. The licensee's Staffing and Scheduling policy dated August 1, 2021, indicated the clinical nurse supervisor would develop and implement a written staffing plan that provided an adequate number of qualified direct-care staff to meet the residents' needs 24-hours a day, seven-days a week. The daily work schedule would be posted at the beginning of each work shift in a central location in each building of a facility or campus. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 490 SS=F	144G.41 Subd 1 (13) (ii)-(vii) Minimum requirements (ii) weekly housekeeping; (iii) weekly laundry service; (iv) upon the request of the resident, provide direct or reasonable assistance with arranging for transportation to medical and social services appointments, shopping, and other recreation,	0 490		

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0 490	Continued From page 6 and provide the name of or other identifying information about the persons responsible for providing this assistance; (v) upon the request of the resident, provide reasonable assistance with accessing community resources and social services available in the community, and provide the name of or other identifying information about persons responsible for providing this assistance; (vi) provide culturally sensitive programs; and (vii) have a daily program of social and recreational activities that are based upon individual and group interests, physical, mental, and psychosocial needs, and that creates opportunities for active participation in the community at large; and This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to have a daily program of social and recreational activities based on individual and group interests, physical, mental, and psychosocial needs. This had the potential to affect all nine (9) residents residing at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include:	0 490		

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0 490	Continued From page 7 During observations on December 21 and 22, 2021, the surveyor did not observe any activities planned or offered to the residents. Some residents remained in their room most of the day. On December 22, 2021, at 3:48 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B stated they did take residents out on some special outings; however, confirmed the licensee had not developed a daily activity program. A policy regarding the development and implementation of a daily activity program was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 490		
0 510 SS=F	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b) The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by:	0 510		

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0 510	Continued From page 8 Based on observation, interview, and record review, the licensee failed to ensure infection control standards were followed for one of one unlicensed personnel (ULP-C) during personal cares. In addition, the licensee failed to establish and maintain an effective infection control program that complied with accepted health care, medical and nursing standards for infection control related to COVID-19. This had the potential to affect the licensee's nine (9) current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: HAND HYGIENE On December 22, 2021, at approximately 7:20 a.m., the surveyor observed ULP-C provide transfer and toileting assistance to R1. ULP-C donned (put on) gloves and transferred R1 from wheelchair to toilet, removed R1's soiled brief then stepped out of the bathroom with gloved hands, and waited outside the bathroom door allowing R1 privacy. ULP-C re-entered the bathroom with same gloved hands, provided perineal care to R1, put on clean brief, assisted R1 to standing position, washed R1's bottom, and dressed R1's lower body. Wearing the same pair of gloves, ULP-C washed R1's back, armpits, applied deodorant, and dressed R1's upper body. At approximately 7:31 a.m., ULP-C transferred R1 from toilet to wheelchair, removed gloves,	0 510		

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0 510	Continued From page 9 washed hands, then escorted R1 to the breakfast table. On December 22, 2021, at 4:05 p.m. registered nurse (RN)-B stated her expectations were for staff to change gloves after providing incontinent cares and complete hand hygiene after removal of gloves. The Licensee's Hand Washing policy dated August 1, 2021, indicated hand washing should be completed after changing incontinence products or cleaning up after someone has used the toilet. The policy further directed hand hygiene should be completed before donning (putting on) and after removing gloves. COVID-19 On December 22, 2021, at approximately 3:55 p.m., licensed assisted living director (LALD)-A confirmed it was the licensee's expectation staff follow the current Minnesota Department of Health (MDH) and Center for Disease Control and Prevention (CDC) guidelines with regards to COVID-19. VISITOR SCREENING The licensee failed to ensure visitors were appropriately screened for signs and symptoms of COVID-19 prior to entry into the facility. On December 21, 2021, at approximately 10:15 a.m., RN-B and LALD-A allowed two MDH surveyors to enter the facility without first requiring the surveyors conduct a COVID-19 screening. On December 21, 2021, at approximately 11:30 a.m., an MDH engineering specialist entered the facility without a COVID-19 screening.	0 510		

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0 510	Continued From page 10 On December 22, 2021, at approximately 7:00 a.m., ULP-D allowed two MDH surveyors to enter the facility without first requiring the surveyors conduct a COVID-19 screening. On December 22, 2021, at approximately 12:05 p.m., LALD-A allowed an MDH sanitarian to enter the facility without first requiring the sanitarian conduct a COVID-19 screening prior to entry into the facility. On December 22, 2021, at approximately 3:50 p.m., LALD-A and RN-B confirmed the licensee had not screened visitors for signs and symptoms of COVID-19 since April 2021. The MDH document titled COVID-19 Guidance: Long-term Care Indoor Visitation for Nursing Facilities and Assisted Living Type Settings, dated May 20, 2021, indicated providers should follow basic core principles for preventing COVID-19 infection, including screening all who enter the setting for signs and symptoms of COVID-19, and deny entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the past 14 days. EMPLOYEE SCREENING The licensee lacked evidence employees were screened for signs and symptoms of COVID-19 prior to entering the facility. On December 22, 2021, at approximately 3:55 p.m., LALD-A confirmed the licensee had not required staff conduct COVID-19 self-screenings since April 2021. The MDH document titled, Template: COVID-19 Response Summary for Long-term Care	0 510		

