



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

April 2, 2026

Licensee

Long Lake Assisted Living LLC

345 North Brown Road

Long Lake, MN 55356

RE: Project Number(s) SL30339016

Dear Licensee:

On November 18, 2025, the Minnesota Department of Health completed a follow-up survey of your facility to determine correction of orders from the survey completed on August 20, 2025. This follow-up survey verified that the facility is in substantial compliance.

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

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Jess Schoenecker'.

Jess Schoenecker, Supervisor

State Evaluation Team

Email: Jess.Schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 6, 2025

Licensee

Long Lake Assisted Living LLC
345 North Brown Road
Long Lake, MN 55356

RE: Project Number(s) SL30339016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 20, 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:

0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - \$1,000.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

To submit a hearing request, please visit:

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you

may request a reconsideration or a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: <https://forms.office.com/g/Bm5uQEPhVa>. Your input is important to us and will enable MDH to improve its processes and communication with providers. 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,



Jess Schoenecker, Supervisor

State Evaluation Team

Email: jess.schoenecker@state.mn.us

Telephone: 651-201-3789 Fax: 1-866-890-9290

JMD

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
0 000	Initial Comments *****ATTENTION***** ASSISTED LIVING PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a survey. Determination of whether violations are corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL30339016-0 On August 18, 2025, through August 20, 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 37 residents; 37 receiving services under the Assisted Living Facility license.	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.		
0 630 SS=F	144G.42 Subd. 6 (b) Compliance with requirements for reporting ma	0 630			

