Electronically Delivered

October 28, 2026

Licensee
Lewiston Senior Living
505 East Main Street
Lewiston, MN 55952

RE: Project Number(s) SL33311016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on October 15, 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 - 0775 - 144g.45 Subd. 2. (a) - Fire Protection And Physical Environment - $500.00
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 $1,000.00**. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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

The correction order documentation should include the following:

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

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

To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

factor.

To submit a hearing request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers.

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,



Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: _____ B. WING _____	10/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(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: SL33311016-0 On October 12, 2026, through October 15, 2026, the Minnesota Department of Health conducted a change of ownership (CHOW) survey at the above provider and the following correction orders are issued. At the time of the survey, there were 23 resident(s); 23 receiving services under the Assisted Living Facility with Dementia Care 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.	
0 510 SS=D	144G.41 Subd. 3 Infection control program (a) All assisted living facilities must establish and	0 510		

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0 510	Continued From page 1 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. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted health care, medical and nursing standards for infection control related to glove use and handwashing by two of five unlicensed personnel (ULP-E, ULP-C) during personal cares. 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: ULP-E On October 12, 2026, at 6:30 a.m., the surveyor observed ULP-E provide morning cares to R7. ULP-E donned clean gloves, selected clothing for	0 510		

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0 510	Continued From page 2 R7, assisted R7 to the bathroom on the toilet, and removed R7's pajama pants and soiled incontinence brief. ULP-E then went to the bathroom sink and wet and soaped a washcloth and with the same gloves washed R7's face and upper body. ULP-E applied diclofenac gel (a topical pain medication) to R7's knees and then removed her gloves. R7 donned clean gloves, assisted R7 to a standing position, washed R7's bottom and put on a clean incontinence brief and finished dressing R7 with those same gloves. ULP-E did not change her gloves between the steps of working from soiled areas of the body to clean areas. ULP-C On October 13, 2026, at 8:00 a.m., the surveyor observed ULP-C set up and administer R3's morning medications. ULP-C then assisted R3 with a transfer from her recliner to the bathroom for toileting. ULP-C donned clean gloves while R3 was toileting, removed R3's soiled brief and began removing a wound dressing on R3's left leg/foot. R3 asked to return to her recliner and ULP-C wiped R3's bottom, placed a clean brief and with the same gloves, assisted R3 with a gait transfer belt to ambulate back to her recliner. ULP-C then removed her soiled gloves and donned clean gloves and continued with the process of R3's wound care to both lower extremities. ULP-C did not remove her gloves, sanitize hands and don clean gloves after managing the steps of toileting and then touching clean surfaces/clothing. On October 15, 2026, at 12:30 p.m., owner/clinical nurse supervisor (O/CNS)-A stated	0 510		

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0 510	Continued From page 3 she expected staff to change gloves in between the steps of working from dirty to clean areas to minimize contamination of clean areas of the body or clean surfaces. The licensee's Gloves policy dated August 8, 2025, indicated gloves must be worn whenever there may be direct contact between any employee and contaminated objects or as instructed. 1. Wash hands 2. Apply gloves to both hands 3. Remove contaminated materials 4. Place materials in proper receptacle 5. Remove gloves by grasping cuff of one glove and pulling it off, turning it inside out. With ungloved hand tuck finger inside cuff of remaining glove and pull it off, turning it inside out. 6. Dispose used gloves in proper receptacles. 7. Rewash hands. No further information provided TIME PERIOD FOR CORRECTION: Seven (7) days	0 510		
0 680 SS=F	144G.42 Subd. 10 Disaster planning and emergency preparedness (a) The facility must meet the following requirements: (1) have a written emergency disaster plan that contains a plan for evacuation, addresses elements of sheltering in place, identifies temporary relocation sites, and details staff assignments in the event of a disaster or an emergency; (2) post an emergency disaster plan prominently; (3) provide building emergency exit diagrams to	0 680		

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0 680	Continued From page 4 all residents; (4) post emergency exit diagrams on each floor; and (5) have a written policy and procedure regarding missing residents. (b) The facility must provide emergency and disaster training to all staff during the initial staff orientation and annually thereafter and must make emergency and disaster training annually available to all residents. Staff who have not received emergency and disaster training are allowed to work only when trained staff are also working on site. (c) The facility must meet any additional requirements adopted in rule. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have a written emergency preparedness (EP) plan with all the required content. This had the potential to affect all current residents, staff, and visitors. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents). The findings include: On October 13, 2026, at 9:15 a.m., the surveyor reviewed the contents of the licensee's Emergency Preparedness Plan. The findings include:	0 680		

