



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

November 13, 2025

Licensee
Lake Song Assisted Living
206 Crosier Drive North
Onamia, MN 56359

RE: Project Number(s) SL30547016

Dear Licensee:

On November 6, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your facility to determine correction of orders found on the survey completed on August 13, 2025. This follow-up survey determined your facility had not corrected all of the state correction orders issued pursuant to the August 13, 2025 survey.

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

In accordance with Minn. Stat. § 144G.31 Subd. 4 (a), state correction orders issued pursuant to the last survey, completed on August 13, 2025, found not corrected at the time of the November 6, 2025, follow-up survey and/or subject to penalty assessment are as follows:

2310-Appropriate Care And Services-144g.91 Subd. 4 (a)

The details of the violations noted at the time of this follow-up survey completed on November 6, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

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

DOCUMENTATION OF ACTION TO COMPLY

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

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order(s) issued,

including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 calendar days of the correction order receipt date.

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

We urge you to review these orders carefully. If you have questions, please contact Jessie Chenze at 218-332-5175.

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

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze". The ink is dark and the signature is fluid, with the first and last names being clearly legible.

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

CLN

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/06/2025
NAME OF PROVIDER OR SUPPLIER LAKE SONG ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 206 CROSIER DRIVE NORTH 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 FOLLOW UP SURVEY WITH RE-ISSUE OF ORDERS INITIAL COMMENTS SL30547016-1 On November 5, 2025, through November 6, 2025, the Minnesota Department of Health conducted a follow-up survey at the above provider to follow-up on orders issued pursuant to a survey completed on August 13, 2025. At the time of the survey, there were 27 residents; all 27 receiving services under the Assisted Living with Dementia Care license. As a result of the follow-up survey, the following orders were reissued.	{0 000}	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
{0 470} SS=F	144G.41 Subdivision 1 Minimum requirements	{0 470}			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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{0 470}	Continued From page 1 (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 (v) capable of following directions; This MN Requirement is not met as evidenced by:	{0 470}			
{0 485} SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious	{0 485}	Not reviewed during this survey.		

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{0 485}	Continued From page 2 meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by:	{0 485}	Not reviewed during this survey.		
{0 500} SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident	{0 500}			

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{0 500}	Continued From page 3 evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by:	{0 500}	Not reviewed during this survey.		
{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 email contact information for the individuals who are responsible for handling resident	{0 550}			

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{0 640}	Continued From page 5	{0 640}	Not reviewed during this survey.		
{0 640} SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by:	{0 640}			
{0 650} SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following infomation: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision;	{0 650}			

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{0 650}	Continued From page 6 (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by:	{0 650}	Not reviewed during this survey.		
{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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also	{0 680}			

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{0 680}	Continued From page 7 working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by:	{0 680}	Not reviewed during this survey.		
{0 775} SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by:	{0 775}			
{01290} SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits.	{01290}			

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{01290}	Continued From page 8	{01290}			
	This MN Requirement is not met as evidenced by:		Not reviewed during this survey.		
{01500} SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning	{01500}			

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{01500}	Continued From page 9 and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by:	{01500}	Not reviewed during this survey.		
{01540} SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the	{01540}			

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{01540}	Continued From page 10 initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by:	{01540}	Not reviewed during this survey.		
{01690} SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are	{01690}			

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{01690}	Continued From page 11 administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by:	{01690}	Not reviewed during this survey.		
{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 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;	{01780}			

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{01780}	Continued From page 12 This MN Requirement is not met as evidenced by:	{01780}	Not reviewed during this survey.		
{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 (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;	{01790}			

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{01790}	Continued From page 13 (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:	{01790}			
{01930} SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed	{01930}	Not reviewed during this survey.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 11/06/2025
NAME OF PROVIDER OR SUPPLIER LAKE SONG ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 206 CROSIER DRIVE NORTH ONAMIA, MN 56359			
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{01930}	Continued From page 14 under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by:	{01930}	Not reviewed during this survey.		
{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 provides detailed instructions to staff in the event a resident elopes; (4) medication management, including an assessment of residents for the use and effects	{02110}			

Minnesota Department of Health

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{02110}	Continued From page 15 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:	{02110}	Not reviewed during this survey.		
{02170} SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their	{02170}			

Minnesota Department of Health

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{02170}	Continued From page 16 activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by:	{02170}			
{02310} SS=D	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the care and services	{02310}	Not reviewed during this survey.		

Minnesota Department of Health

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{02310}	Continued From page 17 were provided according to acceptable health care and medical, or nursing standards for one of one resident (R4) with an assistive device (consumer bed rail). 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: R4's diagnoses included dementia, atrial fibrillation (rapid irregular heartbeat), cerebral vascular accident / stroke (when blood flow to the brain is interrupted, causing brain tissue damage) , and degenerative joint disease of the knees (chronic condition causing the breakdown of cartilage). R4's Service Plan dated April 2, 2025, indicated R4 received services including assistance with bathing, dressing, grooming, and medication administration. R4's Assessment dated October 14, 2025, indicated R4 had a U-shaped bar on the right side of the bed, was independent with toileting, has knee pain and some limitations to range of motion in the left shoulder. It noted a portable bed rail to aid in turning and repositioning and transferring from the bed. Risk versus benefits were reviewed with the resident/family and they verbalized understanding. It also noted "Family	{02310}			

