Electronically Delivered

March 29, 2023

Licensee
Lake Song Assisted Living
206 North Elm Street
Onamia, MN 56359

RE: Project Number(s) SL30547015

Dear Licensee:

The Minnesota Department of Health completed an evaluation on March 1, 2023, 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.

LICENSING ORDERS
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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this evaluation of your facility**.

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 evaluations. 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 reconsideration requests to: **Health.HRD.Appeals@state.mn.us**. Please attach this letter as part of your reconsideration request. Please clearly indicate which tag(s) you are contesting and submit information supporting your position(s).

Please address your cover letter for reconsideration requests to:

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

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,

Casey DeVries, Supervisor
Health Regulation Division
State Evaluation Team
85 East Seventh Place, Suite 220
P.O. Box 3879
St. Paul, MN 55101-3879
Email: casey.devries@state.mn.us
Phone: 651-201-5917 Fax: 651-215-6894

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30547	A. BUILDING: _____ B. WING _____	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SONG ASSISTED LIVING	206 NORTH ELM STREET ONAMIA, MN 56359

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments ******ATTENTION****** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30547015-0 On February 27, 2023, through March 1, 2023, 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 32 residents, all of whom received services under the provider's Assisted Living with Dementia 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.	
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements (11) develop and implement a staffing plan for determining its staffing level that:	0 470		

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0 470	Continued From page 1 (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 (v) capable of following directions; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement a staffing plan to determine staffing levels to meet the needs of the residents. This had the potential to affect all residents, staff and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death) and	0 470		

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0 470	Continued From page 2 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 with dementia care license. The facility was licensed for a capacity of 37 residents and had a current census of 32 residents. During the entrance conference on February 27, 2023, at 11:00 a.m., the evaluator asked if the facility had a staffing plan. Licensed assisted living director (LALD)-A stated the facility posts a daily staffing schedule, but "has no formal staffing plan currently." LALD-A stated the usual staffing schedule for the facility was as follows: - clinical nurse supervisor (CNS) on site 32 hours or more a week. - the day shift was staffed with two unlicensed personnel (ULP) from 6:00 a.m. to 2:30 p.m.; and one ULP from 7:00 a.m. to 3:30 p.m. - the evening shift was staffed with two ULP from 2:00 p.m. to 10:30 p.m.; and one ULP from 4:00 p.m. to 9:00 p.m. - the night shift was staffed with two ULP from 10:00 p.m. to 6:30 a.m. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 470		
0 480 SS=F	144G.41 Subd 1 (13) (i) (B) Minimum requirements	0 480		

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0 480	Continued From page 3 (13) offer to provide or make available at least the following services to residents: (B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This had the potential to affect all 32 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 the residents). The findings include: Please refer to the included document titled, Food and Beverage Establishment Inspection Report dated February 27, 2023, for the specific Minnesota Food Code deficiencies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 480		
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for	0 640		

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0 640	Continued From page 4 reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information to include posting the 911 emergency number in common areas and near telephones provided by the assisted living facility 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, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee lacked a posting of the 911 emergency number in commons area and near a telephone provided by the assisted living. During a first floor facility tour on February 27, 2023, at 1:06 p.m., with licensed assisted living	0 640		

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0 640	Continued From page 5 director (LALD)-A, the evaluator observed the commons area lacked the required posting for the 911 emergency number. During a tour of secured memory care unit on February 27, 2023, at 1:35 p.m., with LALD-A, the evaluator observed the 911 emergency number was not posted on or near the telephone. LALD-A said the phone was used by both staff and residents and some residents had phones in their rooms. LALD-A was unaware of the requirement for posting 911 at phones utilized by staff and residents. The licensee's Vulnerable Adult Reporting policy failed to include posting the 911 emergency number in commons area and near telephones provided by the assisted living. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640		
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	0 800		

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0 800	Continued From page 6 failed to maintain the physical environment in a continuous state of good repair and operation regarding the health, safety, comfort, and well-being of the residents. This deficient condition had the potential to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: On a facility tour on March 1, 2023, at approximately 10:00 a.m. with the Licensed Assisted Living Director (LALD)-A and Facilities Manager (FM)-J, survey staff observed the following: 1. The exterior exit door from the northwest stairway did not open completely in the direction of egress. There also was a significant amount of combustible, decorative items stored within the exit pathway. Two other exterior exits were obstructed by snow and ice and were not maintained for egress. As these paths of egress are labeled with an EXIT sign on top of the exit doors, they are required to be maintained and be clear of obstruction completely to a street or other public way to allow for proper exit in the event of an emergency. 2. Kitchen cabinets within the memory care area were not locked and contained hazardous items, including sharp utensils and hazardous	0 800		