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0 680	Continued From page 5 - the licensee's emergency preparedness plan last reviewed September 7, 2026, - the plan lacked evidence of two annual emergency plan drills/exercises as required; and - the licensee failed to review the missing resident policy on a quarterly basis as required On October 15, 2026, at 12:00 p.m., owner/clinical nurse supervisor (O/CNS)-A stated the licensee had participated in a community missing resident exercise sometime in February 2026. She could not find any exercises from 2025, and found the missing resident policy was reviewed on October 1, 2025, and January 4, 2026, and thought the missing resident policy had been reviewed quarterly. The licensee's Emergency Preparedness Plan-Appendix Z Compliance policy dated August 8, 2025, indicated Exercises and Drills - [licensee name] will conduct, at minimum, two emergency preparedness drills every 12 months - these drills to not include required fire/evacuation drills. One annual exercise will be a full-scale community-wide exercise. The second annual exercise will either be a second full-scale community-wide exercise or a tabletop exercise focused on our assisted living setting. Exercises and drills will be designed to test our emergency plan and to identify gaps and areas for improvement. The licensee's Missing Resident policy dated August 8, 2025, indicated [licensee name] will review this policy and any individual resident plans that pertain to elopement at least quarterly, and all changes will be documented. No further information was provided.	0 680		

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0 680	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 680		
0 775 SS=F	144G.45 Subd. 2. (a) Fire protection and physical environment Each assisted living facility must comply with the State Fire Code in Minnesota Rules, chapter 7511, and: This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the physical environment of the facility was maintained in 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 October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Seven (7) days.	0 775		

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0 810	Continued From page 7	0 810		
0 810 SS=F	144G.45 Subd. 2 (b-f) Fire protection and physical environment (b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to: (1) location and number of resident sleeping rooms; (2) staff actions to be taken in the event of a fire or similar emergency; (3) fire protection procedures necessary for residents; and (4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation. (c) Staff of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter. (d) Fire safety and evacuation plans shall be readily available at all times within the facility. (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	0 810		

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0 810	Continued From page 8 review, the licensee failed to ensure the physical environment of the facility was maintained in 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 October 13, 2026, for the specific violations related the physical environment under Minnesota Statute 144G. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	0 810		
01440 SS=F	144G.62 Subd. 4 Supervision of staff providing delegated nurs (a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment	01440		

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01440	Continued From page 9 administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident. (b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure direct supervision of two of two unlicensed personnel (ULP-D and ULP-G) performing delegated tasks was provided within 30 calendar days after the date on which the individuals began working for the licensee and first performs the delegated tasks. 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: ULP-D ULP-D was hired on June 16, 2026, to provide direct care services to the residents at the	01440		

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01440	Continued From page 10 assisted living facility with dementia care (ALFDC). On October 12, 2026, at 1:21 p.m., the surveyor observed ULP-D to set up and administer medications for R4. ULP-D's record included RN delegated competencies signed July 9, 2026, by owner/clinical nurse supervisor (O/CNS)-A. . ULP-D's employee record included a 30-day direct supervisory review dated July 9, 2026; however, the review was completed/dated the same day as ULP-D's competencies were signed by O/CNS-A and not within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents. ULP-G ULP-G was hired on January 15, 2026, to provide direct care services to the residents at the ALFDC. On October 14, 2026, at 12:25 p.m., the surveyor and ULP-G reviewed the contents of one of the Assisted Living medication carts. ULP-G's record included RN delegated competencies signed March 6, 2026, by O/CNS-A. ULP-G's record included a 30-day direct supervisory review dated March 6, 2026; however, it was dated the same date as ULP-G's RN delegated competencies and not within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents.	01440		