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{02310}	Continued From page 18 brought in portable bed rail which is easily removable to assist resident w/ [with] independence in getting in and out of bed safely. Family also brought a platform for resident to use to get in/out of bed due to the bed being a little too high for her. Resident demonstrated appropriate use w/ RN [registered nurse] present, resident encouraged to request staff assistance PRN [as needed]. Bed rail: Landtale 782917020547. Resident and family made aware that writer is unable to confirm any recalls and unable to determine if manufacturer instructions were followed as manual cannot be located." It noted resident utilized a walker for ambulation, resided in a memory care unit, and has a pendant to use to call for help. It also noted R4 has become more forgetful. It noted a fall risk of 8, indicating a risk of falling. R4's record lacked information to indicate the consumer bed rail was securely attached to the bed frame per manufacturer guidelines, and lacked evidence the licensee referred to the CPSC for bed rail recall information. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. On November 7, 2025, at 10:35 a.m., clinical nurse supervisor (CNS)-A stated the device has no straps to secure to the bed frame, but it has a grip material in three sections to hold it in place, and added the device cannot be moved unless the mattress is lifted. CNS-A stated they were unable to check for a recall with no full information on the device. In addition, CNS-A stated interventions to mitigate safety risks included the staff assisting R4 to place her legs	{02310}			

Minnesota Department of Health

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{02310}	Continued From page 19 in or out of the bed and regular assessments by the RN. In addition, R4 utilized a pendant to call for help when needed. CNS-A stated R4's record lacked the above content. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - The resident's bed rail use/need assessment; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	{02310}			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 30, 2025

Licensee

Lake Song Assisted Living

206 Crosier Drive North

Onamia, MN 56359

RE: Project Number(s) SL30547016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

STATE CORRECTION ORDERS

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

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

Level 3: a fine of \$1,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;

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

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

St - 0 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$500.00

St - 0 - 2310 - 144g.91 Subd. 4 (a) - Appropriate Care And Services - \$1,000.00

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, **the total amount you are assessed is \$1,500.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

REQUESTING A HEARING

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

To submit a hearing request, please visit:

<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Jessie Chenze".

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

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2025
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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: SL30547016 On August 11, 2025, through August 13, 2025, the Minnesota Department of Health conducted a full survey at the above provider and the following correction orders are issued. At the time of the survey, there were 30 residents; all 30 receiving services under the Assisted Living Facility with Dementia Care license. An immediate correction order was identified on August 12, 2025, for correction order tag identification 2310; the licensee took action to mitigate the risk, however, non-compliance remains at a scope and level of widespread, three (I).	0 000	Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.		
0 470 SS=F	144G.41 Subdivision 1 Minimum requirements	0 470			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

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0 470	Continued From page 1 (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 (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 post a daily work schedule at the beginning of each work shift. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a	0 470			

Minnesota Department of Health

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0 470	Continued From page 2 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: The facility held an assisted living with dementia care license effective May 1, 2025, with a current census of 30 residents. During the entrance conference on August 11, 2025, at 10:40 a.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated they had shifts as follows: - day shift: two unlicensed personnel (ULP) from 6:00 a.m. - 2:30 p.m., one ULP from 7:00 - 3:30 p.m.; - evening shift: two ULP from 2:00 p.m. - 10:30 p.m., one ULP from 4:00 p.m. - 9:00 p.m.; and - night shift: two ULP from 10:00 p.m. - 6:30 a.m. On August 11, 2025, at 11:25 a.m., during the facility tour with LALD-B, the surveyor observed the posted staff schedule on a board in the main hallway on the first floor, opposite the dining room. The untitled posting for August 11, 2025, through August 24, 2025, included a space for all staff names, with a letter in the box for that day if they were working. The letters included D for 6:00 a.m. - 2:30 p.m., D2 for 7:00 a.m. - 3:30 p.m., E for 2:00 p.m. - 10:30 p.m., E2 for 4:00 p.m. - 9:00 p.m., and N for 10:00 p.m. - 6:30 a.m. Although all shifts were assigned to staff, the posting included one ULP that no longer worked	0 470			

Minnesota Department of Health

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0 470	Continued From page 3 for the licensee with scheduled shifts, and lacked identification of the replacement staff. On August 11, 20525, at 1:45 p.m., CNS-A stated the schedule posted was not accurate for today's staff and was not updated each day with any changes. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	0 470			
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services (a) All assisted living facilities must offer to provide or make available at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The menus must be prepared at least one week in advance and made available to all residents. The facility must encourage residents' involvement in menu planning. Meal substitutions must be of similar nutritional value if a resident refuses a food that is served. Residents must be informed in advance of menu changes. The facility must not require a resident to include and pay for meals in the resident's contract. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the Assisted Living	0 485			

Minnesota Department of Health

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0 485	Continued From page 4 contract did not require any resident to include and pay for meals as a part of their assisted living package fee. This had the potential to affect all residents of the facility. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: The licensee's Resident Agreement template dated June 2022, noted on page four, "The Community offers the meal plan attached to this contract. You are not required to select the meal plan to live at the Community." The agreement also included a Minnesota Assisted Living Meal Option Acknowledgement form which indicated "I understand that 3 meals per day are offered and I have the right to choose a meal plan under Minnesota Statutes 144G.41, Lake Song Assisted Living offers the following plans:" - 3 meals per day. Monthly cost of \$100.00; and - I elect not to participate in the meal plan and do not want the meals provided. On August 13, 2025, at 2:20 p.m., licensed assisted living director (LALD)-B stated the same template was utilized for all residents. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485			

