



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

September 25, 2026

Licensee
Lakewood Manor
222 5th Street Northeast
Staples, MN 56479

RE: Project Number(s) SL20201016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on August 28, 2026, 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 . . ."

IMPOSITION OF FINES

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

Level 1: no fines or enforcement;

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

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

- Level 4: a fine of \$3,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20;
- Level 5: a fine of \$5,000 per violation, in addition to any enforcement mechanism authorized in § 144G.20.

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

St - 0 - 0810 - 144g.45 Subd. 2 (b-F) - Fire Protection And Physical Environment - \$500.00

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

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

To submit a reconsideration request, please visit:

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

REQUESTING A HEARING

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

matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

To submit a hearing request, please visit:

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

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

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

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in black ink that reads "Jessie Chenze". The signature is written in a cursive, flowing style.

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

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 222 5TH STREET NE STAPLES, MN 56479		
(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: SL20201016-0 On August 25, 2026, through August 28, 2026, 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 26 resident(s); 21 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.		
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services	0 480			

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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0 480	Continued From page 1 (a) Except as provided in paragraph (b), food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626. (b) For an assisted living facility with a licensed capacity of ten or fewer residents: (1) notwithstanding Minnesota Rules, part 4626.0033, item A, the facility may share a certified food protection manager (CFPM) with one other facility located within a 60-mile radius and under common management provided the CFPM is present at each facility frequently enough to effectively administer, manage, and supervise each facility's food service operation; (2) notwithstanding Minnesota Rules, part 4626.0545, item A, kick plates that are not removable or cannot be rotated open are allowed unless the facility has been issued repeated correction orders for violations of Minnesota Rules, part 4626.1565 or 4626.1570; (3) notwithstanding Minnesota Rules, part 4626.0685, item A, the facility is not required to provide integral drainboards, utensil racks, or tables large enough to accommodate soiled and clean items that may accumulate during hours of operation provided soiled items do not contaminate clean items, surfaces, or food, and clean equipment and dishes are air dried in a manner that prevents contamination before storage; (4) notwithstanding Minnesota Rules, part 4626.1070, item A, the facility is not required to install a dedicated handwashing sink in its existing kitchen provided it designates one well of a two-compartment sink for use only as a handwashing sink; (5) notwithstanding Minnesota Rules, parts 4626.1325, 4626.1335, and 4626.1360, item A, existing floor, wall, and ceiling finishes are	0 480			

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0 480	Continued From page 2 allowed provided the facility keeps them clean and in good condition; (6) notwithstanding Minnesota Rules, part 4626.1375, shielded or shatter-resistant lightbulbs are not required, but if a light bulb breaks, the facility must discard all exposed food and fully clean all equipment, dishes, and surfaces to remove any glass particles; and (7) notwithstanding Minnesota Rules, part 4626.1390, toilet rooms are not required to be provided with a self-closing door. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure food was prepared and served according to the Minnesota Food Code. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Food and Beverage Establishment Inspection Report (FBEIR) dated August, 25, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection.	0 480			

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0 480	Continued From page 3	0 480			
0 640 SS=F	TIME PERIOD FOR CORRECTION: Please refer to the FBEIR for any compliance dates. 144G.42 Subd. 7 Posting information for reporting suspected c The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by: (1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility; (2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and (3) providing reasonable accommodations with information and notices in plain language. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to post required content to include posting the 911 emergency number in common areas at the assisted living. This had the potential to affect all residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).	0 640			

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0 640	Continued From page 4 The findings include: During the entrance conference on August 25, 2026, at 11:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee was familiar with current minimum assisted living requirements. On August 25, 2026, at 1:02 p.m., the surveyor toured the building with ALDIR/CNS-A and did not observe 911 posted in any common areas of the assisted living facility. ALDIR/CNS-A stated ALDIR/CNS-A was not familiar with the requirement. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 640			
0 650 SS=E	144G.42 Subd. 8 (a) Staff records (a) The facility must maintain current records of each paid staff member, each regularly scheduled volunteer providing services, and each individual contractor providing services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification if licensure, registration, or certification is required by this chapter or rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff persons providing supervision; (4) documentation of annual performance	0 650			