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

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 630	Continued From page 1 (b) The facility must develop and implement an individual abuse prevention plan for each vulnerable adult. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For purposes of the abuse prevention plan, abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop an individual abuse prevention plan (IAPP) with the required content for two of three residents (R1, R3) This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client'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 the residents). The findings include: R1 R1 was admitted on February 16, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 630	Continued From page 2 R1's record included a Service Plan/Agreement signed September 11, 2024, indicated R1's services included assistance with bathing, dressing, grooming, medication administration, and behavior management. R1's record included a Sample Vulnerability Assessment/Abuse Prevention Plan last updated May 1, 2024. R3 R3 was admitted on October 31, 2018, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's record included a Service Plan/Agreement signed on May 1, 2025, indicating R3's services included assistance with dressing, grooming, bathing, medication administration, and behavior management. R3's record included a Sample Vulnerability Assessment/Abuse Prevention Plan last updated July 1, 2021. R1 and R3's abuse prevention plans lacked an assessment of the residents' susceptibility to abuse by another individual. On August 19, 2025, at 12:26 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated they used the same IAPP form for all residents and were unaware the abuse prevention plan did not include the required content. LALD/CNS-A stated they would begin using an updated form for all residents. The licensee's 6.05 Individual Abuse Prevention	0 630			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 630	Continued From page 3 Plan policy, undated, indicated all resident IAPPs would include an assessment of the person's susceptibility to abuse by another individual. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 630			
0 775 SS=I	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to maintain facility in compliance with Minnesota State Fire Code under Minnesota Rules Chapter 7511. This had the potential to affect some residents, staff, and visitors. This practice resulted in a level three violation (a violation that harmed a resident's health or safety, or a violation that had the potential to cause more than minimal harm to the resident) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On August 19, 2025, from approximately 11:45 a.m. to 1:50 p.m., the surveyor toured the facility with administrator (ADM)-B and the surveyor observed the following:	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 775	Continued From page 4 No carbon monoxide (CO) alarms were provided within the facility. CO alarms are important to alert facility occupants to detect the poisonous gas and give an early warning to avoid harm. CO alarms should be installed and maintained in required locations within proximity of sleeping units. CO alarms are especially important given presence of common sources of CO such as fuel-burning appliances. ADM-B confirmed that there were no CO alarms present and indicated there was one CO alarm which had been present in the second-floor hallway, but that it had been removed and would be replaced. Appropriate CO alarms must be installed and maintained. Rated exit stairwells in the Northwest corner of the facility and Northeast corner of the facility had rated fire doors propped open on all floors. The doors being propped open prevent them from closing during a fire emergency and maintaining the stairwell exits to protect from smoke and fire. Fire doors must remain self-closing or automatic closing and rated exits must be maintained. Fire doors may not be propped open unless tied in with fire alarm system to close in event of a fire. The sprinkler system standpipes contained inspection tags with the most recent tag observed from Brothers Fire and Security from Novemeber 6, 2022. The surveyor asked ADM-B if there were more recent records of inspection and ADM-B indicated that they believed it was in their documents. Later during the record review portion of the survey, ADM-B provided documents on inspections and maintenance of building safety equipment. ADM-B provided records that indicated the same inspection from Novemeber 6, 2022 as the latest inspection on	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
0 775	Continued From page 5 the sprinkler system. ADM-B called brothers Fire and Security, and the company confirmed over the phone that the last inspection was done in 2022. ADM-B requested to schedule an inspection with the company over the phone during survey. The sprinkler system must be inspected by licensed inspector annually and records retained. A sprinkler head in the kitchen was obstructed by high stacked food items and boxes on a shelf. Proper clearance must be maintained around the sprinkler head to allow operation during a fire. Resident room 106 had an extension cord in use, which were not properly rated for continuous use and may pose risk of fire hazard. Extension cords may not be used in lieu of permanent wiring. Resident room 217 had an extension cord in use, which were not properly rated for continuous use and may pose risk of fire hazard. Extension cords may not be used in lieu of permanent wiring. The dryer in the laundry room on the first floor had a significant buildup of lint. Accumulation of lint may pose fire risk and lint should be removed. The dryer in the laundry room on the third floor had a significant buildup of lint. Accumulation of lint may pose fire risk and lint should be removed. Resident room 112 contained a space heater. Space heaters are not permitted in resident rooms and should be removed.	0 775			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 775	Continued From page 6 Resident room 116 contained a space heater. Space heaters are not permitted in resident rooms and should be removed. A significant amount of flammable material was stored below an exit staircase in an sprinklered storage room near the maintenance room. This storage of items should be removed. ADM-B acknowledged the noted deficiencies during the tour and expressed that they would correct the deficiencies. TIME PERIOD FOR CORRECTION: Two (2) days	0 775			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility.	