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01440	Continued From page 11 On October 15, 2026, at 4:05 p.m., owner/clinical nurse supervisor (O/CNS)-A stated she misunderstood the 30-day delegation and thought it was with original competency training. The licensee's Supervision of Staff-Delegated Services policy dated April 8, 2025, indicated direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for [licensee name] and first performs the delegated tasks for residents and thereafter as needed based on performance. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01440		
01640 SS=D	144G.70 Subd. 4 (a-e) Service plan, implementation and revisions to (a) No later than 14 calendar days after the date that services are first provided, an assisted living facility shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the facility and by the resident documenting agreement on the services to be provided. The service plan must be revised, if needed, based on resident reassessment under subdivision 2. The facility must provide information to the resident about changes to the facility's fee for services and how to contact the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities. (c) The facility must implement and provide all services required by the current service plan.	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: _____ B. WING _____	10/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
01640	Continued From page 12 (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 one of six resident's (R1) service plan was developed and provided to the resident for signature documenting agreement on the services to be provided. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R1 began receiving services from the licensee on February 23, 2026, with diagnoses including dementia and failure to thrive. On October 12, 2026, at 11:50 a.m., the surveyor observed unlicensed personnel (ULP)-C check R1's blood sugar with her Dexcom monitor (a wearable medical device that tracks your blood sugar levels 24 hours a day and sends real-time readings to a dedicated receiver every five minutes without routine fingerstick). ULP-C stated R1's blood sugar is checked by staff three to four	01640		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	33311	A. BUILDING: _____ B. WING _____	10/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEWISTON SENIOR LIVING	505 EAST MAIN STREET LEWISTON, MN 55952

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01640	Continued From page 13 times daily. On October 13, 2026, at 7:14 a.m., the surveyor observed ULP-C assist R1 with one oral medication, assist with ambulation with her walker to the bathroom to toilet, apply R1's compression stockings, assisted with dressing, assisted with hearing aids and checked R1's blood sugar via her Dexcom unit. R1's Task documentation dated October 2026, indicated she received services including medication administration, blood sugar monitoring, assistance with dressing, grooming, toileting hearing aids, home exercise plan, managing hallucination, compression stockings, positioning/repositioning. R1's comprehensive RN assessment dated September 10, 2026, indicated R1 needed assistance with the above listed services. R1's record lacked a signed service plan documenting the agreement on the services to be provided. On October 15, 2026, at 12:30 p.m., owner/clinical nurse supervisor (O/CNS)-A stated she was unable to find R1's Service Plan. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01640		
01750 SS=D	144G.71 Subd. 7 Delegation of medication administration When administration of medications is delegated	01750		

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	33311	A. BUILDING: _____ B. WING _____	10/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
01750	Continued From page 14 to unlicensed personnel, the assisted living facility must ensure that the registered nurse has: (1) instructed the unlicensed personnel in the proper methods to administer the medications, 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 records; and (3) communicated with the unlicensed personnel about the individual needs of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to specify in writing, specific instructions for as needed (PRN) medications and documented those instructions for two of four residents (R3, R10) with medication administration delegated to unlicensed personnel (ULP). This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: R3 R3 was admitted to the Assisted Living Facility with Dementia Care (ALFDC) on October 22, 2025, with diagnoses of cognitive impairment, venous stasis dermatitis bilateral lower extremities (skin breakdown related to insufficient	01750		

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	33311	A. BUILDING: _____ B. WING _____	10/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 15 blood flow), and atrial fibrillation (irregular heartbeat). R3's Service Plan dated October 23, 2025, indicated R3 received services including medication management/administration. On October 12, 2026, at 1:11 p.m., the surveyor observed ULP-C administer buspirone to R3 as R3's daughter stated R3 was becoming more agitated and wanting to go home. R3's signed medication orders dated September 5, 2026, indicated scheduled medications including one for mild pain, two for depression/anxiety, one for constipation, two for agitation, and three topical creams. R3's signed orders further indicated PRN medications including one for anxiety/agitation, and one for hallucinations/anxiety. R3's medication administration record (MAR) dated October 2026, included the following PRN medications: - buspirone 7.5 milligrams (mg), give one tablet daily as needed for agitation/anxiety; and - haloperidol 2 milligrams/milliliter (mg/ml), give 1 mg every one hour as needed for hallucinations/agitation R3's MAR dated October 2026, indicated R3 received: - buspirone on October 12, 2026; and -haloperidol on October 7, 9, 10, 2026. The licensee did not provide instruction for the ULP to understand which PRN medication for anxiety/agitation should be used first, second, etc. Furthermore, the licensee did not clearly depict R3's symptoms of agitation verses anxiety for consistent use of the PRN medications.	01750		

