Electronically Delivered

December 20, 2024

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

RE: Project Number(s) SL20285016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 19, 2024, 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.

MDH 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.

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 . . ."

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 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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jessie Chenze

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

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20285	A. BUILDING: _____ B. WING _____	11/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LONG LAKE LOON LODGE	7747 LOON LODGE LANE NE BEMIDJI, MN 56601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments 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: SL20285016-0 On November 18, 2024, through November 19, 2024, the Minnesota Department of Health conducted a full survey at the above provider. At the time of the survey, there were 10 residents; 10 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.	
0 340 SS=F	144G.30 Subd. 5 Correction orders (a) A correction order may be issued whenever	0 340		

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0 340	Continued From page 1 the commissioner finds upon survey or during a complaint investigation that a facility, a managerial official, an agent of the facility, or staff of the facility is not in compliance with this chapter. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail or email copies of any correction order to the facility within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the facility and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the facility must: (1) document in the facility's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the facility's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to have sufficient documentation with actions taken to comply with correction order tag identification 0460 for a survey completed on December 23, 2021. This had the potential to affect all residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a	0 340		

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0 340	Continued From page 2 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 November 18, 2024, at 10:38 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. At 10:43 a.m., LALD-A further stated wireless doorbells were installed for residents to press to request assistance from staff. The licensee provided an undated Plan of Correction binder from a survey completed on December 23, 2021. Under the tab labeled 0460, the documentation indicated wireless doorbells were installed at the facility for residents to request assistance 24 hours per day. On November 19, 2024, at 1:17 p.m., the surveyor observed with unlicensed personnel (ULP)-C wireless doorbells installed in resident shared bathrooms. ULP-C stated wireless doorbells were only installed in two shared resident bathrooms and two resident rooms who were fall risks (R3, R5). On November 19, 2024, at 2:23 p.m., R2 stated the licensee did not provide R2 with a device to request assistance from staff, however, R2 stated if R2 needed assistance at night R2 would message staff via R2's personal cell phone. On November 19, 2024, at 2:53 p.m., LALD-A and clinical nurse supervisor (CNS)-B stated most residents were independent and would	0 340		

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0 340	Continued From page 3 come out of their room if assistance was needed or residents would call out for help. On November 19, 2024, the survey concluded, and correction order 0460 was reissued. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 340		
0 460 SS=F	144G.41 Subdivision 1 Minimum requirements (5) provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week; (6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract; (7) permit residents access to food at any time; (8) allow residents to choose the resident's visitors and times of visits; (9) allow the resident the right to choose a roommate if sharing a unit; (10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit; This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to provide a means for one of three residents (R2) to request assistance	0 460		

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0 460	Continued From page 4 for health and safety needs as required. The licensee did not have a system in place for residents at the facility to request assistance for health and safety needs 24 hours a day, seven days a week. This had the potential to affect eight of 10 residents at the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: The licensee held an assisted living facility license and was licensed for a capacity of 10 residents. The current census at the facility was 10 residents. During the entrance conference on November 18, 2024, at 10:38 a.m., licensed assisted living director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. At 10:43 a.m., LALD-A further stated wireless doorbells were installed for residents to press to request assistance from staff. R2's diagnoses included morbid obesity, major depressive disorder, and obstructive sleep apnea. R2's Service Plan dated May 1, 2024, indicated R2's services included medication administration, assistance with bathing, grooming, dressing, and stand by assistance during ambulation.	0 460		

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0 460	Continued From page 5 On November 19, 2024, at 1:17 p.m., the surveyor observed with unlicensed personnel (ULP)-C wireless doorbells installed in resident shared bathrooms. ULP-C stated wireless doorbells were only installed in two shared resident bathrooms and two resident rooms who were fall risks (R3, R5). On November 19, 2024, at 2:23 p.m., R2 stated the licensee did not provide R2 with a device to request assistance from staff, however, R2 stated if R2 needed assistance at night R2 would message staff via R2's personal cell phone. On November 19, 2024, at 2:53 p.m., LALD-A and clinical nurse supervisor (CNS)-B stated most residents were independent and would come out of their room if assistance was needed or residents would call out for help. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 460		
0 485 SS=C	144G.41 Subdivision 1.a (a) Minimum requirements; required food services 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	0 485		