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0 650	Continued From page 5 reviews that identify areas of improvement needed and training needs; (5) for individuals providing assisted living services, verification that required health screenings under subdivision 9 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records contained the required content for two of three employees (unlicensed personnel (ULP)-C, ULP-I). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2026, at 11:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee was aware of the required contents of the employee record. ULP-C ULP-C was hired on July 6, 2009, and August 1, 2021, begin to provide direct assisted living services to residents at the facility.	0 650			

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0 650	Continued From page 6 On August 26, 2026, at 7:21 a.m., the surveyor observed ULP-C administering R5's scheduled medications. ULP-C's employee record included a performance review dated April 29, 2024; however, ULP-C's employee record lacked evidence an annual performance review was completed in 2025. On August 26, 2026, at 2:39 p.m., registered nurse (RN)-G stated the licensee could not find a performance review completed in 2025 for ULP-C and stated ULP-C was scheduled to have a 2026 annual performance review August 25, 2026, however, ULP-C did not come to work that day. ULP-I ULP-I was hired on April 17, 2026, to provide assisted living services to residents at the facility. ULP-I's employee record included Training and Competency Evaluation dated May 19, 2026, indicating ULP-I completed training in administering medication and treatments with RN-G; however, did not indicate ULP-I was trained and demonstrated competency to RN-G on all medication administration routes or preparing medications for residents who will be out of the facility. In addition, ULP-I's training records lacked documented evidence ULP-I was trained on treatment and therapy tasks delegated to ULP-I to include nebulizer treatments and wound cares. R1's May 2026, medication administration record included ULP-I's initials indicating ULP-I administered R1's medications and provided wound care and assisted with R1's personal cares on May 5, 2026, before ULP-I completed	0 650			

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0 650	Continued From page 7 training and demonstrated competency by the RN. On August 26, 2026, at 2:45 p.m., RN-G stated the nurses trained and competency tested ULPs upon hire for unplanned time away; however, did not document the unplanned time away training and competency testing in employee records. RN-G stated the licensee changed staff training documents and the new training checklist and if the nurses were onsite the nurses prepared the resident medications to send out and there was a form with instructions. ALDIR/CNS-A and RN-G stated staff after staff completed training, ULPs worked alongside other ULPs on the floor assisting with administering resident medications, treatments, and personnel care and after the new ULP had hands on experience, the nurse would have the ULP demonstrate competency and at that time completed the ULPs 30-day supervisory visit. Per Assisted Living Facilities: Minnesota Rules Chapter 4659.0190, Subp. 6, effective October 2022, the licensee must maintain a record of staff training and competency required under this part and Minnesota Statutes, chapter 144G, that documents the following information for each competency evaluation, training, retraining, and orientation topic: (1) facility name, location, and license number; (2) name of the training topic or training program, and the training methodology, such as classroom style, web-based training, video, or one-to-one training; (3) date of the training and competency evaluation, and the total amount of time of the training and competency evaluation; (4) name and title of the instructor and the instructor's signature, and the name and title of	0 650			

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0 650	Continued From page 8 the competency evaluator, if different from the instructor, and the evaluator's signature with a statement attesting that the employee successfully completed the training and competency evaluation; and (5) name and title of the staff person completing the training, and the staff person's signature with statement attesting that the staff person successfully completed the training as described in the training documentation. The license's Delegation and Competency Validation policy dated May 21, 2026, indicated the facilities delegate nursing services in accordance with resident needs, applicable regulations, accepted nursing standards, and the Minnesota Nurse Practice Act. Delegated nursing tasks may be assigned only to staff who have completed required training, demonstrated competency, and received appropriate supervision. The Registered Nurse (RN) retains responsibility for the appropriateness of the delegation, oversight of delegated services, and ongoing evaluation of staff competency and resident safety. The Registered Nurse (RN) may delegate selected nursing tasks to licensed or unlicensed staff consistent with the resident's condition, staff competency, applicable law, and accepted nursing practice. The RN retains accountability for the appropriateness of the delegation and overall nursing oversight of delegated services. Staff performing delegated nursing tasks must: -complete required training and orientation; -demonstrate competency prior to performing delegated tasks independently; -receive resident-specific instruction as appropriate; and -receive ongoing supervision based on resident	0 650			