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0 500	Continued From page 5	0 500			
0 500 SS=F	144G.41 Subd. 2 Policies and procedures Each assisted living facility must have policies and procedures in place to address the following and keep them current: (1) requirements in section 626.557, reporting of maltreatment of vulnerable adults; (2) conducting and handling background studies on employees; (3) orientation, training, and competency evaluations of staff, and a process for evaluating staff performance; (4) handling complaints regarding staff or services provided by staff; (5) conducting initial evaluations of residents' needs and the providers' ability to provide those services; (6) conducting initial and ongoing resident evaluations and assessments of resident needs, including assessments by a registered nurse or appropriate licensed health professional, and how changes in a resident's condition are identified, managed, and communicated to staff and other health care providers as appropriate; (7) orientation to and implementation of the assisted living bill of rights; (8) infection control practices; (9) reminders for medications, treatments, or exercises, if provided; (10) conducting appropriate screenings, or documentation of prior screenings, to show that staff are free of tuberculosis, consistent with current United States Centers for Disease Control and Prevention standards; (11) ensuring that nurses and licensed health professionals have current and valid licenses to practice; (12) medication and treatment management; (13) delegation of tasks by registered nurses or	0 500			

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0 500	Continued From page 6 licensed health professionals; (14) supervision of registered nurses and licensed health professionals; and (15) supervision of unlicensed personnel performing delegated tasks. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to show they had met the requirements of licensure, by attesting the managerial officials who were in charge of the day-to-day operations, had developed and implemented current policies and procedures, as required. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:40 a.m., the licensee's policies and procedures were requested. The provided policies lacked development of: - ensuring that nurses and licensed health professionals have current and valid licenses to practice. On August 13, 2025, at 2:30 p.m., licensed assisted living director (LALD)-B stated he would look for a policy. However, no policy was	0 500			

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0 500	Continued From page 7 provided. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 500			
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 email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the 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. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post in a conspicuous place, the contact information for the Office of Ombudsman for Mental Health and Developmental Disabilities (OOMHDD). This had the potential to affect the licensee's current residents, staff, and visitors. This practice resulted in a level two violation (a	0 550			

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0 550	Continued From page 8 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: On August 11, 2025, at 11:25 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the the building to have two floors and a basement. The two floors included resident rooms, with a dining room and the secured dementia care unit on the first floor. The hallway on the first floor had postings, but lacked the contact information for OOMHDD. On August 13, 2025, at 2:50 p.m., LALD-B stated the contact information was given to residents on admission, but was not posted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 550			
0 580 SS=F	144G.42 Subd. 2 Quality management The facility shall engage in quality management appropriate to the size of the facility and relevant to the type of services provided. "Quality management activity" means evaluating the quality of care by periodically reviewing resident services, complaints made, and other issues that have occurred and determining whether changes	0 580			

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0 580	Continued From page 9 in services, staffing, or other procedures need to be made in order to ensure safe and competent services to residents. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to maintain documentation of quality management activity programs appropriate to the size and relevant to the type of services provided. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:40 a.m., licensed assisted living director (LALD)-B stated the licensee met quarterly and a the main focus was on employee retention. In addition, LALD-B stated they met weekly to go over any resident care or concern areas for each resident. Clinical nurse supervisor (CNS)-A stated another focus topic included working on getting updated on all vaccinations including pneumonia, COVID, and shingles.	0 580			

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0 580	Continued From page 10 The provided notes from the quality management meetings included: - October 2, 2024, review for the second quarter of 2024; and - undated document noted for the fourth quarter of 2023. On August 13, 2025, at 2:25 p.m., LALD-B stated no additional minutes were available, and said they did not take notes during their weekly meetings. The licensee's Quality Management Plan policy dated January 11, 2024, noted meeting minutes would be retained for two years. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 580			
0 640 SS=F	144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced	0 640			

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0 640	Continued From page 11 by: Based on observation and interview, the licensee failed to support protection and safety by not posting the 911 emergency number in common areas and near telephones provided by the facility as required. 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 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 August 11, 2025, at 11:25 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the the building to have two floors and a basement. The two floors included resident rooms, with a dining room and the secured dementia care unit on the first floor. The hallway on the first floor had postings, but lacked the 911 emergency number. On August 13, 2025, at 2:55 p.m., LALD-B stated the information was posted on phones in the staff offices near phones, but not in common areas. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 640			

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0 650	Continued From page 12	0 650			
0 650 SS=F	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record contained the required content for two of three employees (clinical nurse supervisor/CNS-A, unlicensed personnel/ULP-C). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	0 650			

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0 650	Continued From page 13 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: CNS-A CNS-A was hired on November 21, 2023, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record lacked: - documentation of annual performance reviews that identified areas of improvement needed and training needs. ULP-C ULP-C was hired on March 19, 2024, to provide direct care services to residents of the facility. On August 12, 2025, at 7:25 a.m., the surveyor observed ULP-C assist residents in the dementia care unit. ULP-C's employee record lacked: - documentation of annual performance reviews that identified areas of improvement needed and training needs. On August 13, 2025, at 1:59 p.m., licensed assisted living director (LALD)-B stated the licensee had not conducted annual performance evaluations for any staff, but were working on a plan to do this. No further information was provided.	0 650			

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0 650	Continued From page 14	0 650			
0 680 SS=F	TIME PERIOD FOR CORRECTION: Twenty-one (21) days 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 residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to develop a written emergency preparedness plan (EPP) with all the required content defined in Appendix Z. This had	0 680			