Minnesota Department of Health

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NAME OF PROVIDER OR SUPPLIER LONG LAKE LOON LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7747 LOON LODGE LANE NE BEMIDJI, MN 56601		
(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
0 510	Continued From page 11 Facilities, dated December 17, 2020, indicated all staff should be monitored for signs/symptoms of COVID-19 prior to their shift. Exclude ill staff from working. RESIDENT SCREENING R1 and R3's records did not contain evidence of daily COVID-19 symptom screening and monitoring. On December 22, 2021, at approximately 3:58 p.m., LALD-A and RN-B confirmed the licensee's residents had not been screened daily for signs and symptoms of COVID-19. LALD-A stated the licensee stopped daily screening in April 2021. The CDC Interim Infection Prevention Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes-Nursing Home and Long-Term Care Facilities dated September 10, 2021, indicated all residents should be monitored upon admission and at least daily for fever and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. SIGNAGE AT ENTRANCE On December 21, 2021, at approximately 10:15 a.m., upon arrival to the facility, two surveyors observed no signage regarding visitor restrictions or alerting visitors that they would be screened and monitored for signs and symptoms of COVID-19 upon entry into the establishment. On December 22, 2021, at approximately 4:00 p.m., LALD-A confirmed there was no signage posted on the entrance door regarding visitor restrictions or alerting visitors that they would be screened for COVID-19 symptoms.	0 510		

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0 510	Continued From page 12 The CDC document titled Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities dated May 21, 2020, indicated signs should be posted at all entrances providing information about current visitation policies and restrictions. PERSONAL PROTECTIVE EQUIPMENT (PPE) On December 21, 2021, at approximately 10:15 a.m., upon entrance to the facility, the surveyor observed LALD-A, RN-B and ULP-C in resident care areas wearing medical-grade masks and their own eyeglasses. On December 22, 2021, at approximately 7:17 a.m., the surveyor observed ULP-C assist R1 with dressing, grooming and toileting. At approximately 7:49 a.m., ULP-C administered R1's morning medications. ULP-C wore a medical-grade mask and her own eyeglasses. On December 22, 2021, at approximately 8:30 a.m., the surveyor observed ULP-C administer R3 his scheduled morning medications and conduct a blood glucose (sugar) check. ULP-C wore a medical-grade mask and her own eyeglasses. On December 22, 2021, at approximately 4:05 p.m., LALD-A confirmed staff were not wearing appropriate eye protection. RN-B and LALD-A stated they were unaware eye protection was still a requirement. According to the COVID-19 Integrated County View, on December 21-22, 2021, Beltrami county (this facility's county) was identified as having a high transmission level. The MDH document titled, The COVID-19	0 510		

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0 510	Continued From page 13 Personal Protective Equipment and Source Control Grids dated December 7, 2021, indicated for counties with a high transmission level, eye protection should be worn when working with residents with or without COVID-19 infection. The CDC COVID-19, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated September 10, 2021, indicated eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	0 510		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee	0 550		

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0 550	Continued From page 14 failed to post the required information related to the grievance procedure, as well as information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center (MAARC) as required. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individuals who are responsible for handling grievances; the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities; and the information for reporting suspected maltreatment to MAARC. During a facility tour on December 21, 2021, at approximately 11:15 a.m., with licensed assisted living director (LALD)-A, the surveyor observed the main entrance and/or common areas lacked a posting of the grievance procedure; contact information for the Ombudsman offices; and information related to reporting suspected maltreatment to MAARC. The surveyor observed the above noted postings posted on a bulletin board in the locked nursing office.	0 550		

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0 550	Continued From page 15 On December 21, 2021, at approximately 11:35 a.m., LALD-A confirmed the required content noted above was not posted as required. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, noted the licensee would post in the facility office information about the licensee's complaint/grievance procedure, and the name, telephone number, and email contact information for the individuals who were responsible for handling resident complaints/grievances. The posting would also include contact information for the Ombudsman offices, and information for reporting suspected maltreatment to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language.	0 640		

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0 640	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; and (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center (MAARC) to report suspected maltreatment of a vulnerable adult under section 626.557. This had the potential to affect all current residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in common areas and near telephones provided by the assisted living and the information for reporting suspected maltreatment to MAARC. During a facility tour on December 21, 2021, at approximately 11:15 a.m., with licensed assisted living director (LALD)-A, the surveyor observed the common areas lacked the required posting for the 911 emergency number and the reporting number for MAARC. The surveyor observed the MAARC reporting information posted on a bulletin board in the locked nursing office.	0 640		

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0 640	Continued From page 17 On December 21, 2021, at approximately 11:25 a.m., LALD-A stated the cordless telephone, which was located on the kitchen counter was the telephone the residents used, if needed. LALD-A confirmed the 911 emergency number was not posted on or near the cordless telephone. At 11:35 a.m., LALD-A confirmed the contact information or reporting number for MAARC was not posted as required. The licensee's Complaint/Grievance Posting policy dated August 1, 2021, noted the licensee would post in the facility office information for reporting suspected maltreatment to MAARC. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing tenant residents.	0 680		

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0 680	Continued From page 18 (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and post a written emergency disaster plan with all the required content. This had the potential to affect all nine (9) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 21, 2021, at approximately 11:20 a.m., the surveyor made a request to view the licensee's emergency preparedness plan, which was provided to and later reviewed by the surveyor. On December 21, 2021, at approximately 11:15 a.m., the surveyor conducted a facility tour with licensed assisted living director (LALD)-A. The surveyor observed no signage posted or	0 680		

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0 680	Continued From page 19 information regarding the licensee's emergency plan in the common areas of the facility. The licensee's plan included a Hazard Vulnerability Assessment Tool, undated, which identified thirty-four (34) events such as fire, drought, power outage, tornado, weapon, chemical exposure; and scored each event based on probability. However, the plan did not identify a severity level, a response, or risk level for each event. The plan included an Emergency Preparedness policy which provided a generic outline of what would be included in the licensee's emergency preparedness plan. The licensee's emergency preparedness (EP) plan lacked the following required content: - a description of the facilities approach to meeting the health/safety/security needs of the staff and residents; - process for EP cooperation with state and local EP officials/organizations; - a thoroughly completed risk assessment; - arrangements/contracts to re-establish utility services; and - a description of the population served by the licensee. - development of policies/procedures to address: - procedure for tracing staff and residents; - subsistence needs for staff and residents during an emergency; - evacuation plan; - shelter in place; - a medical record documentation system to preserve resident information, security, and availability; - emergency staffing strategies to include volunteers; - development of arrangements with other facilities and providers to receive residents if	0 680		