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0 650	Continued From page 9 needs, task complexity, and staff performance. The RN was responsible for determining whether the resident's condition and the task are appropriate for delegation and whether the staff member has demonstrated competency to safely perform the task. Competency validation may include direct observation, return demonstration, skills review, verbal instruction, written instruction, or other methods determined appropriate by the RN. Staff performing delegated tasks shall receive direct supervision within 30 calendar days of which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance, resident needs, or identified concerns. This requirement also applies to staff who have not performed delegated tasks for one year or longer. The facility shall maintain documentation related to delegated task training, competency validation, and supervision activities in accordance with facility policy and regulatory requirements. The licensee's Performance Appraisal policy dated November 4, 2025, indicated performance appraisal were typically conducted annually. Each manager is responsible for the timely and equitable assessment of their employees' performance and contributions. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 650			
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment	0 810			

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0 810	Continued From page 10 (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. (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 ensure the physical environment of the facility was maintained in	0 810			

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0 810	Continued From page 11 compliance with the requirements of Minnesota Statute 144G. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: Please refer to the document titled, Physical Environment Inspection Report (PEIR) dated August 25, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: SEVEN (7) days.	0 810			
01500 SS=D	144G.63 Subd. 5 Required annual training (a) All staff that perform direct services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the facility or another source and must include topics relevant to the provision of assisted living services. The annual training must include: (1) training on reporting of maltreatment of vulnerable adults under section 626.557; (2) review of the assisted living bill of rights and staff responsibilities related to ensuring the exercise and protection of those rights; (3) review of infection control techniques used in	01500			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 20201	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/28/2026
NAME OF PROVIDER OR SUPPLIER LAKEWOOD MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 222 5TH STREET NE STAPLES, MN 56479		
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01500	Continued From page 12 the home and implementation of infection control standards including a review of hand washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting communicable diseases; (4) effective approaches to use to problem solve when working with a resident's challenging behaviors, and how to communicate with residents who have dementia, Alzheimer's disease, or related disorders; (5) review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and (6) the principles of person-centered planning and service delivery and how they apply to direct support services provided by the staff person. (b) In addition to the topics in paragraph (a), annual training may also contain training on providing services to residents with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) the health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies,	01500			

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01500	Continued From page 13 assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure an employee received all the required content for annual training for each 12 months of employment for one of one employee (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, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 25, 2026, at 11:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee was aware of required contents in an employee record. ULP-C was hired on July 6, 2009, and effective August 1, 2021, began to provide direct care services to residents at the assisted living facility. On August 26, 2026, at 6:45 a.m., the surveyor observed ULP-C administering R4's scheduled medications. ULP-C's employee record lacked the following	01500			

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01500	Continued From page 14 required annual training: -review of the facility's policies and procedures relating to the provision of assisted living services and how to implement those policies and procedures; and -Assisted Living Bill of Rights. On August 27, 2026, at 8:07 a.m., ALDIR/CNS-A stated the licensee was unable to find documentation ULP-C completed the required training noted above. The licensee's Required Annual Training policy dated December 10, 2025, indicated all staff that perform direct services would complete a minimum of eight hours of annual training for each 12 months of employment. The following elements must be included: -review of the appropriate home care bill of rights and a review of the home care provider's policies and procedures relating to the provisions of home care services and how to implement those policies and procedures. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01500			
01770 SS=F	144G.71 Subd. 9 Documentation of medication setup Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup. This MN Requirement is not met as evidenced	01770			

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01770	Continued From page 15 by: Based on observation, interview, and record review, the licensee failed to ensure documentation of medication setup included all the required content for one of one resident (R6). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents). The findings include: During the entrance conference on August 25, 2026, at 11:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee provided medication set up services for residents completed by the licensed practical nurse (LPN) weekly. On August 25, 2026, at 1:59 p.m., the surveyor reviewed the medication cart with unlicensed personnel (ULP)-D and observed a medication planner (multi-compartment device used to setup medications to be given on a certain day and/or time) for R6. ULP-D stated the LPN set up R6's medications weekly in the medication planner and ULPs administer. ULP-D stated R6's electronic medication record did not indicate how many days R6's medications were set up by the nurse. ULP-D stated ULP-D counts the medications in the planner and compare the number of medications against R6's medication administration record to make sure both numbers	01770			