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0 800	Continued From page 7 chemicals. All hazardous items in a memory care unit should be removed or secured to prevent residents from causing harm to themselves or others. 3. Apartment 172 had broken bedroom door trim. These deficient conditions were visually verified by LALD-A and FM-J during the survey. 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	0 810		

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0 810	Continued From page 8 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 drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to maintain the required resident and employee training on fire safety and evacuation plans. This deficient condition had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). Findings include: An interview and record review were conducted on March 1, 2023, at approximately 2:00 p.m. with the Licensed Assisted Living Director (LALD)-A and Facilities Manager (FM)-J on the fire safety and evacuation plan, the required training, and evacuation drills for the facility. The review indicated the following. On the tour it was noted that the posted evacuation maps did not provide numbers to the	0 810		

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0 810	Continued From page 9 resident rooms. Record review of the fire safety and evacuation plans provided a general overview of the employee actions during an emergency but did not provide specific roles that the employees needed to perform. A more detailed and specific description of employee actions is necessary as it relates to this facility. Record review of the fire safety and evacuation training indicated that proper records were not maintained that showed employees received the required minimum training twice per year after new hire orientation. Record review of the fire safety and evacuation drill records indicated that employees did not perform the required evacuation drills twice per year per shift with at least one evacuation drill every other month. Fire safety and evacuation training records were available for five months from 2022 and no records were available for 2021 or 2023. Record review of resident training indicated that annual training on fire safety and evacuation for those who can self-assist in the event of a fire or emergency was not documented. LALD-A could not provide documents to show this training was offered to the residents. These deficient conditions were verified by LALD-A and FM-J during the survey and the interview. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810		

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01290	Continued From page 10	01290		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of an employee in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was submitted and a clearance received in affiliation with the assisted living with dementia care license for three of three registered nurses ((RN)- E, RN-G and RN-H) utilized to conduct assessments from the integrated health system home care agency. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).	01290		

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01290	Continued From page 11 The findings include: RN-E RN-E was hired on November 10, 2008, under the health systems comprehensive home care agency license and began providing assisted living services to the licensee's residents in September 2022. On February 28, 2023, at approximately 2:00 p.m., the evaluator reviewed assessment records for R1, R2, R3 and R5. The review indicated RN-E had completed comprehensive assisted living assessments for R1, R2, R3 and R5 on the following dates: - October 26, 2022; - November 2, 2022; - November 3, 2022; - December 14, 2022; and - December 26, 2022. RN-E's employee record contained a background study clearance, affiliated with the health care systems comprehensive home care and hospice agency, dated September 29, 2022. RN-G RN-G was hired on April 22, 2022, under the health systems comprehensive home care agency license and began providing assisted living services to the licensee's residents in September 2022. On February 28, 2023, at approximately 2:00 p.m., the evaluator reviewed assessment records for R1, R2, R3 and R5. The review indicated RN-G had completed a comprehensive assisted living assessment with R5 on December 28, 2022.	01290		

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01290	Continued From page 12	01290		

RN-G's employee record contained a background study clearance, affiliated with the health care systems comprehensive home care and hospice agency, dated April 22, 2022.

RN-H
RN-H was hired on March 21, 2022, under the health systems comprehensive home care agency license and began providing assisted living services to the licensee's residents in September 2022.

On February 28, 2023, at approximately 2:00 p.m., the evaluator reviewed assessment records for R1, R2, R3 and R5. The review indicated RN-H had completed a Bed Safety, Fall Risk and comprehensive assessment for R3 on the following dates:
- December 20, 2022; and
- January 24, 2023.

RN-E, RN-G and RN-H's employee records lacked evidence of current, cleared background studies affiliated with the licensee's current assisted living with dementia care license, effective August 1, 2021.