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0 485	Continued From page 6 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 contract did not require any resident to include and pay for meals as a part of their assisted living contract. This had the potential to affect all residents. This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: During the entrance conference on November 18, 2024, at 10:43 a.m., licensed assisted living director (LALD)-A stated the licensee provided residents three meals per day and the licensee did not require a resident to include and pay for meals in the resident contract that the resident did not want. On page one of the undated Client (resident) Contract Monthly rental fee: indicated a base fee plus any waiver funding for additional needs/services included three meals per day. Resident assisted living contract addendums	0 485		

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0 485	Continued From page 7 lacked an option for residents to opt out of payment for one, two, or all meals residents would not want. On November 18, 2024, at 1:45 p.m., LALD-A stated the same assisted living contract was used for all residents and the assisted living contract included three meals per day as part of the monthly base fee. LALD-A further stated the licensee was not aware the assisted living contract could not require a resident to pay for meals a resident would not want. The Minnesota Department of Health Assisted Living Resources and Frequently Asked Questions (FAQs) website, last updated October 15, 2024, indicated the provider cannot have a blanket "one size fits all" meal charge. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 485		
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and maintain an infection control program that complies with accepted health care, medical, and nursing standards for infection control. (b)The facility's infection control program must be consistent with current guidelines from the national Centers for Disease Control and Prevention (CDC) for infection prevention and control in long-term care facilities and, as applicable, for infection prevention and control in assisted living facilities. (c) The facility must maintain written evidence of compliance with this subdivision.	0 510		

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0 510	Continued From page 8 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure services were provided according to accepted health care, medical or nursing standards in regard to infection control during medication administration for one of two employees (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 resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During the entrance conference on November 18, 2024, at 10:43 a.m., licensed assisted living director (LALD)-A stated the licensee provided medication management services to residents. On November 19, 2024, at 8:09 a.m. the surveyor observed ULP-C provide scheduled morning medication to R4. ULP-C handed R4 the scheduled morning medications with a glass of water, R4 dropped two medications onto the shared resident dining room floor, ULP-C stated "oops", ULP-C picked the two medications up off the floor, ULP-C handed the two medications back to R4, and R4 swallowed the medications. The surveyor did not observe ULP-C offer R4 new medication to administer, fill out a medication error report, or notify the registered nurse (RN) of the spillage of medication.	0 510		

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0 510	Continued From page 9 On November 19, 2024, at 11:41 a.m., ULP-C stated ULP-C should have gone to get R4 new medication to administer when R4 dropped the two medications onto the dining room floor. On November 19, 2024, at 11:54 a.m., clinical nurse supervisor (CNS)-B stated if medication spillage occurred, ULPs were trained to place the spilled medication in a labeled envelope, administer new medication, and notify CNS-B. CNS-B further stated generally the floors were not considered a clean space and medications should not have been administered if the medications were on the floor. The licensee's 7.07 Medication Loss or Spillage policy dated August 1, 2021, indicated when a spillage of a medication occurs a notation must be made in the resident's record explaining the spillage and the actions taken. In addition, a medication error report form must be completed, and staff would notify the RN. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 780 SS=F	144G.45 Subd. 2 (a) (1) Fire protection and physical environment (a) Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: (1) for dwellings or sleeping units, as defined in the State Fire Code: (i) provide smoke alarms in each room used	0 780		

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0 780	Continued From page 10 for sleeping purposes; (ii) provide smoke alarms outside each separate sleeping area in the immediate vicinity of bedrooms; (iii) provide smoke alarms on each story within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics; (iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and (v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated; 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 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 November 19, 2024, from 10:45 a.m. to 11:30 a.m., with licensed assisted living director (LALD)-A, the surveyor made the	0 780		