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0 680	Continued From page 15 the potential to affect residents receiving services under the assisted living license, 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 potential to affect a large portion or all of the residents). The findings include: On August 11, 2025, at 11:25 a.m., during the facility tour with licensed assisted living director (LALD)-B, the surveyor observed the the building to have two floors and a basement. The two floors included resident rooms, with a dining room and the secured dementia care unit on the first floor. The licensee's undated Emergency Operation Plan (EOP) provided electronically via email, lacked the following required content: - policy/procedure to address tracking the location of on-duty staff if relocated; - policy/procedure to address the system of medical documentation that preserves resident information, protects confidentiality, and secures/maintains availability of records; - policy/procedure to address development of arrangements with other facilities/providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to residents; - method for sharing information and medical	0 680			

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0 680	Continued From page 16 documentation for residents under the facility's care, as necessary, with other health care providers to maintain continuity of care; - means, in event of evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii); and - means of providing information about general condition/ location of residents under the facility's care as permitted under 45 CFR 164.510(b)(4). On August 13, 2025, at 3:02 p.m., LALD-B stated the plan was last reviewed September 18, 2024, and said the plan lacked the above required content. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 680			
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to comply with the requirements of the Minnesota State Fire Code. This had the potential to directly 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) and was issued at a widespread scope (when problems are pervasive	0 775			

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0 775	Continued From page 17 or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). Findings include: On a facility tour on August 12, 2025, at 9:35 p.m., with licensed assisted living director (LALD)-B, the surveyor made the following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC) in Minnesota Rules Chapter 7511: EXIT DOOR LOCKING ARRANGEMENTS There was a controlled egress locking system installed on the emergency exit doors in the memory care unit leading to the exterior exit path. The controlled egress door locking system was not provided with a device capable of deactivating the delayed egress door hardware to the unlocked position from the nurse station or other approved location for occupants to exit in the event of an emergency. The controlled egress locking system is required to be provided with a switch or device located at the nurse station or other approved location to deactivate the delayed egress locked exit doors for building occupants to exit in the event of an emergency. The procedures required to operate and unlock the controlled egress locking system for occupants to exit in the event of an emergency are required to be included in the fire safety and evacuation plan employee procedures. These procedures are required in accordance with MSFC in Minnesota Rules Chapter 7511. Emergency Exit Door to courtyard	0 775			

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0 775	Continued From page 18 On August 12, 2025, at 9:45 a.m., survey staff toured the facility with LALD-B, it was observed that the emergency exit doors in the memory care exited out into the courtyard that was fenced in with a gate that was locked. This removes a safe means of egress during a fire or similar emergency. These emergency exit doors were identified with overhead exit signs and are included in the facility's evacuation plan. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775			
01290 SS=E	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure background studies were affiliated with their health facility	01290			

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NAME OF PROVIDER OR SUPPLIER LAKE SONG ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 206 CROSIER DRIVE NORTH 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
01290	Continued From page 19 identification (HFID) for five of six employees (clinical nurse supervisor/CNS-A, registered nurse/RN-H, unlicensed personnel/ULP-C, ULP-E, ULP-G). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of residents are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: During the entrance conference on August 11, 2025, CNS-A stated the licensee was aware of the required contents of an employee record. CNS-A CNS-A was licensed as a registered nurse effective January 20, 2016. CNS-A was hired on November 21, 2023, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record included a background study clearance letter dated October 24, 2023, submitted through a separate license of an affiliated company. RN-H RN-H was licensed as a registered nurse effective June 15, 2009.	01290			

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01290	Continued From page 20 RN-H was hired on December 10, 2024, to provide services through an affiliated company and to provide on call services for the facility. RN-H's employee record included a background study clearance letter dated April 26, 2024, submitted through a separate license of an affiliated company. ULP-C ULP-C was hired on March 19, 2024, to provide direct care services to residents of the facility. ULP-C's employee record contained a background study clearance letter dated March 1, 2024, submitted through a separate license of an affiliated company. ULP-E ULP-E was hired on January 7, 2025, to provide direct care services to residents of the facility. ULP-E's employee record contained a background study clearance letter dated December 17, 2024, submitted through a separate license of an affiliated company. ULP-G ULP-G was hired on May 15, 2024, to provide direct care services to residents of the facility. ULP-G's employee record contained a background study clearance letter dated August 18, 2022, submitted through a separate license of an affiliated company. On August 13, 2025, at 3:05 p.m., licensed assisted living director (LALD)-B stated the	01290			

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01290	Continued From page 21 licensee was affiliated with the attached health system, and the background study clearance letters for these employees had not been affiliated with the licensee's HFID. No further information was provided. TIME PERIOD FOR CORRECTION: Two (2) days	01290			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders;	01500			

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01500	Continued From page 22 (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure annual training included all required topics for each 12 months of employment for one of three employees (clinical nurse supervisor/CNS-A). This practice resulted in a level two violation (a violation that did not harm a client's health or	01500			

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01500	Continued From page 23 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: CNS-A was hired on November 21, 2023, to provide direct care services to residents and to provide staff supervision at the facility. CNS-A's employee record lacked documented evidence of the required annual training to include: - reporting maltreatment of vulnerable adults or minors; - assisted living Bill of Rights; and - principles of person-centered planning/service delivery. On August 13, 2025, at 1:50 p.m., CNS-A stated the required training had been assigned but not completed. The licensee's Assisted Living with Memory Care Annual Training policy dated April 18, 2024, noted employees would complete annual training including reporting of maltreatment of vulnerable adults, assisted living Bill of Rights, and principles of person-centered planning and service delivery. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			