On February 27, 2023, at approximately 2:45 p.m., the evaluator reviewed and verified through Department of Human Services NetStudy Roster, RN-E, RN-G and RN-H did not have a cleared background study under the licensee's name or license number.

On February 27, 2023, at approximately 2:55 p.m., licensed assisted living director (LALD)-A stated the background studies for RN-E, RN-G and RN-H were under the comprehensive home care agency license, which is a part of the Mille Lacs Health System (MLHS). LALD-A stated the

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LAKE SONG ASSISTED LIVING	206 NORTH ELM STREET ONAMIA, MN 56359

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01290	Continued From page 13 licensee is a part of the same health system and was unaware that a background would be needed for the licensee to utilize home care agency RNs. Additionally, LALD-A stated the home care agency RNs filled in for "a couple months" after the licensee's clinical nurse supervisor (CNS) left employment and a new CNS was hired. The licensee's backgound policy titled Mille Lacs Health System Recruitment/Hiring, undated, indicated following an offer of employment, candidates would be required to complete a background check. The policy did not address employees meeting assisted living licensure requirements. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.	01440		

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01440	Continued From page 14 (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure direct supervision of staff performing delegated tasks was provided within 30 calendar days after the date on which the individual begins working for the licensee for two of two unlicensed personnel (ULP)-D, ULP-F) This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: ULP-D ULP-D was hired on November 14, 2022, to provide direct care services to residents of the facility. On February 27, 2023, at 1:45p.m., the evaluator observed ULP-D administer R1's scheduled afternoon medications.	01440		

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01440	Continued From page 15 On February 28, 2023, at 9:00 a.m., the evaluator asked licensed assisted living director (LALD)-A if there was a 30-day supervision of delegated tasks completed for ULP-D by a registered nurse (RN). LALD-A stated the documentation would be in the employee files if there were any. ULP-F ULP-F was hired on December 1, 2022, to provide direct care services to residents of the facility. On February 28, 2023, at approximately 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R3's morning medications and dismantle/clean R3's Continuous Positive Airway Pressure (CPAP) machine. ULP-F then verified with R3 she was declining to have the TENS unit applied due to a planned appointment. ULP-D and ULP-F's employee records lacked documentation of a RN supervising ULP-D and ULP-F performing a delegated task within 30 days of beginning work with the licensee. The licensee's Supervision of Licensed and Unlicensed Personnel dated February 20, 2023, noted supervision of ULPs by an RN will be direct supervision of the staff performing delegated task(s) within 30 days calendar days after the staff member begins working and first performs the delegated resident tasks. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		

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01460	Continued From page 16	01460		
01460 SS=F	144G.63 Subdivision 1 Orientation of staff and supervisors All staff providing and supervising direct services must complete an orientation to assisted living facility licensing requirements and regulations before providing assisted living services to residents. The orientation may be incorporated into the training required under subdivision 5. The orientation need only be completed once for each staff person and is not transferable to another facility. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide staff orientation to assisted living licensing requirements and regulations for three of three registered nurses ((RN)-E, RN-G, RN-H) who provided RN services for licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a 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: RN-E, RN-G and RN-H's employee record did not contain documentation the licensee oriented RN-E, RN-G and RN-H to assisted living licensing requirements. RN-E was hired on November 10, 2008, under	01460		

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01460	Continued From page 17 the health systems comprehensive home care agency license and began providing assisted living services to the licensee's residents in September 2022. RN-G was hired on April 22, 2022, under the health systems comprehensive home care agency license and began providing assisted living services to the licensee's residents in September 2022. RN-H was hired on March 21, 2022, under the health systems comprehensive home care agency license and began providing assisted living services to the licensee's residents in September 2022. On February 28, 2023, at approximately 10:17 a.m., licensed assisted living director (LALD)-A stated the Mille Lacs Health System (MLHS) RNs from the home care agency would assist with conducting assessments and services for "a couple months" after the licensee's clinical nurse supervisor (CNS) left employment and a new CNS was hired. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01460		
01650 SS=E	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences;	01650		

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01650	Continued From page 18 (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency; and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure service plans included the required content for two of three residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly , but is not	01650		