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0 680	Continued From page 20 needed; and - the facilities role in providing care and treatment at alternative sites. - a communication plan that included: - arrangement with other facilities; - names and contact information for staff, resident physicians, other facilities; - contact information for federal, state, tribal, local EP staff, ombudsman; - primary and alternative means for communicating with facility staff, federal, state, regional and local emergency management agencies; - a method of sharing information and medical documentation for residents; and - a means to provide information regarding the facility's needs, and its ability to provide assistance to include information about their occupancy. On December 22, 2021, at approximately 4:00 p.m., licensed assisted living director (LALD)-A confirmed the licensee had not fully developed and implemented the facility's emergency preparedness plan/program as required. The licensee's Disaster Planning and Emergency Preparedness policy dated August 1, 2021, noted the facility would have in place a general emergency preparedness plan, that was in alignment with facility's requirement to also comply with CMS Appendix Z (a section of the Centers for Medicare and Medicaid Services [CMS] state operations manual which includes the emergency preparedness guidelines). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		

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0 800 SS=F	144G.45 Subd. 2 (a) (4) Fire protection and physical environment (4) keep the physical environment, including walls, floors, ceiling, all furnishings, grounds, systems, and equipment in a continuous state of good repair and operation with regard to the health, safety, comfort, and well-being of the residents in accordance with a maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide the physical environment in a continuous state of good repair and operation with regard to the health, safety and well-being of the residents. This had the potential to directly affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 21, 2021, between 11:30 a.m. and 12:05 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed the mechanical room being used for the storage of supplies that blocked access to electrical panels. During the facility tour interview with LALD-A, it was confirmed that the mechanical room was being used for storage and that electrical panels were obstructed.	0 800		

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0 800	Continued From page 22 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) 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) employee 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) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for 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	0 810		

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0 810	Continued From page 23 drill. This MN Requirement is not met as evidenced by: Based on observation, record review, and interview, the licensee failed to provide the required evacuation drill frequency and accurate plans for fire safety and evacuation. This had the potential to affect all residents and staff. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: On December 21, 2021, between 11:30 a.m. and 12:05 p.m., survey staff toured the facility with the licensed assisted living director (LALD)-A. During the facility tour, survey staff observed that resident rooms were not numbered, labeled, or identified. On December 21, 2021, at approximately 12:05 p.m., the LALD-A provided records for review. Records were reviewed by survey staff on December 21, 2021, between 12:05 p.m. and 12:35 p.m. 1. Fire drill log sheets dated 4/29/2021 and 10/18/2021 were provided. The 4.05 fire policy dated 08/15/2016 stated that fire drills were not mandatory but were to be conducted 2-3 times per year. 2. The 4.05 fire policy dated 08/15/2016	0 810		

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0 810	Continued From page 24 references: - magnetic door holds, which the facility did not have; - smoke compartment doors, but locations of these doors were not identified; - a fire alarm system that is wired directly to the fire station, the LALD-A confirmed during an interview at approximately 12:35 p.m. that the fire alarm system was not wired to the fire station. On December 21, 2021, between 12:30 p.m. and 12:45 p.m., during the exit interview with LALD-A, they confirmed that the resident rooms required identification, that the fire policy required revision, and that evacuation drill frequency was not met. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 810		
0 900 SS=C	144G.50 Subdivision 1 Contract required (a) An assisted living facility may not offer or provide housing or assisted living services to any individual unless it has executed a written contract with the resident. (b) The contract must contain all the terms concerning the provision of: (1) housing; (2) assisted living services, whether provided directly by the facility or by management agreement or other agreement; and (3) the resident's service plan, if applicable. (c) A facility must: (1) offer to prospective residents and provide to the Office of Ombudsman for Long-Term Care a	0 900		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 900	Continued From page 25 complete unsigned copy of its contract; and (2) give a complete copy of any signed contract and any addendums, and all supporting documents and attachments, to the resident promptly after a contract and any addendum has been signed. (d) A contract under this section is a consumer contract under sections 325G.29 to 325G.37. (e) Before or at the time of execution of the contract, the facility must offer the resident the opportunity to identify a designated representative according to subdivision 3. (f) The resident must agree in writing to any additions or amendments to the contract. Upon agreement between the resident and the facility, a new contract or an addendum to the existing contract must be executed and signed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide to the Office of Ombudsman for Long-Term Care a complete unsigned copy of its contract. This had the potential to affect all current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included diabetes and	0 900		

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0 900	Continued From page 26 cerebrovascular accident (CVA-stroke). R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. On December 22, 2021, at approximately 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with dressing, grooming and toileting. At approximately 7:49 a.m., ULP-C administered R2's morning medications. R1's record included a signed copy of an assisted living contract dated August 1, 2021. On December 23, 2021, at approximately 10:44 a.m., licensed assisted living director (LALD)-A confirmed an unsigned copy of the contract had not been provided to the Office of Ombudsman for Long-Term Care as required. A policy related to the contract was requested, but not provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 900		
0 930 SS=C	144G.50 Subd. 2 Contract information (d) The contract must include a description of the facility's complaint resolution process available to residents, including the name and contact information of the person representing the facility	0 930		