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01540 SS=D	144G.64 (a) (3) Training in Dementia, Mental Illness, and De- (3) for assisted living facilities with dementia care, direct-care staff must have completed at least eight hours of initial training on topics specified under paragraph (b) within 80 working hours of the employment start date. Until this initial training is complete, the staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause (1) must be available for consultation with the new staff member until the training requirement is complete. Direct-care staff must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure one of three employees (unlicensed personnel/ULP-E) received the required amount of mental illness and de-escalation training within the required time frame. 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	01540			

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01540	Continued From page 25 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: The facility held an assisted living with dementia care license effective May 1, 2025, with a current census of 30 residents. During the entrance conference on August 11, 2025, at 10:20 a.m., clinical nurse supervisor (CNS)-A and licensed assisted living director (LALD)-B stated they were aware of the contents of the employee record. ULP-E was hired on January 7, 2025, to provide direct care services to residents of the facility. ULP-E's employee record lacked documented evidence of completed training in mental illness or de-escalation by July 1, 2025. On August 13, 2025, at 2:07 p.m., licensed assisted living director (LALD-B stated the required training had not been completed by ULP-E yet. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01540			
01690 SS=F	144G.71 Subdivision 1 Medication management services (a) This section applies only to assisted living	01690			

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01690	Continued From page 26 facilities that provide medication management services. (b) An assisted living facility that provides medication management services must develop, implement, and maintain current written medication management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse, licensed health professional, or pharmacist consistent with current practice standards and guidelines. (c) The written policies and procedures must address requesting and receiving prescriptions for medications; preparing and giving medications; verifying that prescription drugs are administered as prescribed; documenting medication management activities; controlling and storing medications; monitoring and evaluating medication use; resolving medication errors; communicating with the prescriber, pharmacist, and resident and legal and designated representatives; disposing of unused medications; and educating residents and legal and designated representatives about medications. When controlled substances are being managed, the policies and procedures must also identify how the provider will ensure security and accountability for the overall management, control, and disposition of those substances in compliance with state and federal regulations and with subdivision 23. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written medication management policies and procedures under the supervision and direction of a registered nurse (RN).	01690			

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01690	Continued From page 27 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's provided policies lacked: - verifying that prescription drugs are administered as prescribed; - monitoring and evaluation of medication use; - resolving medication errors; and - educating resident and legal and designated representatives about medications. On August 13, 2025, at 2:40 p.m., CNS-A stated the policy lacked the required content. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01690			
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	01780			

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01780	Continued From page 28 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 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 develop and implement policies and procedures for giving accurate and current medications for those residents who received medication management services having planned and unplanned times away from home. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents.	01780			

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01780	Continued From page 29 The licensee's Sending Residents out with Medications policy dated July 1, 2002, lacked the following required content: - for planned time away, the medications must be obtained from the pharmacy or set up by the registered nurse (RN); - 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; and - 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. On August 11, 2025, at 2:40 p.m., CNS-A stated the licensee did not have a policy with this required content. 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	01790			

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01790	Continued From page 30 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 (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	01790			

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01790	Continued From page 31 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 (RN) developed comprehensive written procedures for the unlicensed personnel (ULP) providing medications for residents having unplanned time away when the licensed nurse was not available. 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: During the entrance conference on August 11, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided medication management services to the licensee's residents. The licensee's Delegation of Medications to be	01790			

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01790	Continued From page 32 Given to Residents by Unlicensed Staff for Residents Time Away From Home policy dated August 1, 2021, lacked written procedures to include: - the type of container or containers to be used for the medications appropriate to the provider's medication system; and - how the container or containers must be labeled. On August 11, 2025, at 2:40 p.m., CNS-A stated the staff were trained on this, but it was not included in the written procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01790			
01930 SS=F	144G.72 Subd. 2 Policies and procedures (a) An assisted living facility that provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting treatment or therapy activities, educating and communicating with residents about treatments or therapies they are receiving, monitoring and evaluating the treatment or therapy, and	01930			

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01930	Continued From page 33 communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain current written treatment management policies and procedures under the supervision and direction of a registered nurse (RN). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 11, 2025, at 10:40 a.m., clinical nurse supervisor (CNS)-A stated the licensee provided treatment management services to the licensee's residents. The licensee's provided policies lacked: - educating and communicating with residents about treatments or therapies they are receiving; and - monitoring and evaluating the treatment or therapy. On August 13, 2025, at 2:30 p.m., licensed assisted living director (LALD)-B stated he would look for the policies. However, no additional policies were provided.	01930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2025
NAME OF PROVIDER OR SUPPLIER LAKE SONG ASSISTED LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 206 CROSIER DRIVE NORTH 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
01930	Continued From page 34 No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01930			
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 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.	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2025
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02110	Continued From page 35 (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 ensure policies and procedures required in the licensing of assisted living facilities with dementia care were developed and provided to each resident and the residents' legal and designated representative at the time of move-in. 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 is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The facility held an assisted living with dementia care license effective May 1, 2025, with a current census of 30 residents. The licensee lacked the required policies to include: - medication management, including an assessment of residents for the use and effects of medications, including psychotropic medications.	02110			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2025
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02110	Continued From page 36 On August 13, 2025, at 2:58 p.m., licensed assisted living director (LALD)-B and clinical nurse supervisor (CNS)-A stated the licensee did not have this policy. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	02110			
02170 SS=D	144G.84 SERVICES FOR RESIDENTS WITH DEMENTIA (b) Each resident must be evaluated for activities according to the licensing rules of the facility. In addition, the evaluation must address the following: (1) past and current interests; (2) current abilities and skills; (3) emotional and social needs and patterns; (4) physical abilities and limitations; (5) adaptations necessary for the resident to participate; and (6) identification of activities for behavioral interventions. (c) An individualized activity plan must be developed for each resident based on their activity evaluation. The plan must reflect the resident's activity preferences and needs. (d) A selection of daily structured and non-structured activities must be provided and included on the resident's activity service or care plan as appropriate. Daily activity options based on resident evaluation may include but are not limited to: (1) occupation or chore related tasks; (2) scheduled and planned events such as entertainment or outings; (3) spontaneous activities for enjoyment or those	02170			