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01650	Continued From page 19 found to be pervasive). The findings include: On February 27, 2023 at 11:00 a.m., during entrance conference, clinical nurse supervisor (CNS-C) stated she had recently started working at Lake Song Assisted Living and was currently familiarizing herself with the residents and needed to audit resident records to ensure service plans were up to date. R1 R1s diagnoses included dementia (memory loss), anxiety disorder and chronic low back pain. R1s service plan dated March 15, 2022, resident received the following services: medication set up, medication assistance, resident aid visits, blood pressure monitoring, housekeeping, laundry, assistance with bathing and nail care. R1s service plan lacked brace care two times a day. R1s Service Recap Summary dated February 2023, indicated brace care had been provided daily throughout the month of February 2023 with staff electronically signing off task completion. R3 R3's diagnoses included dementia, frequent falls and chronic kidney disease stage 3 (CKD3). On February 28, 2023, at approximately 8:20 a.m., the surveyor observed unlicensed personnel (ULP)-F administer R3's morning medications and dismantle/clean R3's Continuous Positive Airway Pressure (CPAP) machine. ULP-F then verified with R3 she was declining to have the TENS unit applied due to a	01650		

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01650	Continued From page 20 planned appointment. R3's service plan dated February 9, 2022, unsigned, indicated R3 received treatment services to include wound care every 14 days and monthly, however, did not include R3's transcutaneous electrical nerve stimulation (TENS) unit treatment or Continuous Positive Airway Pressure (CPAP) or indicate what category of staff would complete the service. R3's Service Recap Summary dated February 2023, indicated CPAP assistance had been provided daily throughout the month of February 2023 with staff electronically signing off task completion. The licensee's Initial and On-Going Assessment of Residents policy and procedures noted the registered nurse (RN) following re-assessments will update the service plan as necessary based on the resident's needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01650		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy	01940		

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01940	Continued From page 21 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 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 an individual treatment management plan with all required content for one of three residents (R3) who received ordered treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).	01940		

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01940	Continued From page 22 The findings include: During the entrance conference on February 27, 2023, at approximately 10:45 a.m., licensed assisted living director (LALD)-A confirmed the licensee provided treatment and therapy services to residents. R3 R3's diagnoses included dementia, frequent falls and chronic kidney disease stage 3 (CKD3). R3's service plan dated February 9, 2022, unsigned, indicated R3 received treatment services to include wound care every 14 days and monthly, however, did not include R3's transcutaneous electrical nerve stimulation (TENS) unit treatment or Continuous Positive Airway Pressure (CPAP). On February 28, 2023, at approximately 8:20 a.m., the evaluator observed unlicensed personnel (ULP)-F administer R3's morning medications and dismantle/clean R3's Continuous Positive Airway Pressure (CPAP) machine. ULP-F then verified with R3 she was declining to have the TENS unit applied due to a planned appointment R3 was going out of the facility for. R3's record lacked an Individualized Treatment and Therapy plan to include the following: - a statement of the type of services that will be provided; - documentation of specific resident instructions relating to the treatment or therapy administration; - identification of treatment or therapy tasks that will be delegated to unlicensed personnel; and	01940		

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01940	Continued From page 23 - any resident-specific requirements related to documentation of treatment and therapy was received, verification all treatment and therapy was administered as prescribed, and monitoring occurred to prevent possible complications or adverse reactions. On February 28, 2023, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed R3's Individualized Treatment and Therapy Plan lacked the above noted requirements and stated, licensee may not have everything required at this time, however, "we have a working plan to address everything". Additionally, LALD-A stated there was a two month window that home care nurses from Mille Lacs Health System (MLHS) were assisting while the new clinical nurse supervisor was hired and trained and items missed were in the process of being corrected. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the	01950		

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01950	Continued From page 24 registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions and documented those instructions in the resident record for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3's diagnoses included dementia, frequent falls and chronic kidney disease stage 3 (CKD3). R3's service plan dated February 9, 2022, unsigned, indicated R3 received treatment services to include wound care every 14 days and monthly, however, did not include R3's transcutaneous electrical nerve stimulation (TENS) unit treatment or Continuous Positive	01950		