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0 930	Continued From page 27 who is designated to handle and resolve complaints. (e) The contract must include a clear and conspicuous notice of: (1) the right under section 144G.54 to appeal the termination of an assisted living contract; (2) the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer; (3) contact information for the Office of Ombudsman for Long-Term Care, the Ombudsman for Mental Health and Developmental Disabilities, and the Office of Health Facility Complaints; (4) the resident's right to obtain services from an unaffiliated service provider; This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to execute a written contract with the required content for one of one resident (R1) with record reviewed. This affected all nine (9) current residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a 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 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke).	0 930		

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0 930	Continued From page 28 R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. R1's assisted living contract signed August 1, 2021, lacked the following required content: -the facility's policy regarding transfer of residents within the facility, under what circumstances a transfer may occur, and the circumstances under which resident consent is required for a transfer. On December 22, 2021, at approximately 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with dressing, grooming and toileting. At approximately 7:49 a.m., ULP-C administered R1's morning medications. On December 22, 2021, at approximately 3:25 p.m., licensed assisted living director (LALD)-A confirmed R1's contract lacked the above content and stated the same contract was utilized for all residents. The licensee's Transfer of Resident within Facility policy dated August 1, 2021, indicated when entering into the assisted living contract, the facility must provide a conspicuous notice of the circumstance under which the facility may require a transfer, including any transfer that may be required if the resident would be receiving housing support. A policy on content of the assisted living contract was requested, but not received. No further information was provided.	0 930		

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0 930	Continued From page 29	0 930		
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days.			
0 950 SS=D	144.50 Subd. 3 Designation of representative (a) Before or at the time of execution of an assisted living contract, an assisted living facility must offer the resident the opportunity to identify a designated representative in writing in the contract and must provide the following verbatim notice on a document separate from the contract: "RIGHT TO DESIGNATE A REPRESENTATIVE FOR CERTAIN PURPOSES. You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf. A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable." (b) The contract must contain a page or space for the name and contact information of the designated representative and a box the resident must initial if the resident declines to name a designated representative. Notwithstanding subdivision 1, paragraph (f), the resident has the right at any time to add, remove, or change the name and contact information of the designated representative. This MN Requirement is not met as evidenced by:	0 950		

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0 950	Continued From page 30 Based on interview and record review, the licensee failed to offer one of two residents (R1) the opportunity to designate a representative with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. R1's record lacked a form to identify a designated representative. On December 22, 2021, at approximately 3:25 p.m., licensed assisted living director (LALD)-A confirmed R1's record did not include a designated representative form because R1 had a legal guardian in place and did not need to have a designated representative form completed. The licensee's Designated Representative policy dated August 1, 2021 indicated the licensee will offer residents the opportunity to identify a designated representative in writing. The policy further indicated, a signed Designated	0 950		

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0 950	Continued From page 31 Representative form must be filled out documenting the resident's choice in designated representative, and the form will be kept in the resident record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 950		
01700 SS=D	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent diversion of medications. For purposes of this section, "diversion of medication" means misuse,	01700		

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01700	Continued From page 32 theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the medication assessment for self-administration was followed for one of one resident (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R3's diagnoses included diabetes, hypertension (high blood pressure) and cognitive decline. R3's Service Plan and Individualized Medication Management Plan dated October 27, 2021, indicated R3 received medication management services to include medication administration by the facility staff. R3's prescriber orders dated June 21, 2021, included an order for Novolog insulin to be administered with meals per the below sliding scale (a scale directing the amount of insulin that should be administered based off the blood glucose [sugar] result): - 140 - 180 = administer 4 units; - 181 - 240 = administer 6 units; - 241 - 300 = administer 8 units;	01700		

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01700	Continued From page 33 - 301 - 350 = administer 10 units; - 350 - 400 = administer 12 units; and - greater than 401 = administer 14 units and call the physician. On December 22, 2021, at approximately 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-C use appropriate technique to conduct a blood glucose check on R3, which resulted in a reading of 171 milligrams (mg)/deciliter (dL). ULP-C confirmed with R3 according to the sliding scale, R3 should receive 4 units of Novolog insulin. ULP-C handed the Novolog insulin pen (a multiple dose pen shaped injector device used for insulin administration) and the capped needle to R3. R3 placed the needle on the end of the insulin pen and immediately dialed the pen to 4 units. ULP-C observed R3 dial the Novolog insulin pen to the correct dosage and visually checked the pen to assure the pen was dialed to 4 units. R3 raised his shirt up and ULP-C used an alcohol wipe to cleanse an area on R3's abdomen. R3 proceeded to inject the 4 units of Novolog insulin into his upper abdomen. The surveyor did not observe R3 prime the insulin pen prior to dialing up the prescribed Novolog insulin dose. R3's Uniform Assessment Tools dated October 27, 2021, and November 9, 2021, indicated R3 was deemed unable to safely administer his own Novolog insulin due to having some dementia and cognitive difficulties. On December 22, 2021, at approximately 3:35 p.m., registered nurse (RN)-B confirmed she had not completed a self-administration medication assessment for R3. A policy regarding self-administration assessment	01700		

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01700	Continued From page 34 was requested but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700		
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 medications were administered according to manufacturer's instructions for one of one resident (R3) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number	01760		

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01760	Continued From page 35 of staff are involved, or the situation has occurred only occasionally). The findings include: R3's Novolog insulin was not administered per manufacturer's instructions. R3's diagnoses included diabetes, hypertension (high blood pressure) and cognitive decline. R3's Service Plan and Individualized Medication Management Plan dated October 27, 2021, indicated R3 received medication management services to include medication administration. R3's Uniform Assessment Tool dated November 9, 2021, indicated R3 was deemed unable to safely administer his own Novolog insulin due to having some dementia and cognitive difficulties. R3's prescriber orders dated June 21, 2021, included an order for Novolog insulin to be administered with meals per the below sliding scale (a scale directing the amount of insulin that should be administered based off the blood glucose [sugar] result): - 140 - 180 = administer 4 units; - 181 - 240 = administer 6 units; - 241 - 300 = administer 8 units; - 301 - 350 = administer 10 units; - 350 - 400 = administer 12 units; and - greater than 401 = administer 14 units and call the physician. On December 22, 2021, at approximately 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-C use appropriate technique to conduct a blood glucose check on R3, which resulted in a reading of 171 milligrams (mg)/deciliter (dL). ULP-C confirmed with R3	01760		