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0 780	Continued From page 11 following observations of non-compliance with the requirements of the Minnesota State Fire Code (MSFC): USED SMOKING MATERIALS There was a plastic zip lock bag of cigarette butts outside in the designated smoking area laying next to the building. There were appropriate cigarette butt containers provided on the table in the smoking area. The surveyor explained all used smoking materials are required to be discarded in appropriate containers in accordance with MSFC Sections 308 and 310. FIRE SPRINKLER SYSTEM MAINTENANCE On November 20, 2024, at 7:40 a.m., the surveyor requested required water based automatic fire sprinkler maintenance records from LALD-A, by email. Water based automatic sprinkler systems are required to be inspected, tested, and maintained in accordance with MSFC Section 901 and National Fire Protection Association (NFPA) 25. No sprinkler system maintenance documentation was provided. During the facility tour LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 780		
0 790 SS=F	144G.45 Subd. 2 (a) (2)-(3) Fire protection and physical environment	0 790		

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0 790	Continued From page 12 (2) install and maintain portable fire extinguishers in accordance with the State Fire Code; (3) install portable fire extinguishers having a minimum 2-A:10-B:C rating within Group R-3 occupancies, as defined by the State Fire Code, located so that the travel distance to the nearest fire extinguisher does not exceed 75 feet, and maintained in accordance with the State Fire Code; and This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to provide or maintain fire extinguishers as required throughout the facility. This deficient condition had the ability to affect all staff, visitors, and 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 potential to affect a large portion or all of the residents). The findings include: On a facility tour on November 19, 2024, from 10:45 a.m. to 11:30 a.m., with licensed assisted living director (LALD)-A, it was observed that the provided fire extinguisher was a 1A-10BC rated fire extinguisher. The provided fire extinguisher was stored in a kitchen base cabinet that was not marked indicating the location of the fire	0 790		

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	20285	A. BUILDING: _____ B. WING _____	11/19/2024

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0 790	Continued From page 13 extinguisher. The surveyor explained that at least one fire extinguisher with minimum 2-A:10-B:C rating is required to be provided, mounted, maintained, and located within 75 feet of travel throughout the facility in accordance with Minnesota State Fire Code Section 906. The surveyor explained that there shall be a sign marking the location of the extinguisher inside the kitchen cabinet or mount as required in a plainly visible location. Fire extinguishers are required to be mounted at least 4 inches off the floor and not higher than 60 inches from the floor to the top of the extinguisher. Documentation is required to demonstrate fire extinguishers have been inspected by facility personnel monthly, and annually replaced with a new extinguisher (of current year manufacture date) or serviced by a certified technician. During the facility tour LALD-A, verified the above listed observations while accompanying on the tour. TIME PERIOD FOR CORRECTION: Two (2) days	0 790		
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;	0 810		

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0 810	Continued From page 14 (2) employee actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. (f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation 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 and provide required training and drills. 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	0 810		

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0 810	Continued From page 15 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 November 19, 2024, at 10:05 a.m., licensed assisted living director (LALD)-A, provided documents on the fire safety and evacuation plan (FSEP), fire safety and evacuation training, and evacuation drills for the facility. FIRE SAFETY AND EVACUATION PLAN The licensee provided FSEP undated, failed to include the following: The available FSEP did not identify specific fire protection actions for residents as evident by not providing procedures for residents to take in this specific facility in the event of a fire or similar emergency in writing in the FSEP. During an interview on November 19, 2024, at 10:15 a.m., LALD-A, stated resident procedures required during a fire or similar emergency were not provided in the FSEP. TRAINING Record review of the available documentation indicated the licensee failed to provide evacuation training to residents at least once per year as evident by not providing documentation the residents were provided training based on written procedures in the FSEP.	0 810		

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0 810	Continued From page 16 During an interview on November 19, 2024, at 10:25 a.m., LALD-A, stated documentation was not available that residents were provided FSEP training annually, but residents were provided training verbally during drills. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 810		
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; (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	01060		

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01060	Continued From page 17 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 written notice with required content to the resident, legal representative, and designated representative, and failed to provide the notification to the Office of Ombudsman for Long-Term Care (OOLTC) when the resident did not return from the emergency relocation within four days for one of one resident (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), 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 November 18, 2024, at 10:38 a.m., licensed assisted living	01060		