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01950	Continued From page 25 Airway Pressure (CPAP). R3's Service Recap Summary for February 2023, indicated R3's treatment record lacked inclusion of the TENS unit treatments. R3's progress notes dated February 7, 2023, at 11:39 a.m., written by registered nurse (RN)-H, indicated RN-H had "instructed [ULP-F] on how to use [R3's] TENS unit". On February 28, 2023, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed R3's treatment record lacked requirements and stated, licensee may not have everything required at this time, however, "we have a working plan to address everything". Additionally, LALD-A stated there was a two month window that home care nurses from Mille Lacs Health System (MLHS) were assisting while the new clinical nurse supervisor was hired and trained and items missed were in the process of being corrected. The licensee's Delegation of Nursing Tasks policy dated February 20, 2023, reviewed and revised by LALD-A, indicated when needed, the RN would provide written instructions for performing a delegated procedure. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
01960 SS=D	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an	01960		

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01960	Continued From page 26 assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure 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 three (R3) residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 R3's diagnoses included dementia, frequent falls and chronic kidney disease stage 3 (CKD3). R3's service plan dated February 9, 2022, unsigned, indicated R3 received treatment services to include wound care every 14 days and monthly, however, did not include R3's	01960		

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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
01960	Continued From page 27	01960		

transcutaneous electrical nerve stimulation (TENS) unit treatment or Continuous Positive Airway Pressure (CPAP).

On February 28, 2023, at approximately 8:20 a.m., the evaluator observed unlicensed personnel (ULP)-F administer R3's morning medications and dismantle/clean R3's Continuous Positive Airway Pressure (CPAP) machine. ULP-F then verified with R3 she was declining to have the TENS unit applied due to a planned appointment R3 was going out of the facility for.

R3's Service Recap Summary for February 2023, indicated R3's treatment record lacked documentation of completed or declined TENS unit treatments.

R3's progress notes dated February 7, 2023, at 11:39 a.m., written by registered nurse (RN)-H, indicated RN-H had "instructed [ULP-F] on how to use [R3's] TENS unit".

On February 28, 2023, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed R3's treatment record lacked the required documentation and stated, licensee may not have everything required at this time, however, "we have a working plan to address everything". Additionally, LALD-A stated there was a two month window that home care nurses from Mille Lacs Health System (MLHS) were assisting while the new clinical nurse supervisor was hired and trained and items missed were in the process of being corrected.

No further information was provided.

TIME PERIOD FOR CORRECTION: Seven (7)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30547	A. BUILDING: _____ B. WING _____	03/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE SONG ASSISTED LIVING	206 NORTH ELM STREET ONAMIA, MN 56359

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01960	Continued From page 28 days	01960		
01970 SS=D	144G.72 Subd. 6 Treatment and therapy orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the resident, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure up-to-date written or an electronically recorded order was maintained for one of three residents (R3) who received a treatment managed by the provider. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on February 27, 2023, at approximately 10:45 a.m., licensed assisted living director (LALD)-A stated the licensee provided treatment management services to residents in the facility.	01970		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30547	A. BUILDING: _____ B. WING _____	03/01/2023

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01970	Continued From page 29 R3's diagnoses included dementia, frequent falls and chronic kidney disease stage 3 (CKD3). R3's service plan dated February 9, 2022, unsigned, indicated R3 received treatment services to include wound care every 14 days and monthly, however, did not include R3's transcutaneous electrical nerve stimulation (TENS) unit treatment or Continuous Positive Airway Pressure (CPAP). R3's physician orders, signed and dated December 14, 2022, lacked inclusion of the TENS unit. On February 28, 2023, at approximately 8:20 a.m., the evaluator observed unlicensed personnel (ULP)-F administer R3's morning medications and dismantle/clean R3's Continuous Positive Airway Pressure (CPAP) machine. ULP-F then verified with R3 she was declining to have the TENS unit applied due to a planned appointment R3 was going out of the facility for. On February 28, 2023, at approximately 3:30 p.m., licensed assisted living director (LALD)-A confirmed R3's treatment record lacked the required documentation and stated, licensee may not have everything required at this time, however, "we have a working plan to address everything". Additionally, LALD stated, "we likely wouldn't have that (referring to TENS order), that would be a therapy thing". The licensee's Medication and Treatment Orders policy, undated, indicated a current, written prescriber's order must be obtained for any treatment to be provided to a resident.	01970		