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01760	Continued From page 36 according to the sliding scale, R3 should receive 4 units of Novolog insulin. ULP-C handed the Novolog insulin pen (a multiple dose pen shaped injector device used for insulin administration) and the capped needed to R3. R3 placed the needle on the end of the insulin pen and immediately dialed the pen to 4 units. ULP-C observed R3 dial the Novolog insulin pen to the correct dosage and visually checked the pen to assure the pen was dialed to 4 units. R3 raised his shirt up and ULP-C used an alcohol wipe to cleanse an area on R3's abdomen. R3 proceeded to inject the 4 units of Novolog insulin into his upper abdomen. The surveyor did not observe R3 prime the insulin pen prior to dialing up the prescribed Novolog insulin dose. The surveyor did not observe ULP-C remind R3 to prime the insulin pen prior to administration of the 4 units of Novolog insulin. On December 22, 2021, at approximately 8:35 a.m., ULP-C confirmed she had not reminded R3 to prime the insulin pen prior to dialing the prescribed insulin dose. ULP-C stated she should have directed R3 to prime the Novolog insulin pen with two units prior to dialing up the prescribed 4 units. On December 22, 2021, at approximately 3:30 p.m., registered nurse (RN)-B confirmed the ULP should make sure R3 primed the insulin pen prior to dialing up the prescribed dose of insulin and if R3 did not do so, the ULP should remind him. The manufacturer's instructions for the use of Novolog insulin pens, dated January 2019, directed for the insulin pen to be primed with two units prior to dialing the prescribed dosage. If not completed before each injection, too much or too little insulin may be administered.	01760		

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01760	Continued From page 37 The licensee's Insulin policy dated August 1, 2021, noted insulin medications must be administered according to the prescriber's orders, however, did not include verbiage regarding priming of the insulin pen prior to administration of the prescribed insulin dosage. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01760		
01770 SS=D	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup was completed accurately at the time of set up for one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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).	01770		

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01770	Continued From page 38 The findings include: R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's service plan dated March 20, 2019, indicated R1 received services including medication administration. R1's Individualized Medication Management Plan dated September 7, 2021, included medication set up by facility nurse, and administration by facility staff. R1's prescriber orders included: -aspirin enteric coated (ASA EC) 81 milligrams (mg) two tablets by mouth daily; -ferrous sulfate (iron) 325 mg one tablet one tablet by mouth daily; and -melatonin (supplement to promote sleep) five mg two tablets by mouth every night at bedtime. On December 21, 2021 at approximately 12:02 p.m., the surveyor observed registered nurse (RN)-B setting up the following medication in R1's medication planner: -ASA 81 mg two tablets placed in the a.m. slots of the medication planner for two weeks; -ferrous sulfate 325 mg one tablet placed in the a.m. slots of the medication planner for two weeks; and -melatonin five mg two tablets placed in the hour of sleep (h.s.) slots of the medication planner for two weeks. Upon completion of the medication set up, RN-B stated she normally initialed the medication administration record (MAR) and draws a line through the dates for which she set up. Review of R1's December 2021, MAR indicated a line was already drawn from December 1 through	01770		

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01770	Continued From page 39 December 31 for the set up of ASA, ferrous sulfate, and melatonin, indicating the medications had been set up for the entire month of December. RN-B confirmed she had already drawn a line across the entire month of December and should have only drawn and initialed the MAR for the dates the medications were set up. The licensee's Medication Management-Dosage Box Setup policy dated August 1, 2021, indicated when the licensed nurse completed setting up medications into the dosage box, the set-up would be documented on the MAR. The licensee's Medication and Treatment Record Documentation and Refusal policy dated August 1, 2021, directed documentation of medication/treatments/therapy administration would be completed by the person who performed the task immediately after the task was completed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770		
01780 SS=F	144G.71 Subd. 10 Medication management for residents who will (a) An assisted living facility that is providing medication management services to the resident must develop and implement policies and procedures for giving accurate and current medications to residents for planned or unplanned times away from home according to the resident's individualized medication management plan. The policies and procedures	01780		

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NAME OF PROVIDER OR SUPPLIER LONG LAKE LOON LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7747 LOON LODGE LANE NE BEMIDJI, MN 56601		
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01780	Continued From page 40 must state that: (1) for planned time away, the medications must be obtained from the pharmacy or set up by the licensed nurse according to appropriate state and federal laws and nursing standards of practice; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to implement policies and procedures for giving accurate and current medications for those residents who received medication management services during planned times away from home. This has the potential to affect all nine (9) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 21, 2021, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed all nine (9) residents who resided at the facility received medication management services. On December 22, 2021, at approximately 4:10 p.m., LALD-A stated it was usually herself or RN-B who set up the medications for resident's planned time away. RN-B confirmed for planned and unplanned times away, unlicensed personnel (ULP) have, at times, prepared and sent	01780		

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01780	Continued From page 41 medications with the resident or the resident's representative. The licensee's Medication Management - Planned and Unplanned Time Away policy dated August 1, 2021, indicated for planned time away, the medications must be obtained by the pharmacy or set up by a licensed nurse. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01780		
01790 SS=F	144G.71 Subd. 10 Medication management for residents who will (2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall provide medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days; (3) the resident must be provided written information on medications, including any special instructions for administering or handling the medications, including controlled substances; and (4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the resident's name and the dates and times that the medications are scheduled. (b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if: (1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to residents; and	01790		