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01060	Continued From page 18 director (LALD)-A stated the licensee was familiar with current minimum assisted living requirements. R3's diagnoses included diabetes, hypertension (HTN-high blood pressure), and osteoarthritis. R3's Service Plan dated October 27, 2021, indicated R3 received medication administration, blood glucose monitoring, and assistance with bathing, grooming, toileting, and dressing. R3's Resident Notes-One Resident included the following entries: -November 9, 2024, at 8:14 a.m., dispatch was called to have EMS (emergency medical services) transport R3 to the ER (emergency room). -November 9, 2024, at 4:05 p.m., R3 had been admitted to the hospital. R3's Clinical Update Assessment dated November 13, 2024, indicated R3 was in the hospital from November 9, 2024, through November 13, 2024. R3's record lacked a written notice that contained, 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 OOLTC; - 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 - a statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal under section	01060		

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01060	Continued From page 19 144G.54. The facility must provide contact information for the agency to which the resident may submit an appeal. In addition, R3's record lacked notification to the OOLTC that the resident had been relocated and had not returned to the facility within four days. On November 19, 2024, at 11:19 a.m., clinical nurse supervisor (CNS)-B stated an emergency relocation was not completed for R3. CNS-B further stated the licensee understanding was emergency relocations did not need to be completed if the plan was for the resident to return to the facility. The licensee's 1.23 Emergency Relocation policy dated August 1, 2021, indicated in the event of an emergency relocation, (licensee name) will provide a written notice to the resident, legal representative, designated representative, resident's case manager, if applicable, and the OOLTC (if the resident has not returned to the facility within four days) 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 OOLTC; -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 -A statement that, if the facility refuses to provide housing or services after a relocation, the resident has the right to appeal. No further information was provided.	01060		

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01060	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01060		
01640 SS=E	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 observation, interview, and record review, the licensee failed to ensure the service plan was revised to reflect the current services provided for two of three residents (R5, R2) who had treatments or therapies managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or	01640		

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01640	Continued From page 21 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 November 18, 2024, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services, including oxygen management, to residents at the facility. R5 R5's diagnoses included diabetes, congestive heart failure (CHF), and asthma. On November 19, 2024, at 9:47 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication for R5. During the observation, the surveyor noted an oxygen concentrator in R5's room, however, the oxygen concentrator was not in use. R5's prescriber orders dated July 22, 2024, included an order for oxygen 2 liters (L)/minute applied with activity. R5's Assessment dated September 8, 2024, indicated R5 received oxygen as needed with shortness of breath (during activity). When R5 required oxygen, R5 needed full assistance with applying oxygen and ensuring nasal cannula (a flexible tube with two prongs that delivers oxygen through the nose) was in place. R5 needed full assistance with oxygen tanks including tank set up, monitoring oxygen level in tank and replacing (tank) when empty. R5's Service Plan dated May 27, 2024, lacked oxygen management daily. R2 R2's diagnoses included morbid obesity, major	01640		

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01640	Continued From page 22 depressive disorder, and obstructive sleep apnea. On November 19, 2024, at 9:29 a.m., ULP-C stated ULPs turn down R2's oxygen concentrator to 1L/minute every morning. On November 19, 2024, at 2:23 p.m., the surveyor observed R2 wearing oxygen 1L/minute via nasal cannula at the dining room table. R2 stated R2 wore oxygen 24 hours per day and staff assisted R2 with changing the oxygen rate as needed and at night per physician orders. R2's prescriber orders dated June 10, 2024, included an order for oxygen 1-3 L/minute applied continuous (24 hours per day), 3L/min with activity. R2's Assessment dated November 6, 2024, indicated R2 was independent with application of the nasal cannula, however, R2 would need help with portable oxygen tank in the case of an emergency. R2 used oxygen at 1L/minute during the day and 3L/minute at night on BiPap (noninvasive breathing machine). R2's Service Plan dated May 1, 2024, indicated R2 received assistance with oxygen and BiPap every night, however, lacked oxygen management via nasal cannula continuous daily. On November 19, 2024, at 2:57 p.m., CNS-B stated R5 and R2's service plans did not reflect the current oxygen management services provided by the licensee. CNS-B further stated the service plans should have been revised to reflect current oxygen management services R5 and R2 were receiving. The licensee's 6.10 Service Plan Modifications policy dated August 1, 2021, indicated when a resident at (licensee name) receives assisted living services and a change(s) to the service plan occurs, the service plan must be amended in writing and signed by the resident or the resident's designated representative. No further information was provided.	01640		