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	33311	A. BUILDING: _____ B. WING _____	10/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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01750	Continued From page 16 R10 R10 was admitted to the ALFDC on November 28, 2021, with diagnoses of neoplasm of the cerebellum (cancer in part of the brain). R10's Service Plan dated December 3, 2025, included the service of medication management/administration. On October 13, 2026, at 10:10 a.m., the surveyor observed ULP-C and ULP-E provide personal cares to R10, including changing her clothing, emptying her urinary catheter bag and transferring her from the bed to a specialized chair. ULP-E stated R10 had already received her oral medications for the morning. R10's signed medication orders dated October 6, 2026, indicated scheduled medications including one for depression, one for thyroid, one for sleep, one topical hormone replacement, one topical skin treatment, and one topical pain medication. R10's signed orders further indicated PRN medications including two for constipation, two for pain management, and one for agitation. R10's MAR dated October 2026, included the following PRN medications: - polyethylene glycol 17 grams (gm), give 17 gm orally, daily as needed for constipation; - glycerin suppository 2 gm, give one suppository every 24 hours rectally as needed for constipation; - acetaminophen 500 mg, give two tablets orally every six hours as needed for pain; and - ibuprofen 400 mg, give one tablet orally every four hours as needed for pain The licensee did not provide instruction for the	01750		

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	33311	A. BUILDING: _____ B. WING _____	10/15/2026

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01750	Continued From page 17 ULP to understand which PRN medication for constipation or pain should be used first, second, etc. On October 15, 2026, at 2:45 p.m., owner/clinical nurse supervisor (O/CNS)-A stated she knew that written instructions were required for the ULP to follow; however, these were missed. The licensee's Medication and Treatment Administration and Delegation policy dated August 8, 2025, indicated when administration of medications or treatment/therapy is delegated or assigned to unlicensed personnel, [licensee name] will ensure that the registered nurse has specified, in writing, specific instructions for each resident and documented those instructions in the resident's records. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01750		

Rochester District Office
Minnesota Department of Health
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Phone: 651-201-4500

Food & Beverage Inspection Report

Establishment Info

LEWISTON SENIOR LIVING
505 East Main Street
Lewiston, MN 55952
Winona County
Parcel:

Phone:

License Info

License: HFID 33311

Risk:
License:
Expires on:
CFPM:
CFPM #: ; Exp:

Inspection Info

Report Number: F1009261209
Inspection Type: Full - Single
Date: 10/13/2026 Time: 10:34:13 AM
Duration: 90 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 0
Total Priority 3 Orders: 0
Delivery: Emailed

No orders were issued for this inspection report.

Food & Beverage General Comment

Cole Krismer is the new Culinary Manager. He has a current MDH Certified Food Protection Manager certificate. Cole demonstrates very good food safety knowledge, and keeps very well organized food safety records and logs.

We discussed staff illness and illness reporting. No illnesses have been reported recently.

Foods come from approved sources. They are checked at receiving for condition and temperatures.

Cooler and freezer temperatures are monitored and logged, as are food cook temperatures and sanitizer concentrations.

There is a small amount of cooling of leftover foods, which is done in shallow metal pans in the walk-in cooler or freezer. We discussed keeping the food uncovered until it reaches 41F or below. There is also an ice paddle available, as well as an ice machine and prep sink so ice baths and ice paddle method could be used for soups/stocks. Cole is also implementing a cooling log to track the rate of cooling.

Thawing is done in the walk-in cooler. Discussed rapid thawing using cool running water over the frozen product in a container in the prep sink.

No vacuum packaged fish is currently used in this facility. If vacuum packaged fish is used in the future, please be sure to open the package during thawing to introduce oxygen in order to prevent the possibility of the growth of Clostridium botulinum.

I observed excellent date marking practices today.

Foods are properly stored so as to prevent cross-contamination between raw animal foods and ready to eat foods.

Shell eggs are not pasteurized, and they are mainly used in baked products. No undercooked eggs are allowed. Scrambled eggs are made with pasteurized liquid eggs.