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 810	Continued From page 7 (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for staff twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to develop the fire safety and evacuation plan with required content. 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 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 19, 2025, at approximately 1:20 p.m., administrator (ADM)-B provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 810	Continued From page 8 drills for the facility. The licensee FSEP failed to include the following: The FSEP failed to identify specific fire protection actions for residents. There was no section in the provided documents that addressed the responsibilities or basic evacuation procedures that residents should follow in case of a fire or similar emergency. ADM-B expressed that training is done verbally with residents, but there is no recorded plan or procedures. Record review indicated the licensee failed to provide and document adequate training to employees on the FSEP upon hire and at least twice per year. Staff was unable to provide documentation showing adequate trainings were provided for employee training on the fire safety and evacuation plan. ADM-B stated that employees are trained at hire and during drills, but did not have additional training. Employees should be provided training upon hire and at least twice a year thereafter and trainings should be specific to the facility and FSEP plans. Record review indicated that the licensee failed to provide and document adequate evacuation drills. Evacuation drills occurred at appropriate intervals, however all documented drills in the past year occurred between the hours of 1 p.m. and 3:30 p.m.. ADM-B confirmed that staff on the overnight shift do not regularly participate in evacuation drills. Conducting drills on all shifts ensures staff is prepared to respond to emergencies appropriately during different times and conditions. Evacuation drills are required for employees at least twice per year per shift and at least once every other month. ADM-B indicated	0 810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 810	Continued From page 9 that drills would be scheduled for overnight workers in the future. The FSEP failed to include documentation of training for residents on evacuation procedures. Residents capable of assisting in their evacuation must be offered training at least once a year and trainings should be recorded. ADM-B indicated that the facility would initiate trainings for residents. During an interview on August 19, 2025, at approximately 1:45 p.m., the surveyor explained the requirements for employee trainings, resident training, evacuation drills and FSEP documentation. ADM-B stated they understood the requirements. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 810			
0 970 SS=C	144G.50 Subd. 5 Waivers of liability prohibited The contract must not include a waiver of facility liability for the health and safety or personal property of a resident. The contract must not include any provision that the facility knows or should know to be deceptive, unlawful, or unenforceable under state or federal law, nor include any provision that requires or implies a lesser standard of care or responsibility than is required by law. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the assisted living contract did not include language waiving the licensee's liability for health, safety, or personal	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
0 970	Continued From page 10 property for three of three residents (R1, R2, R3). This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: The licensee provided a blank copy of their Assisted Living Contract which was undated. The licensee's blank Assisted Living Contract, along with R1, R2, and R3's Assisted Living Contracts, included the following waiver of liability on page 12 of 15 of the contract: "22. Indemnification As an occupant of [Licensee], resident assumes the risk for resident's own safety... Resident will indemnify and hold harmless Provider, its employees, officers, managers, owners and agents from and against any and all claims, actions, damages, and liability and expense in connection with loss of life, personal injury or damage to property, arising from or out of, or caused wholly or in part by, an act of omission of Resident... 24. Liability Provider is not liable to Resident... for any injury, death, or property damage occurring in the apartment or on Provider's premises unless such injury, death or property damage occurs as the result of Provider's own negligent acts or omissions, or those of its employees, officers, managers, owners or agents... Unless caused by	0 970			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
0 970	Continued From page 11 one of the aforementioned excepted reasons, Resident agrees to hold Provider harmless from any and all claims for injuries, property damage, or any other loss resulting from an accident or other occurrence in the apartment or on Provider's premises." On August 19, 2025, at 12:26 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the blank contract provided was currently in use for current and future residents. LALD/CNS-A stated the contract had been reviewed by their legal team and they thought it did not include a liability waiver. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 970			
01060 SS=F	144G.52 Subd. 9 Emergency relocation (a) A facility may remove a resident from the facility in an emergency if necessary due to a resident's urgent medical needs or an imminent risk the resident poses to the health or safety of another facility resident or facility staff member. An emergency relocation is not a termination. (b) In the event of an emergency relocation, the facility must provide a written notice that contains, at a minimum: (1) the reason for the relocation; (2) the name and contact information for the location to which the resident has been relocated and any new service provider; (3) contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities;	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