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01790	Continued From page 42 (2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The procedures must address: (i) the type of container or containers to be used for the medications appropriate to the provider's medication system; (ii) how the container or containers must be labeled; (iii) written information about the medications to be provided; (iv) how the unlicensed staff must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; (v) how the registered nurse shall be notified that medications have been provided and whether the registered nurse needs to be contacted before the medications are given to the resident or the designated representative; (vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and (vii) how the unlicensed personnel must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each returned medication. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse	01790		

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01790	Continued From page 43 (RN) developed a written procedure for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. This had the potential to affect all nine (9) current residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on December 21, 2021, at approximately 10:30 a.m., licensed assisted living director (LALD)-A and RN-B confirmed all nine (9) residents who resided at the facility received medication management services. On December 22, 2021, at approximately 4:10 p.m., LALD-A and RN-B confirmed the ULP and LALD-A would prepare and send medications with residents for unplanned times away. The licensee failed to develop and implement a written procedure for the ULP providing medications for residents having unplanned times away. The licensee's Medication Management - Planned and Unplanned Time Away policy dated August 1, 2021, indicated for unplanned resident time away when a pharmacist or licensed nurse was not available, the RN may delegate this task to ULP if the RN has developed written	01790		

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01790	Continued From page 44 procedures for the ULP, including any special instructions or procedures regarding controlled substances that are prescribed for the resident. The licensee's policy lacked the written procedure to include: - the type of container or containers to be used for the medication appropriate to the provider's medication system; - how the container or containers must be labeled; - written information about the medications to be provided; - how the ULP must document in the resident's record that medications have been provided, including documenting the date the medications were provided and who received the medications, the person who provided the medications to the resident, the number of medications that were provided to the resident, and other required information; - how the RN would be notified that medications have been provided and whether the RN needs to be contacted before the medications are given to the resident or the designated representative; - a review by the RN of the completion of this task to verify that this task was completed accurately by the ULP; and - how the ULP must document in the resident's record any unused medications that are returned to the facility, including the name of each medication and the doses of each medication returned. On December 22, 2021, at approximately 4:15 p.m., RN-B confirmed the licensee's Medication Management - Planned and Unplanned Time Away policy did not include the above noted written procedure as required.	01790		

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01790	Continued From page 45 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790		
01890 SS=D	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 for expired medication dates for two of two residents (R3, and R4) reviewed for medication storage. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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: On December 21, 2021, at approximately 11:37 a.m., the surveyor observed the locked medication storage room with registered nurse (RN)-B. The surveyor observed the following expired medications, which were confirmed by RN-B.	01890		

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01890	Continued From page 46 R3's had two bottles of antacid, both with an expiration date of November 2020. RN-B confirmed the contents of one bottle was ¾ empty and the other bottle was unopened. R4's had a bottle of Lisinopril 20 mg with an expiration date of January 21, 2021. The licensee's Medication Disposal policy dated August 1, 2021, indicated any expired medication managed by the licensee would be disposed of according to the accepted practices of the Minnesota board of Pharmacy and the label from the containers would be destroyed. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy management 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 provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 47 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 maintain a complete individualized treatment or therapy management plan for two of two residents (R1 and R3) reviewed with treatments or therapies 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) 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 December 21, 2021, at approximately 10:35 a.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed the licensee provided	01940		

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01940	Continued From page 48 treatment and therapy services to residents as prescribed. R1 R1's service plan dated March 20, 2019, lacked a written statement of the treatment services being provided to include the application of R1's splints and braces. R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's Individual Treatment or Therapy Management plan dated September 7, 2021, indicated R1 required assistance with braces. R1's December 2021, care plan of documented services included the application and removal of splints. On December 22, 2021, at approximately 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 with applying right ankle foot orthosis (AFO-custom built brace worn on the foot or lower leg). At approximately 7:49 a.m., ULP-C was observed to assist in applying R1's right hand splint. On December 22, 2021, at approximately 3:19 p.m., licensed assisted living director (LALD)-A and registered nurse (RN)-B confirmed R1's service plan did not include a written statement of the treatment services for the application of R1 hand splint and AFO brace. R3 R3's record lacked evidence of an individualized treatment or therapy management plan to include the resident's blood glucose (sugar) monitoring.	01940		

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01940	Continued From page 49 R3's diagnoses included diabetes, hypertension (high blood pressure) and cognitive decline. R3's prescriber orders dated July 6, 2021, included an order for blood glucose monitoring four (4) times daily. R3's Uniform Assessment Tool dated November 9, 2021, indicated R3 required assistance with blood glucose monitoring. R3's December 1, 2021, through December 21, 2021, medication administration record (MAR) indicated R3 received blood glucose monitoring four (4) times daily. On December 22, 2021, at approximately 8:30 a.m., the surveyor observed unlicensed personnel (ULP)-C use appropriate technique to conduct a blood glucose check on R3, which resulted in a reading of 171 milligrams (mg)/deciliter (dL). R3's service plan dated October 27, 2021, lacked a written statement of the treatment services R3 received including blood glucose monitoring. R3's record lacked evidence of an individualized treatment or therapy management plan, which included the following: - a statement of the type of services that would be provided; - identification of treatment or therapy tasks that would be delegated to ULP; - procedures for notifying a RN or appropriate licensed health professional when a problem arises with treatments or therapy services; and - any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible	01940		