Chemicals are stored separate and away from foods and equipment

Plunkett's services the facility for pest management. No signs of pests were seen today. Plunkett's service reports were reviewed.

The facility was found to be very clean and well maintained today.

Report emailed to: Deb Jacobson, MDH
Cole Krismer (koelkrismer@yahoo.com)
Heidi Duncanson (hduncanson@lewistonseniorliving.com)

Please be aware that Norovirus, often thought to be the "stomach flu" continues to be the leading cause of foodborne illness outbreaks. A person who has contracted Norovirus continues to be contagious at least three days after symptoms have subsided. Because of this, it is important to report and record any illnesses, even if staff did not report to work while ill.

Also, to further reduce the risk of transmitting Norovirus and other pathogens, continue to closely monitor hand washing, proper cleaning and sanitizing of equipment and surfaces, and do not allow bare-hand contact with ready-to-eat foods.

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 Rochester District Office inspection report number F1009261209 from 10/13/2026

Lesli Haines

Cole Krismer
Culinary Manager

Lesli Haines,
Public Health Sanitarian 3
507-206-2745
lesli.haines@state.mn.us

DEPARTMENT OF HEALTH

/Physical Environment Inspection Report

ENGINEERING | ASSISTED LIVING

Project No: SL33311016-0	**Date:** October 13, 2026
Facility Name: LEWISTON SENIOR LIVING	
Facility Address: 505 EAST MAIN ST, LEWISTON, MN 55952	

☒ **TAG IDENTIFICATION: 0775**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Seven (7) days

1. Each assisted living facility must comply with the provisions of the Minnesota State Fire Code (MSFC) in Minnesota Rules chapter 7511. [Minn. Stat. 144G.45 subd. 2]

2. Fire detection and alarm systems, emergency alarm systems, gas detection systems, fire-extinguishing systems, mechanical smoke exhaust systems and smoke and heat vents shall be maintained in an operative condition at all times and shall be replaced or repaired where defective. [Minn. Stat. 144G.45 subd. 2; MSFC 901.6]

   Comments: The annual wet sprinkler system inspection report dated 9/03/2026 had open deficiencies that need to be corrected. The annual fire alarm inspection report dated 6/17/2026 had open deficiencies that need to be corrected.

3. A means of egress shall be free from obstructions that would prevent its use, including the accumulation of snow and ice. Means of egress shall remain free of any material or matter where its presence would obstruct or render the means of egress hazardous. No combustible material storage is allowed in the corridors or exit stairs. [Minn. Stat. 144G.45 subd. 2; MSFC 1031.3]

   Comments: The exterior fenced in area outside of the facility dementia care egress door had a padlock on the fence gate.

4. Controlled egress locking systems shall: unlock upon activation of either the automatic sprinkler system or automatic fire detection system, unlock upon loss of power controlling the lock, have the capability of being unlocked from the fire command center, a nursing station, or other approved location. Building occupants shall not be required to pass through more than one controlled egress locked door before entering an exit. The procedures for operation of the unlocking system shall be

described as part of the fire safety and evacuation plan. [Minn. Stat. 144G.45 subd. 2; MSFC 1010.1.9.7]

Comments: Facility controlled egress system was not equipped with a separate de-activate system in the fire command center or other approved location in place to unlock the system.

5. Hoods, grease-removal devices, fans, ducts and other appurtenances shall be inspected at intervals specified in table 607.3.3.1. Inspections shall be completed by qualified individuals. [Minn. Stat. 144G.45 subd. 2; MSFC 607.3.3.1]

   Comments: The facility kitchen didn't have a current inspection sticker or documentation that the kitchen hood had been inspected in the past year.

☒ **TAG IDENTIFICATION: 0810**

SCOPE/ SEVERITY: Level 2; Widespread **TIME PERIOD OF CORRECTION:** Twenty One (21) days

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

   Comments: The FSEP failed to provide specific employee actions to take in the event of a fire or similar emergency relative to the facility's building layout and environmental risks. The plan included the acronym R.A.C.E. (Rescue, Alarm, Confine, and Extinguish or Evacuate).

2. 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. [Minn. Stat. 144G.45 subd.2]

   Comments: The licensee lacked documentation showing evacuation drills occurred twice per year, per shift, with at least one evacuation drill every other month.