01060	Continued From page 12 (4) if known and applicable, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and (5) a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. (c) The notice required under paragraph (b) must be delivered as soon as practicable to: (1) the resident, legal representative, and designated representative; (2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, the resident's case manager; and (3) the Office of Ombudsman for Long-Term Care if the resident has been relocated and has not returned to the facility within four days. (d) Following an emergency relocation, a facility's refusal to provide housing or services constitutes a termination and triggers the termination process in this section.currently known; and This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to provide a written notice with required content for an emergency relocation and failed to notify the Office of Ombudsman for Long-Term Care of the emergency relocation for two of two residents (R1, R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01060	Continued From page 13 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 residents). The findings include: R1 R1 was admitted on February 16, 2017, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1's record included a Service Plan/Agreement signed on September 11, 2024, indicating R1's services included assistance with dressing, grooming, bathing, medication administration, and behavior management. R1's progress notes indicated R1 was hospitalized between April 1, 2025, through April 8, 2025. R1's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01060	Continued From page 14 housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident may submit an appeal. R3 R3 was admitted on October 21, 2018, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's service plan dated May 1, 2025, indicated R3's services included assistance with dressing, grooming, bathing, medication administration, and behavior management. R3's progress notes indicated R3 was admitted to the hospital on March 11, 2025, through March 17, 2025, and April 24, 2025, through April 28, 2025. R3's record lacked evidence of a written notice provided to the resident, the residents' legal representative, and designated representative that contained, at a minimum: - the reason for the relocation; - the name and contact information for the location to which the resident had been relocated and any new service provider; - contact information for the Office of Ombudsman for Long-Term Care (OOLTC); - if known and applicable, the approximate date or range of dates within which the resident was expected to return to the facility, or a statement that a return date was not currently known; and - a statement that, if the facility refused to provide housing or services after a relocation, the resident had the right to appeal and the contact information for the agency to which the resident	01060			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
01060	Continued From page 15 may submit an appeal. On August 19, 2025, at 12:29 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated that emergency relocation forms had not been completed for R1 or R3 and they were unaware of the requirement of emergency relocation notification. LALD/CNS-A stated they had not been sending emergency relocation notices for any resident hospitalizations. The licensee's 1.23 Emergency Relocation policy, undated, indicated in the event of an emergency relocation, [licensee] will provide written notice of emergency relocation that contains at a minimum: -the reason for the relocation; -the name and contact information for the location to which the resident has been relocated and any new service provider; -contact information for the Office of Ombudsman for Long-Term Care; -if known, the approximate date or range of dates within which the resident is expected to return to the facility, or a statement that a return date is not currently known; and -a statement that, if the facility refuses to provide housing or services after relocation, the resident has a right to appeal. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01060			
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
01440	Continued From page 16 (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure supervision was completed within 30 calendar days after hire and beginning to provide the delegated to tasks to residents for two of two unlicensed personnel (ULP)-D, ULP-E). 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	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
01440	Continued From page 17 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 residents). The findings include: On August 19, 2025, at 7:30 a.m., ULP-D was observed administering medication to R3. ULP-D was hired on May 6, 2024, and began providing assisted living services. ULP-E was hired on January 13, 2025, and began providing assisted living services. ULP-D and ULP-E's employee records lacked documentation of direct supervision of delegated tasks within 30 days of hire or performing delegated tasks. On August 19, 2025, at 2:09 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the supervision documentation was not in employee records for ULP-D and ULP-E. LALD/CNS-A stated they had not completed the required 30-day supervision for the unlicensed staff. The licensee's 6.17 Supervision of Staff - Delegated Services policy, undated, indicated direct supervision of staff performing delegated tasks would be provided within 30 calendar days after the date on which the individual begins working for [licensee] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided.	01440			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
01440	Continued From page 18	01440			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days				
01530 SS=F	144G.64 (a) (1-2) Training in Dementia, Mental Illness, and De- (a) All assisted living facilities must meet the following dementia care, mental illness, and de-escalation training requirements: (1) supervisors of direct-care staff must have at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 120 working hours of the employment start date. Supervisors must have at least two hours of training on topics related to dementia and one hour of training on topics related to mental illness and de-escalation for each 12 months of employment thereafter; (2) direct-care staff must have completed at least eight hours of initial training on dementia topics specified under paragraph (b), clauses (1) to (5), and two hours of initial training on mental illness and de-escalation topics specified under paragraph (b), clauses (6) to (8), within 160 working hours of the employment start date. Until this initial training is complete, a staff member must not provide direct care unless there is another staff member on site who has completed the initial eight hours of training on topics related to dementia and the initial two hours of training on topics related to mental illness and de-escalation and who can act as a resource and assist if issues arise. A trainer of the requirements under paragraph (b) or a supervisor meeting the requirements in clause	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 19 (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 the required hours of dementia care training was received by two of two employees (unlicensed personnel (ULP)-D, ULP-E). Additionally, the licensee failed to ensure that one of two employees (ULP-D) had completed at least two (2) hours of training on topics related to dementia care for each twelve (12) months of employment thereafter. 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 the residents). The findings include: ULP-D ULP-D was hired on May 6, 2024, and began providing assisted living services. ULP-D's employee record included an Educare	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