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01640	Continued From page 23 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01640		
01940 SS=E	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by:	01940		

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01940	Continued From page 24 Based on observation, interview, and record review, the licensee failed to develop and implement a treatment or therapy management plan to include all required content for two of three residents (R5, R2) who had treatments or therapies managed by the licensee. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 November 18, 2024, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services, including oxygen management, to residents at the facility. R5 R5's diagnoses included diabetes, congestive heart failure (CHF), and asthma. R5's Service Plan dated May 27, 2024, lacked oxygen management daily. R5's prescriber orders dated July 22, 2024, included an order for oxygen 2 liters (L)/minute applied with activity. On November 19, 2024, at 9:47 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication for R5.	01940		

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01940	Continued From page 25 During the observation, the surveyor noted an oxygen concentrator in R5's room, however, the oxygen concentrator was not in use. R2 R2's diagnoses included morbid obesity, major depressive disorder, and obstructive sleep apnea. R2's Service Plan dated May 1, 2024, indicated R2 received assistance with oxygen and BiPap every night, however, lacked oxygen management via nasal cannula (a flexible tube with two prongs that delivers oxygen through the nose) continuous daily. R2's prescriber orders dated June 10, 2024, included an order for oxygen 1-3 L/minute applied continuous (24 hours per day), 3L/min with activity. On November 19, 2024, at 9:29 a.m., ULP-C stated ULPs turn down R2's oxygen concentrator to 1L/minute every morning. On November 19, 2024, at 2:23 p.m., the surveyor observed R2 wearing oxygen 1L/minute via nasal cannula at the dining room table. R2 stated R2 wore oxygen 24 hours per day and staff assisted R2 with changing the oxygen rate as needed and at night per physician orders. R5 and R2's record lacked a treatment plan including the following required information: -written statement of the treatment or therapy (oxygen) that would be provided; -documentation of specific resident instructions relating to the oxygen; -identification of treatment or therapy task that would be delegated to ULPs; -procedures for notifying a registered nurse (RN)	01940		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01940	Continued From page 26 when a problem arose with the oxygen; and -and resident-specific requirements relating to documentation of treatment or therapy received, verification that all treatment or therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On November 19, 2024, at 2:57 p.m., CNS-B stated R5 and R2's record lacked a treatment plan for oxygen management. CNS-B further stated the licensee had begun using electronic medical record for resident records, and CNS-B had not entered oxygen management as a treatment to prompt an oxygen management treatment plan for R5 and R2. The licensee's 7.05 Treatment and Therapy Management Plan policy dated August 1, 2021, indicated (licensee name) will develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: -a statement of the type of services that will be provided; -documentation of specific resident instructions relating to the treatments or therapy administration; -identification of treatment or therapy tasks that will be delegated to ULPs; -procedures for notifying a RN or appropriate licensed health professional; -any resident-specific requirements relating to documentation of treatment and therapy received; -verification that all treatment and therapy was administered as prescribed; and -monitoring of treatment or therapy to prevent possible complications or adverse reactions. In addition, the policy indicated treatment or	01940		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20285	A. BUILDING: _____ B. WING _____	11/19/2024

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LONG LAKE LOON LODGE	7747 LOON LODGE LANE NE BEMIDJI, MN 56601

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01940	Continued From page 27 therapy management record must be current and updated when there are any changes. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
01950 SS=E	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's record; and This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instructions for two of three residents (R5, R2) receiving treatment management services.	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	20285	A. BUILDING: _____ B. WING _____	11/19/2024