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01940	Continued From page 50 complications or adverse reactions. On December 22, 2021, at approximately 3:40 p.m., LALD-A and RN-B confirmed R3's service plan did not include a written statement of the treatment services provided for R3; and R3's record lacked a treatment management plan for R3's blood glucose monitoring, which included the above noted content as required. The licensee's Treatment and Therapy Management Plan policy dated August 1, 2021, indicated for each resident receiving management or ordered or prescribed treatments or therapy services, the facility would prepare and include in the service plan a written statement of the treatment or therapy services that would be provided to the resident. The licensee would develop and maintain a current individualized treatment and therapy management record for each resident to include, but not limited to, the above noted content. 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	01950		

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01950	Continued From page 51 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 (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified in writing specific resident instructions for unlicensed personnel (ULP) performing a treatment one of one resident (R1) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and	01950		

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01950	Continued From page 52 assistance with bathing, dressing, grooming, and toileting. R1's service plan did not include assistance with applying R1's right hand splint and right ankle foot orthosis (AFO-custom-built brace that is always worn on the foot or lower leg). R1's Individual Treatment or Therapy Management plan dated September 7, 2021, indicated R1 required assistance with braces, and further indicated specific requirements relating to documentation and instructions of treatments and therapy received were on the treatment administration record (TAR). R1's December 2021, care plan indicated R1's braces were applied 16 days out of 21 for the month of December. R1's care plan lacked specific written instructions for applying and removing R1's right hand splint and right AFO brace. R1's record lacked specific written instructions to include parameters for applying R1's right hand splint or brace to right foot. On December 22, 2021, at approximately 7:17 a.m., the surveyor observed unlicensed personnel ULP-C assist R1 to apply the AFO brace to R1's right foot. At approximately 7:49 a.m., the surveyor observed ULP-C assist with applying R1's right hand splint. On December 22, 2021, at approximately 3:14 p.m., registered nurse (RN)-B stated instructions for applying R1's right hand splint and AFO brace would be in the treatment and medication administration record. On December 23, 2021, at approximately 10:44	01950		

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01950	Continued From page 53 a.m., licensed assisted living director (LALD)-A confirmed R1's record lacked written instructions for applying R1's right hand splint and right AFO brace. The licensee's Medication and Treatment-Administration and Delegation policy dated August 1, 2021 directed the RN to: -instruct the ULP in the proper methods with respect to each resident to administer the medication or perform treatment/therapy, and the ULP has demonstrated the ability to competently follow the procedures, -specified, in writing, specific instructions for each resident and documented those instruction in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01950		
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:	01960		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20285	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/23/2021
NAME OF PROVIDER OR SUPPLIER LONG LAKE LOON LODGE		STREET ADDRESS, CITY, STATE, ZIP CODE 7747 LOON LODGE LANE NE BEMIDJI, MN 56601		
(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
01960	Continued From page 54 Based on observation, interview and record review, the licensee failed to ensure treatments or therapies were administered as prescribed, or to document the reason they were not provided to meet the resident's needs for one of one resident (R1) with 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) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's prescriber orders dated February 11, 2021, directed R1's right hand splint to be worn during sleep hours and directed R1 to wear his right foot brace to next appointment. R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. R1's service plan did not include applying R1's right hand splint or right ankle foot orthosis (AFO-custom-built brace that is always worn on the foot or lower leg). R1's Individual Treatment or Therapy Management plan dated September 7, 2021, indicated R1 required assistance with braces. R1's documented services on R1's December	01960		

Minnesota Department of Health

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01960	Continued From page 55 2021 care plan indicated R1's braces were applied 16 out of 22 days and removed 15 out of 22 days for the month of December. On December 22, 2021, at approximately 7:17 a.m., the surveyor observed unlicensed personnel (ULP)-C assist R1 to apply AFO brace to R1's right foot. At approximately 7:49 a.m., the surveyor observed ULP-C assist in applying R1's right hand splint. On December 23, 2021, at approximately 10:44 a.m., licensed assisted living director (LALD)-A confirmed R1's record lacked documentation R1's right hand splint and AFO brace were applied as R1's care plan directed. The licensee's Resident Record -Documentation policy dated August 1, 2021, indicated staff providing assisted living services would document daily, medications, services, treatments, or therapies provided to resident. The policy further indicated when medications, services, treatments, or therapies were not performed per the service agreement and schedule, staff must document the reason why it was not performed or administered. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
02410 SS=D	144G.91 Subd. 13 Personal and treatment privacy (a) Residents have the right to consideration of their privacy, individuality, and cultural identity as related to their social, religious, and psychological	02410		

Minnesota Department of Health

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02410	Continued From page 56 well-being. Staff must respect the privacy of a resident's space by knocking on the door and seeking consent before entering, except in an emergency or where clearly inadvisable or unless otherwise documented in the resident's service plan. (b) Residents have the right to have and use a lockable door to the resident's unit. The facility shall provide locks on the resident's unit. Only a staff member with a specific need to enter the unit shall have keys. This right may be restricted in certain circumstances if necessary for a resident's health and safety and documented in the resident's service plan. (c) Residents have the right to respect and privacy regarding the resident's service plan. Case discussion, consultation, examination, and treatment are confidential and must be conducted discreetly. Privacy must be respected during toileting, bathing, and other activities of personal hygiene, except as needed for resident safety or assistance. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one resident's (R1) privacy was respected with regards to electronic monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) 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:	02410		

Minnesota Department of Health

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02410	Continued From page 57 R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. On December 21, 2021, at approximately 11:25 a.m., during the initial tour of the facility the surveyor observed a small electronic video monitor (with a screen size of approximately seven inches by five inches) sitting on a side table in the open living room/dining room area. The screen of the monitor was facing towards the open living room/dining room area and could be visualized by any staff, visitor, or resident in the area. There was one unknown resident lying on the couch in full view of the monitor. The monitor was turned on and displayed R1 lying in his bed. Immediately following the above observation, licensed assisted living director (LALD)-A confirmed R1's family had wanted the electronic monitor device placed. LALD-A confirmed the monitor had live feed capability, could not record, and did not include audio. LALD-A verified the live feed could not be accessed on any other electronic device than the monitor. On December 22, 2021, at approximately 7:20 a.m., the surveyor observed the electronic video monitor to be on in the same position as noted above in the open common living room/dining room area. The surveyor was able to visualize R1 lying in his bed in his room.	02410		