01530	Continued From page 20 transcript (online training) that ULP-D received five and one-half (5.5) hours of dementia care training during orientation instead of the required eight (8) hours. Additionally, ULP-D's employee record lacked documentation of training on topics related to dementia care for each 12 months of employment. ULP-E ULP-E was hired on January 13, 2025, and began providing assisted living services. ULP-E's employee record included an Educare transcript indicating ULP-E received five and one-half (5.5) hours of initial training in dementia care. On August 19, 2025, at 3:23 p.m., administrator (ADM)-B stated both ULP-D and ULP-E had worked over 160 hours caring for residents. ADM-B stated ULP-D and ULP-E had not completed all assigned dementia care training during their orientation. ADM-B stated the annual training was provided throughout the year and the dementia training had not yet been completed for 2025. The licensee's 5.03 Dementia Training policy, undated, indicated direct care employees would complete 8 hours of dementia training within 160 hours of their employment start date. The policy also indicated all staff would complete 2 hours of additional training for each 12 months of work thereafter. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01530			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356		
(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
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan. (d) The service plan and the revised service plan must be entered into the resident record, including notice of a change in a resident's fees when applicable. (e) Staff providing services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a written service plan was revised to reflect the current services provided for one of three residents (R3). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01640	Continued From page 22 limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 was admitted on October 31, 2018, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R3's record included a Service Plan signed on May 1, 2025, indicating R3's services included assistance with bathing, toileting, medication administration, and behavior management. R3's record included a Medication Administration record (MAR) dated July 2025, indicating the following services had been provided to R3: -weekly continuous positive airway pressure (CPAP) machine cleaning on July 3, 17, 24, and 31, 2025; -change Freestyle Libre Sensor (continuous blood glucose monitor) every two weeks on July 14, and 28, 2025. -check blood glucose four times (before meals and at bedtime) daily on July 1 through July 31, 2025. R3's Service Plan dated May 1, 2025, lacked documentation of all current services provided including blood glucose monitoring, blood glucose sensor changes, and CPAP cleaning. On August 18, 2025, at 12:45 p.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated R3 was receiving services for blood glucose management and CPAP cleaning, and was unaware the services were not	01640			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01640	Continued From page 23 listed on the service plan. The licensee's 6.08 Service Plan policy, undated, indicated service plans would include a description of the services that are to be provided based on the most recent assessment and resident preferences. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640			
01700 SS=F	144G.71 Subd. 2 Provision of medication management services (a) For each resident who requests medication management services, the facility shall, prior to providing medication management services, have a registered nurse, licensed health professional, or authorized prescriber under section 151.37 conduct an assessment to determine what medication management services will be provided and how the services will be provided. This assessment must be conducted face-to-face with the resident. The assessment must include an identification and review of all medications the resident is known to be taking. The review and identification must include indications for medications, side effects, contraindications, allergic or adverse reactions, and actions to address these issues. (b) The assessment must identify interventions needed in management of medications to prevent diversion of medication by the resident or others who may have access to the medications and provide instructions to the resident and legal or designated representatives on interventions to manage the resident's medications and prevent	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01700	Continued From page 24 diversion of medications. For purposes of this section, "diversion of medication" means misuse, theft, or illegal or improper disposition of medications. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a face-to-face medication management reassessment to include all required content for three of three residents (R1, R2, R3) who received medication management services. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a 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 18, 2025, at approximately 10:52 a.m., licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A stated the licensee provided medication management services to all the licensee's residents. R1 R1 was admitted on February 16, 2017, under the licensee's former comprehensive license, and began receiving assisted living services on August 1, 2021.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01700	Continued From page 25 R1's record included a Service Plan/Agreement signed on September 11, 2024, indicating R1's services included medication administration. R1's record included a Medication Management Assessment form dated June 1, 2024. The medication management assessment lacked the identification and review of all medications the resident is known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. R2 R2 was admitted on February 25, 2015, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R2's record included a Service Plan/Agreement signed September 13, 2024, indicating R2's services included medication administration. R2's record included two Medication Management Assessments dated May 11, 2023, and May 10, 2024. The medication management assessments lacked the identification and review of all medications the resident is known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. R3 R3 was admitted on October 31, 2018, under the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021.	