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01950	Continued From page 28 This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at 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 November 18, 2024, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services, including oxygen management, to residents at the facility. R5 R5's diagnoses included hypertension (HTN-high blood pressure), diabetes, and depression. R5's Service Plan dated May 27, 2024, lacked oxygen management daily. R5's prescriber orders dated July 22, 2024, included an order for oxygen 2 liters (L)/minute applied with activity. On November 19, 2024, at 9:47 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication for R5. During the observation, the surveyor noted an oxygen concentrator in R5's room, however, the oxygen concentrator was not in use. R2 R2's diagnoses included morbid obesity, major	01950		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01950	Continued From page 29 depressive disorder, and obstructive sleep apnea. R2's Service Plan dated May 1, 2024, indicated R2 received assistance with oxygen and BiPap every night, however, lacked oxygen management via nasal cannula (a flexible tube with two prongs that delivers oxygen through the nose) continuous daily. R2's prescriber orders dated June 10, 2024, included an order for oxygen 1-3 L/minute applied continuous (24 hours per day), 3L/min with activity. On November 19, 2024, at 9:29 a.m., ULP-C stated ULPs turn down R2's oxygen concentrator to 1L/minute every morning. On November 19, 2024, at 2:23 p.m., the surveyor observed R2 wearing oxygen 1L/minute via nasal cannula at the dining room table. R2 stated R2 wore oxygen 24 hours per day and staff assisted R2 with changing the oxygen rate as needed and at night per physician orders. R5 and R2's record lacked specific instructions for when ULPs should notify the RN when a problem arises regarding oxygen management. On November 19, 2024, at 2:58 p.m., CNS-B stated R5 and R2's record lacked specific instructions for ULPs to notify the RN regarding oxygen management. CNS-B further stated the licensee had begun using electronic medical records for resident records, and CNS-B had not entered oxygen management as a treatment to prompt an oxygen management treatment plan for R5 and R2, which would have included specific instructions for ULPs to notify the RN.	01950		

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01950	Continued From page 30 The licensee's 7.15 Medication and Treatment-Administration and Delegation policy dated August 1, 2021, indicated the RN has specified in writing, specific instructions for reach resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD OF CORRECTION: Seven (7) days	01950		
01960 SS=E	144G.72 Subd. 5 Documentation of administration of treatments Each treatment or therapy administered by an assisted living facility must be in the resident record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the resident's needs. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure treatment services were documented as administered as prescribed, or to document the reason they were not provided for two of three residents (R5, R2) receiving treatments. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 31 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 November 18, 2024, at 10:53 a.m., clinical nurse supervisor (CNS)-B stated the licensee provided treatment management services, including oxygen management, to residents at the facility. R5 R5's diagnoses included diabetes, congestive heart failure (CHF), and asthma. R5's Service Plan dated May 27, 2024, lacked oxygen management daily. R5's prescriber orders dated July 22, 2024, included an order for oxygen 2 liters (L)/minute applied with activity. On November 19, 2024, at 9:47 a.m., the surveyor observed unlicensed personnel (ULP)-C complete scheduled morning medication for R5. During the observation, the surveyor noted an oxygen concentrator in R5's room, however, the oxygen concentrator was not in use. R2 R2's diagnoses included morbid obesity, major depressive disorder, and obstructive sleep apnea. R2's Service Plan dated May 1, 2024, indicated R2 received assistance with oxygen and BiPap	01960		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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01960	Continued From page 32 every night, however, lacked oxygen management via nasal cannula continuous (a flexible tube with two prongs that delivers oxygen through the nose) daily. R2's prescriber orders dated June 10, 2024, included an order for oxygen 1-3 L/minute applied continuous (24 hours per day), 3L/min with activity. On November 19, 2024, at 9:29 a.m., ULP-C stated ULPs turn down R2's oxygen concentrator to 1L/minute every morning. On November 19, 2024, at 2:23 p.m., the surveyor observed R2 wearing oxygen 1L/minute via nasal cannula at the dining room table. R2 stated R2 wore oxygen 24 hours per day and staff assisted R2 with changing the oxygen rate as needed and at night per physician orders. R5 and R2's record lacked documentation of oxygen being applied, removed, or the oxygen rate being adjusted to a different oxygen flow. On November 19, 2024, at 2:58 p.m., CNS-B stated R5 and R2's record lacked any documentation regarding oxygen management. CNS-B further stated the licensee had begun using electronic medical record for resident records, and CNS-B had not entered oxygen management as a treatment to prompt an oxygen management treatment plan for R5 and R2, which would have included documentation for oxygen management provided by ULPs. The licensee's 7.22 Medication and Treatment Record- Documentation and Refusal policy dated August 1, 2021, indicated (licensee name) will create and maintain a correct and accurate	01960		