Minnesota Department of Health

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02170	Continued From page 37 that may help defuse a behavior; (4) one-to-one activities that encourage positive relationships between residents and staff such as telling a life story, reminiscing, or playing music; (5) spiritual, creative, and intellectual activities; (6) sensory stimulation activities; (7) physical activities that enhance or maintain a resident's ability to ambulate or move; and (8) outdoor activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to conduct an evaluation for activities that addressed all provisions and failed to develop an individualized activity plan based on the evaluation for one of two residents (R2) who resided in an assisted living with dementia care facility. This practice resulted in a level two violation (a violation that did not harm a client'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: The facility held an assisted living with dementia care license effective May 1, 2025, with a current census of 30 residents. R2's diagnoses included Alzheimer's disease and coronary artery disease.	02170			

Minnesota Department of Health

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02170	Continued From page 38 On August 12, 2025, at 7:33 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications to R2. R2's Service Plan dated February 21, 2025, noted R2 received services including assistance with bathing, dressing, grooming, and medication administration. R2's Assessment dated May 27, 2025, noted R2's past interests and hobbies included taking care of her family, required staff or peers to remind and encourage her to come to activities, and noted she enjoyed playing cards, bingo, reading, church and visiting, and spending time with peers. However, it lacked: - adaptations necessary for the resident to participate. In addition, R2's record lacked an individualized activity plan based on the activity evaluation. On August 13, 2025, at 10:10 a.m., clinical nurse supervisor (CNS)-A stated the evaluation lacked adaptations, and said an individualized activity plan had not been completed for R2. The licensee's Description of Life Enrichment Programs and how Activities are Implemented policy dated February 21, 2025, noted each resident would be evaluated for activities including adaptations necessary for the resident to participate. In addition, it noted an individualized activity plan would be developed based on the activity evaluation. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one	02170			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30547	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2025
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02170	Continued From page 39 (21) days	02170			
02310 SS=I	144G.91 Subd. 4 (a) Appropriate care and services (a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the care and services were provided according to acceptable health care and medical, or nursing standards for one of one resident (R1) with an assistive device (consumer bed rail) and one of one resident (R2) with hospital-style bed rails. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to 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). This practice resulted in an immediate order for correction on August 12, 2025. The finding include: ASSISTIVE DEVICE R1 On August 12, 2025, at 8:20 a.m., the surveyor	02310			

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02310	Continued From page 40 observed R1 get up from a supine position on the bed and exit the bed utilizing the assistive device on the right side of her bed. The surveyor also observed a second assistive device on the left side of R1's bed. On August 12, 2025, at 10:40 a.m., the surveyor observed clinical nurse supervisor (CNS)-A observe R1's device on the right side of the bed. CNS-A was able to pull out the device easily from underneath the mattress. The device was a silver metal device which fit nearly to the opposite end of the mattress, had two parallel bars connected at the end with a bar and two rubber grips near the outer portion of the device. The device continued to bend upward on the right edge of the bed and had three horizontal bars with the top bar covered in a rubber material. There was no strap securing the device to the bed. In addition, the device had no identifying information related to the make or model number. The left side of the bed had an assistive device identified as a Medline MDS6800BA and was a dark brown metal. The device was an upside down U-shaped device that went to the floor and had one rubber gripper on the side closest to the middle of the bed, but nothing on the bottom nearest to the head of the bed over the metal. This made the device sit unevenly on the floor, with the top portion not touching the floor. The device had a horizontal bar, one just above the box spring. It also had a material type pocket attached just above the top of the mattress. The device went between the mattress and box spring just shy of the opposite edge of the mattress and had a strap that went around the box spring and bed frame. The strap was clasped just inside the device on the box spring and went through a loop on the edge near the right side of	02310			

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02310	Continued From page 41 the bed. However, it was not looped through the left side of the bed, allowing the device to be easily moved out from the bed approximately eight inches. R1's diagnoses included dementia, anemia, anxiety, atrial fibrillation, chronic pain, hypertension, heart failure, and major depressive disorder. R1's Service Plan dated January 17, 2025, indicated R1 received services which included assistance with ambulation/exercise, compression stockings, dressing, wellness check daily, and medication administration. R1's Assessment dated July 16, 2025, indicated R1 had a history of three falls in the last three months, had an assistive device to use for bed mobility, was independent with toileting, and had pain in the neck, shoulder, and knee. It also noted R1 had partial side rails, an "assistive stick" for repositioning and "pulling self up to seated position". It also noted U-shaped bars attached to bed by the resident's family, and "Family/resident installed side rails and maintains and manages side rails." The assessment noted the bar was 11 1/2 inches wide by 9 inches long in the open areas and 0.2 inches from the mattress. It also noted the right side was different, measuring 10 1/2 inches wide, with 4 1/2 inches length gaps and 0.5 inches from the bed. "Instructed resident on assistive bar safety and risk for strangulation / entrapment. Resident verbalizes understanding. She refuses removal of bars as she states she uses them for positioning and exiting bed safely." The Consumer Product Safety Commission	02310			