01700			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01700	Continued From page 26 R3's record included a Service Plan/Agreement signed on May 1, 2025, indicating R3's services included medication administration. R3's record included a Medication Management assessment dated July 7, 2024. The medication management assessment lacked the identification and review of all medications the resident is known to be taking, including indications for medications, side effects, contraindications, allergic or adverse reactions and actions to address these issues. On August 19, 2025, at 12:44 p.m., LALD/CNS-A stated they were unaware of the content required in the medication management assessment. LALD/CNS-A stated they thought the information was included in physician orders and on the medication administration record (MAR). The licensee's undated 7.03 Individualized Medication Management Plan policy indicated a current medication management record would be developed based on the resident's medication management assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01700			
01810 SS=F	144G.71 Subd. 12 Medications; over-the-counter drugs; dietary An assisted living facility providing medication management services for over-the-counter drugs or dietary supplements must retain those items in the original labeled container with directions for use prior to setting up for immediate or later	01810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01810	Continued From page 27 administration. The facility must verify that the medications are up to date and stored as appropriate. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure over-the-counter medications or dietary supplements were kept up to date and that expired medications were disposed properly. This had the potential to affect all the licensee's residents. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On August 18, 2025, at 2:03 p.m., the surveyor conducted a review of four medication carts in the nursing office and made the following observations: MEDICATION CART #1 The medication cart contained the following expired medications: -a Fleets enema with an expiration date of November 2024; -glucose tablets with an expiration date of July 2, 2024; and -a tube of triple antibiotic ointment with an expiration date of November 2024.	01810			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01810	Continued From page 28 MEDICATION CART #2 The medication cart contained the following expired medications: -a Fleets enema with an expiration date of October 2024; -a bottle of amoxicillin 500 milligram (mg) capsules with an expiration date of November 2022; and -an albuterol inhaler with an expiration date of February 2025. On August 18, 2025, at 2:32 p.m., the medication carts were reviewed with licensed assisted living director/clinical nurse supervisor (LALD/CNS)-A and the expired medications were removed from the carts. On August 18, 2025, at 2:35 p.m., LALD/CNS-A stated the unlicensed personnel (ULPs) were responsible for monitoring the carts for expired medications. LALD/CNS-A stated the medication monitoring process needed to be reviewed. The licensee's undated 7.12 Medications - Prescribed, Not Prescribed, and OTC policy indicated licensee would verify that medications are up to date and stored as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01810			
01910 SS=D	144G.71 Subd. 22 Disposition of medications (a) Any current medications being managed by the assisted living facility must be provided to the resident when the resident's service plan ends or	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01910	Continued From page 29 medication management services are no longer part of the service plan. Medications for a resident who is deceased or that have been discontinued or have expired may be provided for disposal. (b) The facility shall dispose of any medications remaining with the facility that are discontinued or expired or upon the termination of the service contract or the resident's death according to state and federal regulations for disposition of medications and controlled substances. (c) Upon disposition, the facility must document in the resident's record the disposition of the medication including the medication's name, strength, prescription number as applicable, quantity, to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to document the disposition of the medications in the resident's record, for one of one resident (R1). 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: R1 was admitted on February 16, 2017, under	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01910	Continued From page 30 the licensee's former comprehensive license and began receiving assisted living services on August 1, 2021. R1 was discharged on May 9, 2025. R1's record included a Service Plan/Agreement signed on September 24, 2024, indicating R1's services included medication administration. R1's record lacked documentation of medication disposition upon R1's discharge from the facility, including the following required information: -medication name and strength; -prescription number as applicable; -quantity; -to whom the medications were given or method of destruction; -date of destruction; and -names of staff and other individuals involved in that destruction. On August 19, 2025, at 2:22 p.m., licensed practical nurse (LPN)-C stated they were unable to locate the medication disposition documentation for R1. LPN-C stated they disposed of R1's narcotics in a pharmacy bag, but did not document the disposition. The licensee's undated 7.23 Medication Disposal policy indicated upon disposition, the facility must document in the resident's record the medication name, strength, prescription number as applicable, quantity to whom the medications were given, date of disposition, and names of staff and other individuals involved in the disposition. No further information was provided.	01910			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 30339	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER LONG LAKE ASSISTED LIVING LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 345 NORTH BROWN ROAD LONG LAKE, MN 55356			
(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
01910	Continued From page 31 TIME PERIOD FOR CORRECTION: Seven (7) days	01910			