Minnesota Department of Health

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02410	Continued From page 58 On December 22, 2021, at approximately 3:35 p.m., LALD-A confirmed the placement of R1's electronic video monitor was not in a private area and could be visualized by any visitor, staff, or resident who may be in the open common living room/dining room area. A policy regarding maintaining resident privacy was requested, but not received. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02410		
03070 SS=D	144.6502, Subd. 6 Form Requirements Subd. 6. Form requirements. (b) Facilities must make the notification and consent form available to the residents and inform residents of their option to conduct electronic monitoring of their rooms or private living unit. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to obtain consent for electronic monitoring for one of one resident (R1) who had an electronic monitor device in place. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at 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	03070		

Minnesota Department of Health

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03070	Continued From page 59 only occasionally). The findings include: R1's diagnoses included diabetes and cerebrovascular accident (CVA-stroke). R1's service plan dated March 20, 2019, indicated R1 received services including medication administration, blood glucose (sugar) monitoring, housekeeping, laundry, and assistance with bathing, dressing, grooming, and toileting. On December 21, 2021, at approximately 11:25 a.m., during the initial tour of the facility the surveyor observed a small electronic video monitor (with a screen size of approximately seven inches by five inches) sitting on a side table in the open living room/dining room area. The screen of the monitor was facing towards the open living room/dining room area and could be visualized by any staff, visitor, or resident in the area. The monitor was turned on and displayed R1 lying in his bed. Immediately following the above observation, licensed assisted living director (LALD)-A confirmed R1's family had wanted the electronic monitor device placed. LALD-A confirmed the monitor had live feed capability, could not record, and did not include audio. LALD-A verified the live feed could not be accessed on any other electronic device than the monitor. R1's record lacked a consent for the electronic monitoring device that was placed in R1's room. On December 22, 2021, at approximately 3:30 p.m., LALD-A confirmed the licensee did not have	03070		

Minnesota Department of Health

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03070	Continued From page 60 a written consent signed by R1 or his representative to place the electronic monitoring device in R1's room. The licensee's Electronic Monitoring policy dated August 1, 2021, noted the licensee required resident consent as outlined in 144.6502 Subd. 3. The consent must be provided on the form provided by the Minnesota Department of Health. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	03070		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors Subd. 8. Notice to visitors. (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure signage was posted at the main entry way of the establishment to display statutory language to disclose electronic monitoring activity, potentially affecting all nine (9) residents, staff, and visitors of the licensee. This practice resulted in a level one violation (a	03090		

Minnesota Department of Health

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03090	Continued From page 61 violation that has no potential to cause more than a 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 failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On December 21, 2021, at approximately 10:15 a.m., Minnesota Department of Health surveyors entered the facility. There was no signage posted in the entry way of the facility regarding electronic monitoring devices. On December 21, 2021, at approximately 11:15 a.m., the licensed assisted living director (LALD)-A confirmed R1 had an electronic monitoring device. LALD-A confirmed the licensee did not have signage posted in the entry way regarding electronic monitoring. The licensee's Electronic Monitoring policy dated August 1, 2021, indicated the licensee would support the use of electronic monitoring by their residents and resident representatives. Signs would be installed at each facility entrance accessible to visitors that state: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons or activities." No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	03090		

Type: Full
Date: 12/22/21
Time: 13:35:59
Report: 3822211152

Food and Beverage Establishment Inspection Report

Page 1

Location:

Long Lake Loon Lodge
7747 Loon Lodge Lane NE
Bemidji, MN56601
Beltrami County, 04

Establishment Info:

ID #: 0013039
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Long Lake Loon Lodge

Phone #: 2185862925
ID #: 34391

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

Chlorine: = 200 PPM at Degrees Fahrenheit
Location: SPRAY BOTTLE
Violation Issued: No

Hot Water: = at 160 Degrees Fahrenheit
Location: DISHWASHER
Violation Issued: No

Food and Equipment Temperatures

Process/Item: Thawing
Temperature: <41 Degrees Fahrenheit - Location: CHICKEN IN TWO DOOR COOLER
Violation Issued: No

Process/Item: Upright Cooler
Temperature: <41 Degrees Fahrenheit - Location: TWO DOOR COOLER
Violation Issued: No

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

NEW ESTABLISHMENT OPENED IN APRIL 2021. COMMERCIAL TRUE TWO DOOR REACH-IN, HOBART HIGH TEMP UNDER COUNTER DISHWASHER.

SAME DAY SERVICE. SERVED TUNA SALAD WITH FRUIT TODAY. FULLY SERVED BY NOON WHEN I INSPECTED.

2021 WATER TEST RESULTS ON FILE. CHECKED SEPTIC, NEW APRIL 2021.

Type: Full
Date: 12/22/21
Time: 13:35:59
Report: 3822211152
Long Lake Loon Lodge

Food and Beverage Establishment Inspection Report

Page 2

DISCUSSED EMPLOYEE HYGIENE, HAND WASHING, EMPLOYEE ILLNESS REPORTING WITH PERSON IN CHARGE. CURRENTLY HAVE ONE STAFF WITH OVER 20 YEARS OF FOOD SERVICE EXPERIENCE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 3822211152 of 12/22/21.

Certified Food Protection Manager: Amy DeLap

Certification Number: FM102838 Expires: 02/13/23

Inspection report reviewed with person in charge and emailed.

Signed: _____

Amy DeLap
Owner

Signed: _____

3822

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