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01970	Continued From page 30 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01970		
02040 SS=F	144G.81 Subdivision 1 Fire protection and physical environment An assisted living facility with dementia care that has a secured dementia care unit must meet the requirements of section 144G.45 and the following additional requirements: (1) a hazard vulnerability assessment or safety risk must be performed on and around the property. The hazards indicated on the assessment must be assessed and mitigated to protect the residents from harm; and (2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029. This MN Requirement is not met as evidenced by: Based on record review and interview, the licensee failed to provide hazard vulnerability assessment or safety risk assessment of the physical environment on and around the property for the facility. This deficient practice had the ability to affect all staff, residents, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect	02040		

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	30547	A. BUILDING: _____ B. WING _____	03/01/2023

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02040	Continued From page 31 a large portion or all of the residents). Findings include: On March 1, 2023, at approximately 2:00 p.m., a record review and interview were conducted with the Licensed Assisted Living Director (LALD)-A and Facilities Manager (FM)-J on the Hazard Vulnerability Assessment (HVA) of the facility. It indicated the following: The licensee had not performed a hazard vulnerability assessment with mitigation factors on and around the property. During interview, LALD-A verified that the licensee had not performed a hazard vulnerability assessment for the physical environment on or around the property. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	02040		
02110 SS=F	144G.82 Subd. 3 Policies (a) In addition to the policies and procedures required in the licensing of all facilities, the assisted living facility with dementia care licensee must develop and implement policies and procedures that address the: (1) philosophy of how services are provided based upon the assisted living facility licensee's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; (2) evaluation of behavioral symptoms and design of supports for intervention plans, including nonpharmacological practices that are person-centered and evidence-informed; (3) wandering and egress prevention that	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30547	A. BUILDING: _____ B. WING _____	03/01/2023

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02110	Continued From page 32 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications; (5) staff training specific to dementia care; (6) description of life enrichment programs and how activities are implemented; (7) description of family support programs and efforts to keep the family engaged; (8) limiting the use of public address and intercom systems for emergencies and evacuation drills only; (9) transportation coordination and assistance to and from outside medical appointments; and (10) safekeeping of residents' possessions. (b) The policies and procedures must be provided to residents and the residents' legal and designated representatives at the time of move-in. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and implement all required policies and procedures related to dementia care. In addition, the licensee failed to provide dementia care policies to residents and the residents' legal and designated representatives at the time of move in. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large	02110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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02110	Continued From page 33 portion or all of the residents). The findings include: The facility currently held an Assisted Living with Dementia Care license. On February 28, 2023, at 4:18 p.m., licensed assisted living director (LALD)-A provided the licensee's assisted living with dementia care policies and procedures to the evaluator for review. LALD-A stated this was all the dementia policies licensee had and licensee was working on the additional dementia policies. LALD-A stated once completed, the policies would be added to the licensee's admission process. The policies and procedures provided failed to include the following: - philosophy of how services are provided based upon the assisted living facility license's values, mission, and promotion of person-centered care and how the philosophy shall be implemented; - safekeeping of residents' possessions; - transportation coordination and assistance to and from medical appointments; and - limiting the use of public address and intercom systems for emergencies and evacuation drills only. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	02110		
02260 SS=C	144G.90 Subd. 3 Notice of dementia training An assisted living facility with dementia care shall make available in written or electronic form, to residents and families or other persons who	02260		

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02260	Continued From page 34 request it, a description of the training program and related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. A hard copy of this notice must be provided upon request. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide in written or electronic form to residents, families, or other persons who request it, an accurate description of the dementia care training program with the required content. 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 potential to affect a large portion or all of the residents). The findings include: On February 27, 2023, at approximately 10:45 a.m., licensed assisted living director (LALD)-A verified the licensee was licensed for assisted living with dementia care. The evaluator requested to review the licensee's dementia care training program and notice available to residents, families or others that request it. On February 28, 2023, at 4:18 p.m., LALD-A stated the licensee lacked a completed and available notice of dementia training with the required content. Additionally, LALD-A stated licensee was "working on them".	02260		

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02260	Continued From page 35 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02260		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975
651-201-4500

Type: Full
Date: *02/27/23*
Time: 12:00:00
Report: 1017231044

Food and Beverage Establishment Inspection Report

Location:
Lake Song Assisted Living
206 North Elm Street
Onamia, MN56359
Mille Lacs County, 48

Establishment Info:
ID #: 0038793
Risk:
Announced Inspection: No

License Categories:

Expires on: / /

Operator:

Phone #: 3205322000
ID #:

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

The following orders were issued during this inspection.