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01960	Continued From page 33 medication and/or treatment/therapy record for each resident receiving medication assistance or administration and or treatments and therapies. The following must be documented in the resident's medication and/or treatment/therapy records after providing medication assistance or administration: date, time, quantity of dosage, method of administration of all prescribed legend and over the counter medications and or treatments/therapy, signature and title of the authorized person who provided the assistance and/or administration of medications/treatment/therapy [sic]. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01960		
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 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 with regards to safely storing oxygen for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or	02310		

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02310	Continued From page 34 safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: During facility tour with licensed assisted living director (LALD)-A on November 18, 2024, at 11:50 a.m., the surveyor observed five tall oxygen cylinders stored in a small hall closest located near the back entrance of the facility. LALD-A stated the five oxygen cylinders were empty and belonged to R2. In addition, the five oxygen cylinders were not secured in a rack or by chains. On November 18, 2024, at 11:59 a.m., unlicensed personnel (ULP)-C stated R2's oxygen tanks were not stored in a rack or secured by chains since the oxygen management company did not provide one. LALD-A further stated oxygen tanks were stored in racks if the oxygen management company provided the rack. The licensee's 7.40 Oxygen policy dated August 1, 2021, indicated to keep oxygen cylinders and vessels stored upright at all times in a well-ventilated area (not in closets, behind curtains, or other confined spaces). The Minnesota Department of Health (MDH) Oxygen Cylinder Storage Requirements dated April 16, 2020, based on the National Fire Protection Association, Standard 99 (NFPA 99), indicated a common hazard in a health care facility is storing and handling compressed oxygen in cylinders. When storing oxygen cylinders, they must be secured in racks or by	02310		

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02310	Continued From page 35 chains to prevent them from falling over. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	02310		

Minnesota Department of Health
Food, Pools & Lodging Services
P.O. Box 64975
Saint Paul, MN 55164-0975
651-201-4500

Type: Full
Date: *11/19/24*
Time: 12:20:32
Report: 3822241131

Food and Beverage Establishment Inspection Report

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

Establishment Info:
ID #: 0013039
Risk: Medium
Announced Inspection: No

License Categories:

Expires on: / /

Operator:
Long Lake Loon Lodge

Phone #: 2185862925
ID #: 34391

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

No NEW orders were issued during this inspection.

Surface and Equipment Sanitizers

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

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

Food and Equipment Temperatures

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

Process/Item: Thawing
Temperature: <41 Degrees Fahrenheit - Location: MEAT IN TWO DOOR NSF REACH-IN
Violation Issued: No

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

SERVING MAC AND CHEESE WITH VEGETABLES TODAY. SAME DAY SERVICE ONLY, NO LEFTOVERS.

INSPECTED WELL AND SEPTIC. WATER TEST RESULTS FROM 2/20/24 RECEIVED (IN FILE).

DISCUSSION:

MOW TOP OF DRAIN FIELD SPRING AND SUMMER.

Food and Beverage Establishment Inspection Report

HANDWASHING AND GLOVE USE.

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

I acknowledge receipt of the Minnesota Department of Health inspection report number 3822241131 of 11/19/24.

Certified Food Protection Manager: Amy DeLap

Certification Number: FM102838 Expires: 02/14/26

Inspection report reviewed with person in charge and emailed.

Signed: _____

Amy DeLap
Owner

Signed: Dave Kaufman

Dave Kaufman, RS
Environmental Health Specialist
Bemidji District Office
218-308-2100
david.kaufman@state.mn.us