Minnesota Department of Health

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02310	Continued From page 42 (CPSC) website listed the Medline device had been recalled since May 30, 2024, "When the recalled bed rails are attached to an adult's bed, users can become entrapped within the bed rail or between the bed rail and the side of the mattress. This poses a serious entrapment hazard and risk of death by asphyxiation." R1's record lacked a comprehensive assessment of the use of an assistive device, including identification and use of the device according to manufacturer's guidelines, a physical inspection of the device and mattress for stability and correct installation of the device, and lacked evidence the licensee referred to the CPSC for bed rail recall information. R1's record also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. The record lacked information related to interventions implemented by the licensee to mitigate the resident's risk for safety pertaining to the use of the device. HOSPITAL BED RAIL R2 On August 12, 2025, at 10:50 a.m., the surveyor observed CNS-A measure R2's bilateral bed rails affixed to the hospital bed. Both rails were in the lowered position, but raised for measurement, and the left rail was very loose when raised, being able to freely move the left rail side to side and front to back. The nine openings between the bars for zone 1 varied in size from 2.0 inches to 3.5 inches. Zone 2 measurements, under the rail, between the rail supports, measured 0 inches. The measurements between the mattress and bedrail for zone 3, measured 1 1/4 inch. Zone 4 measurements under the rail, at the ends	02310			

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02310	Continued From page 43 of the rail, measured 0 inches. CNS-A stated at this time R2 did not utilize the bed rails. R2's diagnoses included Alzheimer's disease, ankle pain, back pain, and foot pain, and a history of a stroke. R2's Service Plan dated February 21, 2025, indicated R2 received services which included assistance with dressing, grooming, medication administration, toileting, and a wellness check daily. R2's Assessment dated May 27, 2025, indicated R2 was independent with bed mobility, and staff would assist as needed, utilized a four wheeled walker for ambulation, required reminders or assistance to use the bathroom, and was incontinent. It noted under bed safety, a standard bed frame, and "No assistive devices needed for bed." R2's record lacked a comprehensive assessment of the hospital bed rails to include the intended purpose of the bed rail, whether the bed rail had the effect of being an improper restraint, measurements of zones 1, 2, 3, or 4 of the Food and Drug Administration (FDA) guidelines and lacked evidence of a physical inspection of the bed rail and mattress for areas of entrapment and stability of the device including installation and use of the device according to manufacturer's guidelines. It also lacked evidence of an individualized risk and benefit discussion with the resident or the resident's representative. On August 12, 2025, at 11:15 a.m., CNS-A stated she had not completed a physical assessment of	02310			

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02310	Continued From page 44 R1's devices to ensure they were installed per manufacturer guidelines, and stated she had not checked for a recall since she did not have the manufacturer information since family had installed the devices. In addition, CNS-A stated she only checks for recalls when she installs the rails, and does not check with each assessment. CNS-A stated she did not do an assessment of the bed rails for R2's bed since she was not utilizing them to her knowledge. The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) indicated, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The licensee must also consider whether the bed rail has the effect of being an improper restraint." Also included, "Documentation about a resident's bed rails includes, but is not limited to: - Purpose and intention of the bed rail; - Condition and description (i.e., an area large enough for a resident to become entrapped) of the bed rail; - The resident's bed rail use/need assessment; - Risk vs. benefits discussion (individualized to each resident's risks); - The resident's preferences; - Installation and use according to manufacturer's guidelines; - Physical inspection of bed rail and mattress for	02310			

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02310	Continued From page 45 areas of entrapment, stability, and correct installation; and - Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements". Additionally, the MDH website indicated for hospital-style bed rails, the licensee must include in their documentation, the bed rail measurements and that the bed rail has not shifted and is securely attached to the bed frame per manufacturer recommendations. The FDA, "A Guide to Bed Safety" revised April 2010, included the following information: "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." The FDA also identified, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe." No further information was provided. TIME PERIOD FOR CORRECTION: IMMEDIATE	02310			



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

LAKE SONG ASSISTED LIVING
206 NORTH ELM STREET
Onamia, MN 56359
Mille Lacs County
Parcel:

Phone:

License Info

License: HFID 30547

Risk:
License:
Expires on:
CFPM: HOLLY DOWNING
CFPM #: FM 40532; Exp: 11-17-2025

Inspection Info

Report Number: F1017251096
Inspection Type: Full - Single
Date: 8/11/2025 Time: 12:51:35 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities

4-302.13B *Priority Level: Priority 2 CFP#: 48*

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

COMMENT: PROVIDE THERMOMETER TO TEST THE HOT WATER IN DISH MACHINE. DISCUSSED TEMPERATURE LABELS AS AN ALTERNATIVE OPTION.