3-500B Microbial Control: hot and cold holding

3-501.16A2 ** Priority 1 **

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

CREAM LOCATED IN MEMORY CARE UNIT MEASURED 50 DEGREES, MAINTAIN AT 41 MAXIMUM TEMPERATURE. CREAM WAS DISCARDED DURING INSPECTION.

Comply By: 02/27/23

4-300 Equipment Numbers and Capacities

4-302.13B ** Priority 2 **

MN Rule 4626.0710B Provide a readily accessible, irreversible registering temperature indicator for measuring the utensil surface temperature in mechanical hot water warewashing operations.

PROVIDE MIN MAX THERMOMETERS OR THERMO LABELS TO MEASURE TEMPERATURE OF DISH MACHINE.

Comply By: 02/13/23

Surface and Equipment Sanitizers

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

Food and Equipment Temperatures

Process/Item: Hot Holding
Temperature: 162 Degrees Fahrenheit - Location: HOT DISH LOCATED IN STEAM WELL
Violation Issued: No

Type: Full
Date: *02/27/23*
Time: 12:00:00
Report: 1017231044
Lake Song Assisted Living

Food and Beverage Establishment Inspection Report

Process/Item: Hot Holding
Temperature: 187 Degrees Fahrenheit - Location: GREEN BEANS LOCATED IN STEAM WELL
Violation Issued: No

Process/Item: Cold Holding
Temperature: 42 Degrees Fahrenheit - Location: CHEESE LOCATED IN UPRIGHT COOLER
Violation Issued: No

Process/Item: Cold Holding
Temperature: 43 Degrees Fahrenheit - Location: CUT MELON LOCATED IN UPRIGHT COOLER SELF SERVE KITCHEN
Violation Issued: No

Process/Item: Cold Holding
Temperature: 39 Degrees Fahrenheit - Location: CUT MELON LOCATED ON SERVING LINE
Violation Issued: No

Process/Item: Cold Holding
Temperature: 50 Degrees Fahrenheit - Location: CREAM LOCATED IN MEMORY CARE UNIT UPRIGHT COOLER
Violation Issued: Yes

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

AVOID BARE HAND CONTACT WITH READY TO EAT FOOD, EMPLOYEE ILLNESS LOG, HAND WASHING.

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 1017231044 of 02/27/23.

Certified Food Protection Manager: BETH J. KUNSTLEBEN

Certification Number: FM 98083 Expires: 03/30/25

Inspection report reviewed with person in charge and emailed.

Signed: _____
Establishment Representative

Signed: _____
NATE TOPP
PUBLIC HEALTH SANITARIAN
ST. CLOUD
320.223.7333
NATE.TOPP@STATE.MN.US

Report #: 1017231044

Food Establishment Inspection Report

DEPARTMENT OF HEALTH

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. BOX 64975
ST. PAUL, MN 55164-0975

No. of RF/PHI Categories Out	1	**Date**	02/27/23
No. of Repeat RF/PHI Categories Out	0	**Time In**	12:00:00
Legal Authority MN Rules Chapter 4626		**Time Out**	

Lake Song Assisted Living	**Address** 206 North Elm Street	**City/State** Onamia, MN	**Zip Code** 56359	**Telephone** 3205322000

License/Permit # 0038793	**Permit Holder**	**Purpose of Inspection** Full	**Est Type**	**Risk Category**

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item — Mark "X" in appropriate box for COS and/or R

IN= in compliance **OUT=** not in compliance **N/O=** not observed **N/A=** not applicable **COS=** corrected on-site during inspection **R=** repeat violation

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

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

Risk factors (RF) are improper practices or proceedures identified as the most prevalent contributing factors of foodborne illness or injury. **Public Health Interventions** (PHI) are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

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

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

			COS	R
		Safe Food and Water		
30	IN OUT N/A	Pasteurized eggs used where required		
31		Water & ice obtained from an approved source		
32	IN OUT N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	IN OUT N/A N/O	Plant food properly cooked for hot holding		
35	IN OUT N/A N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present		
39		Contamination prevented during food prep, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

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

Food Recalls:

Person in Charge (Signature) **Date:** 03/01/23

Inspector (Signature)