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01770	Continued From page 16 match. R6's diagnoses included hypertension (HTN-high blood pressure), neoplasm of the prostate, obstructive sleep apnea, and emphysema. R6's Individualized Medication Management Plan dated July 7, 2026, indicated R2 received medication administration services; however, did not indicate R6 received weekly medication set up by the facility nurse. R6's Service Plan Report revised August 27, 2026, indicated R6's services included medication setup every week by the facility nurse and administered by unlicensed personnel. R6's August 2026 medication administration record (MAR) included staff initials indicating R6 received the following medications; however, R6's MAR did not indicate medications were set up by the nurse in a separate weekly medication planner. -atorvastatin 20 milligrams (mg) daily for hyperlipidemia; -Azithromycin 250 mg daily on Mon, Wed, Fri for infection prevention; -furosemide 20 mg daily for edema (swelling); -lorazepam 0.25 milliliters (ml) daily for comfort cares; -Oyster Calcium 500 mg/5 micrograms (mcg) daily for prostate cancer; -polyethylene glycol powder 17 grams daily for constipation; -prednisone 5 mg daily for chronic obstructive pulmonary disease (COPD); -senna-s 8.6 mg daily for constipation; -sennosides sodium 8.6-50 mg daily for constipation; -sertraline HCl 25 mg daily for anxiety;	01770			

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01770	Continued From page 17 -Spiriva inhaler 2.5 mcg daily for COPD; -Dulera inhaler 200/5 mcg twice a day for COPD -Ensure 240 ml twice a day for weight loss prevention; -morphine sulfate 15 mg one tablet twice a day for shortness of breath; -Mucinex 600 mg two tables twice a day for congestion; and -morphine sulfate ER 15 mg one tablet three times a day for shortness of breath. On August 27, 2026, at 11:05 a.m., ALDIR/CNS-A stated ALDIR/CNS-A was unable to find any evidence in R6's record indicating at the time of setup documentation to include the dates of medication setup, name of the medication, quantity of dose, times to be administered, and route of administration and was unfamiliar with the requirement. The licensee's Medication Administration System-Weekly Dosage Box policy dated December 12, 2025, indicated the following procedure would be followed for the Bi-Weekly Dosage Box Medication Set-Up and or Medication Card set up under the Medication Administration System. The RN or LPN would transcribe medication orders onto the Medication Profile. This profile includes: -medication name and strength; -visual description of medication (if not in card set up by pharmacy and is set up in pill box); -day and time of administration; -route of administration; -side effects; -any specific instructions for administering the medication to the client-the RN or LPN assures that this Profile is complete; -the RN or LPN will transcribe the medication order onto the Medication Administration Record	01770			

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01770	Continued From page 18 (MAR). For medications included in the dosage box or punch card, the day and time of administration will be noted on the MAR; -medications that cannot be set up in the dosage box (topical or liquid) will be recorded on the MAR to include any special instructions and the MAR will include: -medication name and strength; -dosage to be administered; -day and time of administration; -route of administration; and -side effects. The RN or LPN would set up medication on a weekly/biweekly basis into the dosage boxes. When the RN or LPN has completed setting up the medications into the dosage box, the nurse would document that the medications have been set up on the MAR. The RN or LPN would review the dosage boxes and MARs on a weekly basis to assure that all the previous week's medications were administered as prescribed, and documentation is then made on the MAR (Medication Compliance). No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01770			
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 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.	01910			

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01910	Continued From page 19 (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 in the resident's record all required content for disposition of the medications for one of one resident (R1) upon discharge. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 25, 2026, at 11:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee provided medication management services to residents at the facility.	01910			