Comply By: Complied On Site Originally Issued On: 8/11/2025

Food & Beverage General Comment

DISCUSSION

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

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

I acknowledge receipt of the St Cloud District Office inspection report number F1017251096 from 8/11/2025

HOLLY DOWNING
FOOD DIRECTOR

Nate Topp,
Public Health Sanitarian 2
320-223-7333
nate.topp@state.mn.us



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Temperature Observations/Recordings

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Establishment Info

LAKE SONG ASSISTED LIVING
Onamia
County/Group: Mille Lacs County

Inspection Info

Report Number: F1017251096
Inspection Type: Full
Date: 8/11/2025
Time: 12:51:35 PM

Food Temperature: **Product/Item/Unit:** HAM ; **Temperature Process:** Cold-Holding - KITCHEN

Location: Upright Cooler at 42 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: Upright Cooler - DINING ROOM at 42 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** TATER TOT CASSEROLE ; **Temperature Process:** Hot-Holding

Location: Steam Table at 191 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** BROCCOLI; **Temperature Process:** Hot-Holding

Location: Steam Table at 165 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** MILK; **Temperature Process:** Cold-Holding

Location: Upright Cooler - MEMORY CARE at 41 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CHICKEN; **Temperature Process:** Hot-Holding

Location: Steam Table at 180 Degrees F.

Comment:

Violation Issued?: No

Food Temperature: **Product/Item/Unit:** CUT MELLON; **Temperature Process:** Time as Public Health Control

Location: COUNTERTOP ON ICE BATH at 41 Degrees F.

Comment: 30 MINUTES OUT OF MECHANICAL REFRIGERATION ALSO USING ICE BATH.

Violation Issued?: No



St Cloud District Office
Minnesota Department of Health
4140 Thielman Lane, Suite 101
St Cloud, MN 56301

Sanitizer Observations/Recordings

Establishment Info LAKE SONG ASSISTED LIVING Onamia County/Group: Mille Lacs County	Inspection Info Report Number: F1017251096 Inspection Type: Full Date: 8/11/2025 Time: 12:51:35 PM
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Sanitizing Chemical: Product: Quaternary Ammonia; **Sanitizing Process:** Pre-Soaked Towelettes

Location: Kitchen **Equal To** 400 PPM

Comment:

Violation Issued?: No

Sanitizing Equipment: Product: Hot Water; **Sanitizing Process:** Dish Machine

Location: Kitchen **Equal To** 160 Degrees F.

Comment:

Violation Issued?: No

Minnesota (MDH) Version EH Manager; RPT: F1017251096		Food Establishment Inspection Report		Page 1 of 1	
 St Cloud District Office Minnesota Department of Health 4140 Thielman Lane, Suite 101 St Cloud, MN 56301		No. of Risk Factor/Intervention/Violations		0	Date: 8/11/2025
		No. of Repeat Risk Factor/Intervention/Violations			Time: 12:51:35 PM
		Score (optional)			Dur: min
Establishment: LAKE SONG ASSISTED LIVING		Address: 206 NORTH ELM STREET		City/State: Onamia, MN	Zip: 56359
License/Permit #: HFID 30547		Permit Holder:		Purpose of Inspection: Full	Est. Type: Risk Category:
FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS					
Designated compliance status (IN, OUT, N/O, N/A) for each numbered item IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable					
Compliance Status		COS	R		
Supervision					
1	IN	Person in charge present, demonstrate knowledge and performs duties			
2	IN	Certified Food Protection Manager			
Employee Health					
3	IN	knowledge, responsibilities, and reporting			
4	IN	Proper use of restriction and exclusion			
5	IN	Response to vomiting, diarrheal events			
Good Hygienic Practices					
6	IN	Proper eating, tasting, drinking, tobacco use			
7	IN	No discharge from eyes, nose, and mouth			
Preventing Contamination by Hands					
8	IN	Hands clean and properly washed			
9	IN	No bare hand contact with RTE foods, alternatives			
10	IN	Adequate handwashing sinks supplied and access			
Approved Source					
11	IN	Food obtained from approved source			
12	N/O	Food Received at proper temperature			
13	IN	Food in good condition, safe & unadulterated			
14	IN	Records available: shellstock tags, parasite dest.			
Protection From Contamination					
15	IN	Food separated and protected			
16	IN	Food-contact surfaces; cleaned & sanitized			
17	IN	Proper Disposition of returned, previously served, reconditioned, & unsafe food			
Time/Temperature Control for Safety					
18	N/O	Proper cooking time & temperatures			
19	N/O	Proper reheating procedures for hot holding			
20	N/O	Proper cooling time and temperature			
21	IN	Proper hot holding temperatures			
22	IN	Proper cold holding temperatures			
23	IN	Proper date marking & disposition			
24	IN	Time as public health control; procedures & record			
Consumer Advisory					
25	IN	Consumer advisory provided for raw or undercooked foods			
Highly Susceptible Populations					
26	IN	Pasteurized foods used; prohibited foods not offered			
Food/Color Additives and Toxic Substances					
27	N/A	Food additives; approved & properly used			
28	N/A	Toxic substances properly identified; stored; used			
Conformance with Approved Procedures					
29	N/A	Compliance with variance, specialized processes & HACCP plan			
Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury					
GOOD RETAIL PRACTICES					
Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.					
Mark "X" or OUT in box if numbered item is not in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation					
COS		R			
Safe Food and Water					
30	IN	Pasteurized eggs used where required			
31		Water & ice from approved source			
32	N/A	Variance obtained for specialized processing methods			
Food Temperature Control					
33		Proper cooling methods used; adequate equipment for temperature control			
34	N/O	Plant food properly cooked for hot holding			
35	N/O	Approved thawing methods used			
36		Thermometers provided & accurate			
Food Identification					
37		Food properly labeled; original container			
Prevention of Food Contamination					
38		Insects, rodents, & animals not present; no unauthorized person			
39		Contamination prevented during food prep, storage, & display			
40		Personal cleanliness			
41		Wiping cloths: properly used & stored			
42		Washing fruits & vegetables			
Person in Charge (signature)					
Inspector (signature)					
Follow-up: Follow-up Date:					