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164
Phone: 651-201-4500

Food & Beverage Inspection Report

Page: 1

Establishment Info

LONG LAKE ASSISTED LIVING LLC
345 NORTH BROWN ROAD
Long Lake, MN 55356
Hennepin County
Parcel:

Phone:

License Info

License: HFID 30339

Risk:
License:
Expires on:
CFPM: LUIS A. CISNEROS-CAMPOS
CFPM #: FM115871; Exp: 9/12/2025

Inspection Info

Report Number: F8087251077
Inspection Type: Full - Single
Date: 8/19/2025 Time: 2:00:00 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

THIS WAS AN UNANNOUNCED AND UNSCHEDULED FULL INSPECTION.

INSPECTION DONE WITH KITCHEN MANAGER LUIS A. CISNEROS-CAMPOS.

TOPICS OF DISCUSSION WITH OPERATOR INCLUDED:

HAND WASHING

NOROVIRUS

BARE HAND CONTACT WITH READY TO EAT FOODS

EMPLOYEE ILLNESS

EMPLOYEE EXCLUSION

COOLING METHODS

REHEATING METHODS

SANITIZER CONCENTRATION

DATE MARKING

ALL ITEMS ON THIS REPORT

ALL ITEMS ON PREVIOUS REPORT

ALL FROZEN FOODS FOUND IN FROZEN CONDITION.

REPORT EMAILED TO ESTABLISHMENT AND TO HRD NURSE SURVEYOR.

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 Metro District Office inspection report number F8087251077 from 8/19/2025

John Boettcher

LUIS A. CISNEROS-CAMPOS
KITCHEN MANAGER

John Boettcher,
Public Health Sanitarian 3
651-201-5076
john.boettcher@state.mn.us



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Temperature Observations/Recordings

Page: 1

Establishment Info

LONG LAKE ASSISTED LIVING LLC
Long Lake
County/Group: Hennepin County

Inspection Info

Report Number: F8087251077
Inspection Type: Full
Date: 8/19/2025
Time: 2:00:00 PM

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment: MAIN KITCHEN - LEFT

Violation Issued?: No

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

Location: Upright Cooler at 35 Degrees F.

Comment: MAIN KITCHEN - LEFT

Violation Issued?: No

Food Temperature: Product/Item/Unit: CUT MELON; Temperature Process: Cold-Holding

Location: Upright Cooler at 36 Degrees F.

Comment: MAIN KITCHEN - LEFT

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 37 Degrees F.

Comment: MAIN KITCHEN - MIDDLE

Violation Issued?: No

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

Location: Upright Cooler at 35 Degrees F.

Comment: MAIN KITCHEN - MIDDLE

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Upright Cooler at 40 Degrees F.

Comment: MAIN KITCHEN - RIGHT

Violation Issued?: No

Food Temperature: Product/Item/Unit: GROUND BEEF; Temperature Process: Cold-Holding

Location: Upright Cooler at 38 Degrees F.

Comment: MAIN KITCHEN - RIGHT

Violation Issued?: No

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

Location: Upright Cooler at 38 Degrees F.

Comment: MAIN KITCHEN - RIGHT

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; Temperature Process: Ambient Air

Location: Walk-in Freezer at -16 Degrees F.

Comment:

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; **Temperature Process:** Ambient Air

Location: Upright Freezer at 0 Degrees F.

Comment: FIRST FLOOR KITCHENETTE

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; **Temperature Process:** Ambient Air

Location: Upright Cooler at 41 Degrees F.

Comment: FIRST FLOOR KITCHENETTE

Violation Issued?: No

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

Location: Upright Cooler at 40 Degrees F.

Comment: FIRST FLOOR KITCHENETTE

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; **Temperature Process:** Ambient Air

Location: Upright Freezer at 0 Degrees F.

Comment: SECOND FLOOR KITCHENETTE

Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT AIR; **Temperature Process:** Ambient Air

Location: Upright Cooler at 35 Degrees F.

Comment: SECOND FLOOR KITCHENETTE

Violation Issued?: No

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

Location: Upright Cooler at 35 Degrees F.

Comment: SECOND FLOOR KITCHENETTE

Violation Issued?: No

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

Location: Upright Cooler at 36 Degrees F.

Comment: SECOND FLOOR KITCHENETTE

Violation Issued?: No



Metro District Office
Minnesota Department of Health
625 Robert St N, PO BOX 64975
St Paul, MN 55164

Sanitizer Observations/Recordings

Page: 1

Establishment Info	Inspection Info
LONG LAKE ASSISTED LIVING LLC Long Lake County/Group: Hennepin County	Report Number: F8087251077 Inspection Type: Full Date: 8/19/2025 Time: 2:00:00 PM

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