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01910	Continued From page 20 The licensee's Discharged or Deceased Resident Roster dated August 25, 2026, indicated R1 was admitted to the facility on April 25, 2024, and discharged on June 1, 2026. R1's diagnoses included type 2 diabetes, major depressive disorder, obstructive sleep apnea and hypertension (high blood pressure). R1's August 2026, medication administration record indicated R1 was prescribed and received the following medications: -bupropion HCl 300 milligrams (mg) daily with food for mood stabilization; -cholecalciferol one tablet daily for health maintenance; -clopidogrel bisulfate 75 mg daily for stroke prevention; -cyanocobalamin 250 mg daily for health maintenance; -duloxetine HCl 60 mg daily for mood stabilization; -metformin 500 mg two tablets twice daily for diabetes; -famotidine 10 mg twice daily for gastric upset; -mirabegron ER 50 mg daily for overactive bladder; -oxybutynin 15 mg daily for overactive bladder; -rosuvastatin 40 mg daily for cholesterol; -tamsulosin HCl 0.4 mg daily for prostate hyperplasia; -allopurinol 100 mg twice daily for kidney health; -magnesium oxide one tablet daily for supplementation. R1's prescriber orders dated September 12, 2025, included the above noted medications. R1's Progress Notes dated May 8, 2026,	01910			

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01910	Continued From page 21 indicated R1 was discharged from the facility with family and all medications were sent with in the original bottles. On August 28, 2026, at 2:40 p.m., ALDIR/CNS-A stated the licensee was unable to find a medication disposition record for the list of medications sent with R1 and R1's family. ALDIR/CNS-A stated ALDIR/CNS-A was aware of the requirement documentation for disposition of medications. The licensee's Disposition of Medications policy dated December 10, 2026, indicated staff would document in the client's record the name of the person to whom the medications were given, the time and date, the name of each medication and the amount of medication remaining. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days		01910		
01950 SS=D	144G.72 Subd. 4 Administration of treatments and therapy Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:		01950		

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01950	Continued From page 22 (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) prepared in writing specific instructions for each resident and documented those instructions for one of one resident (R3) receiving blood pressure monitoring. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: During the entrance conference on August 25, 2026, at 11:48 a.m., assisted living director in residency/clinical nurse supervisor (ALDIR/CNS)-A stated the licensee provided treatment and therapy services to the licensee's residents. R3's diagnosis included hypertension (high blood pressure). On August 26, 2026, at 6:56 a.m., the surveyor	01950			

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01950	Continued From page 23 observed unlicensed personnel (ULP)-C monitor R3's blood pressure with an automatic blood pressure machine and obtained a blood pressure reading of 143/75 millimeters of mercury (mmHg). ULP-C documented R3's blood pressure reading in Point Click Care (web-based software program). ULP-C stated there were no written directions in R3's record to indicate specific parameters of when to notify the nurse. R3's Service Plan dated July 17, 2026, indicated R3's blood pressure was monitored twice a day for medication monitoring. R3's Individualized Treatment/Therapy Management Plan dated July 7, 2026, included blood pressure monitoring; however, lacked specific blood pressure parameters. R3's August 2026, medication administration recorded (MAR) indicated R3 was scheduled and received blood pressure monitoring twice daily and record results. R3's MAR lacked specific blood pressure parameters of when to contact the RN. On August 27, 2026, at 10:00 a.m., ALDIR/CNS-A stated blood pressure parameters should be indicated in the resident's electronic medical record. ALDIR/CNS-A reviewed R3's record and stated R3's record did not include specific blood pressure parameters. The licensee's Delegated and Competency Validation policy dated May 21, 2026, indicated the RN may delegate selected nursing tasks to licensed or unlicensed staff consistent with the resident's condition, staff competency, applicable law, and acceptable nursing practice. The RN retains accountability for the appropriateness of	01950			

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01950	Continued From page 24 the delegation and overall nursing oversight of delegated tasks. Staff performing delegated nursing tasks must receive resident specific instructions as appropriate. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01950			



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

Food & Beverage Inspection Report

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Establishment Info

LAKEWOOD MANOR
222 5th St NE
Staples, MN 56479
Todd County
Parcel:

Phone:
tylerdavidson@lakewoodhealthsystem.com

License Info

License: HFID 20201

Risk:
License:
Expires on:
CFPM: Bobbijo Rinas
CFPM #: 33162; Exp: 10/1/2028

Inspection Info

Report Number: F6808261105
Inspection Type: Full - Single
Date: 8/25/2026 Time: 12:30:47 PM
Duration: minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 5-200A Plumbing: approved materials/design

5-203.11A Priority Level: Priority 2 CFP#: 10

MN Rule 4626.1070A Provide at least 1 handwashing sink, or the number of handwashing sinks necessary to allow for the convenient use by employees during food preparation, food dispensing, and warewashing; and in or adjacent to toilet rooms.
COMMENT: DESIGNATE ONE COMPARTMENT OF THE TWO COMPARTMENT SINK IN THE SERVING AREA FOR HANDWASHING. SUPPLY WITH PAPER TOWELS AND HAND SOAP.

Comply By: 8/25/2026 Originally Issued On: 8/25/2026

Food & Beverage General Comment

THE MAIN MEALS ARE DELIVERED FROM LAKEWOOD CARE CENTER IN STAPLES. THIS FACILITY PREPARES BREAKFASTS (CONTINENTAL) AND SNACKS ONLY. DISHES ARE ALSO WASHED HERE.

DISCUSSION:
EMPLOYEE ILLNESS LOG

AVOIDING BARE HAND CONTACT WITH READY TO EAT FOODS (DOUBLE HANDWASHING AND SANITIZER IS NOT A SUBSTITUTE).

DESIGNATING ONE COMPARTMENT OF THE TWO COMPARTMENT SINK IN THE SERVING AREA AS A HAND WASH SINK. USING THE SINK IN THE NURSES OFFICE IS NOT CONVENIENT ENOUGH.

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

I acknowledge receipt of the St Cloud District Office inspection report number F6808261105 from 8/25/2026

Lee Ann Austin

Establishment Representative

Lee Ann Austin,
Public Health Sanitarian 3
320-223-7341
lee.ann.austin@state.mn.us



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

Temperature Observations/Recordings

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Establishment Info

LAKEWOOD MANOR
Staples
County/Group: Todd County

Inspection Info

Report Number: F6808261105
Inspection Type: Full
Date: 8/25/2026
Time: 12:30:47 PM

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

Location: Upright Cooler at 39 Degrees F.

Comment: FRIGIDAIRE REFRIGERATOR

Violation Issued?: No

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

Location: Upright Cooler at 39 Degrees F.

Comment: COOL MORE REFRIGERATOR

Violation Issued?: No



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

Sanitizer Observations/Recordings

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Establishment Info	Inspection Info
LAKEWOOD MANOR	Report Number: F6808261105
Staples	Inspection Type: Full
County/Group: Todd County	Date: 8/25/2026
	Time: 12:30:47 PM

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

Location: Dishwashing Area **Equal To** 167 Degrees F.

Comment:

Violation Issued?: No

Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL20201016	Date: 8/25/2026
Facility Name: Lakewood Manor	
Facility Address: 222 5 th Street NE. Staples, MN 56479	

☒ TAG IDENTIFICATION: 0810

SCOPE/ SEVERITY: Level 2; Widespread

TIME PERIOD OF CORRECTION: Seven (7) days

1. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include employee actions to be taken in the event of a fire or similar emergency. [Minn. Stat. 144G.45 subd.2]

Comments: This fire safety and evacuation plan was directed to staff in general and did not call out specific actions according to how this facility is staffed and the building layout. The plan referenced fire doors and smoke compartments, that were not present inside the facility. It also included another facility owned by the same company in the title of this plan.
2. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include fire protection procedures necessary for residents. [Minn. Stat. 144G.45 subd.2]

Comments: The licensee failed to develop the fire safety and evacuation plan (FSEP) with site specific resident actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. It did not include specific actions that residents should take in a fire or similar emergency.
3. Each assisted living facility shall develop and maintain fire safety and evacuation plans that include 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. [Minn. Stat. 144G.45 subd.2]

Comments: The plan included instructions to evacuate residents but did not include the identification of any residents that needed assistance nor any resident-specific procedures to staff for assisting those residents during evacuation.