DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 27, 2026

Administrator
Lakewood Health System
401 PRAIRIE AVENUE NORTHEAST
STAPLES, MN 56479

RE: CCN:245420

Cycle Start Date: February 19, 2026

Dear Administrator:

On February 19, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email:stacy.line@state.mn.us
Office: 218-332-5159 Mobile: 612-419-0950

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 19, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social

Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 19, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101

Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Health System	**401 PRAIRIE AVENUE NORTHEAST , STAPLES, Minnesota, 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) COMPLETION DATE
E0000	Initial Comments On 2/17/26 to 2/19/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/06/2026
F0000	INITIAL COMMENTS On 2/17/26 to 2/19/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54204720C (2582766 and 2589330). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		03/06/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is	F0554	1. Corrective Action for Resident Affected R44 was immediately assessed by the licensed nurse regarding the ability to safely self-administer medications. A physician order was written after a self-administration nursing assessment was completed and resident was deemed to be able to self-administer	03/06/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0554 SS = D	Continued from page 1 clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 resident (R44) who were observed to self-administer a nebulizer and had not been assessed as safe to self-administer medications. R44's quarterly Minimum Data Set (MDS) dated 12/19/25, indicated R44 had no cognitive impairment and had a diagnosis which included hemiplegia (one-sided weakness), and hypertension (high blood pressure). Furthermore, R5 required maximum assistance with bed mobility, transfers, toileting, and personal hygiene. R44's care plan revised 5/29/25, identified R44 had chronic obstructive pulmonary disease (COPD). Care plan interventions were to elevate head of bed to 30 degrees or propped on pillows or out of bed upright in a chair during episodes of difficulty breathing. Care plan lacked information regarding self-administration of medications. Review of R44's electronic health record (EHR) lacked a self-administered medication (SAM) assessment. R44's Order Review History Report signed 2/16/26, directed staff to administer Ipratropium-Albuterol inhalation solution 0.5-2.5 3 milligrams (mg)/3 milliliters (ml), inhale via nebulizer three times a day related to other specified chronic obstructive pulmonary disease (COPD) and 3 ml inhale orally via nebulizer every 24 hours as needed for wheezing, shortness of breath, rinse mask and allow to air dry after each use. R44's Order Review History Report lacked an order to self-administer medication. R44's electronic medical administration record (EMAR) for February 2026, lacked directions to self-administration medications. During an observation on 2/17/26 at 5:17 p.m., R44 was sitting in room in a wheelchair with a nebulizer mask on his face and no steam coming out of the mask with no staff present. At 5:18 p.m., R44 turned on the call light and stated he had to use the bathroom, with no staff present in the room, nebulizer mask on his face and no steam coming out of the mask. At 5:19 p.m., trained medication aid (TMA)-A went into the room, and	F0554	Continued from page 1 nebs after set up. The resident's care plan and medication administration record were updated. All staff re-education was completed on this process as well as educational resources provided in the Resource Binder for reference to nursing team. 2. Measures Put into Place to Ensure the Practice Will Not Recur All residents in facility were audited and it was found that R44 was the only resident in facility missing this assessment and MAR entry, all other residents in facility had this in place. If a resident wishes to self-administer medications, a formal nursing assessment and physician order will be completed and documented prior to allowing self-administration. Education was provided to all nursing staff: Medication administration policy Requirements for resident self-administration of medications Proper documentation and assessment requirements This facility will reinforce that nebulizer medications are considered medication administration and must follow medication administration policies. 3. Monitoring to Ensure Ongoing Compliance The Director of Nursing or designee will conduct monthly audits of residents who are self-administering medications to ensure assessment completion, physician order in place, and MAR reflection of direction for deemed medication that is being self-administered. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings to ensure continued compliance and reassess ongoing need for audits including frequency. 4. Date of Compliance The facility will achieve compliance by March 6, 2026.	

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F0554 SS = D	Continued from page 2 R44 told TMA-A that his nebulizer was done and he had to use the bathroom. TMA-A took off the nebulizer mask and sat it on the dresser and informed R44 she would rinse the mask out later and was going to find a nursing assistant to help him to the bathroom. During an interview on 2/17/26 at 5:45 p.m., TMA-A verified she had placed the nebulizer mask on R44, turned on the machine, and left the room. TMA-A identified her normal process was to put the medication in the nebulizer, place the mask on R44, and set a timer for ten minutes. TMA-A indicated she does not sit with R44 during his nebulizer treatments. TMA-A stated if a resident was able to self-administer a medication, it would be identified in the EMAR. TMA-A pulled up R44 EMAR and was unable to find information regarding self-administration of medications. During an interview on 2/18/26 11:31 a.m., registered nurse (RN)-A indicated for a resident to self-administer medications, a registered nurse would do an assessment and then reach out to the provider for an order. RN-A verified R44 did not have a self-administration of medication order. RN-A indicated it was important to do the self-administration of medication assessment to ensure a resident does not pull off the nebulizer mask, and ensure the resident get the medication in the nebulizer treatment. If a resident does not have a self-administration assessment done, she would have expected staff to sit with the resident during the nebulizer treatment. During an interview on 2/18/26 at 2:24 p.m., director of nursing (DON) indicated a resident needed to have a self-administration assessment completed to self-administer medication. After a resident was assessed and was deemed safe to self-administer medications, staff would identify in the care plan the resident was safe to self-administer medications and would obtain orders from the provider. DON verified R44 did not have a SAM assessment completed. DON stated this is important to ensure the resident received the medication as ordered. A facility policy titled Self-Administration of Medications reviewed 6/13/25, identified if the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual abilities to carry out this responsibility, during the care planning process. The licensed nurse will determine resident's ability to self-administer medications by a means of a skill assessment, which is conducted on a quarterly basis. The results of the	F0554		

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F0554 SS = D	Continued from page 3 licensed nurse's assessment are recorded on the medication self-administration assessment, which is placed in the resident's medical record. If a resident has orders for nebulizers the nurse may assess that the resident is able to deliver the nebulizer after set up and then will go back after nebulizer has run and shut off the machine and take care of the equipment.	F0554		
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and	F0628		03/06/2026

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F0628 SS = A	Continued from page 4 manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F0628		

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F0628 SS = A	Continued from page 5 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return-	F0628		

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F0628 SS = A	Continued from page 6 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility	F0628		

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F0628 SS = A	Continued from page 7 failed to send a copy of the notice of discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 1 residents (R87) reviewed for discharge. Findings Include: R87's admission Minimum Data Set (MDS) dated 12/3/25, identified R87 had short and long term memory loss and diagnoses which included; hip and knee replacement, deep vein thrombosis (blood clot occurs in one or more deep veins, usually in the legs), and arthritis. R87 required substantial maximal assistance with dressing, hygiene and transfers. Review of R87's progress notes from 11/19/25 to 12/20/25, identified the following:-11/26/25 at 12:06 p.m.,- R87 seen by nurse practitioner for discharge. R87 demanding to go home. R87 seen by physical therapy. R87's significant was present. -11/26/25 at 2:35 p.m., R87 observed getting into vehicle with significant other. R87's medical record lacked documentation that a notification of R87’s discharge was sent to the LTC ombudsman.During an interview on 2/18/26 at 2:23 p.m., social service designee (SSD)-A verified R87 was discharged home from the facility. SSD-A stated the facility's usual practice was not to notify the ombudsman of a planned discharge. On 2/19/26 at 12:27 p.m., SSD-A confirmed the ombudsman had not been notified of R87's discharge. SSD-A indicated the facility would only notify the ombudsman of residents who were transferred to the hospital. During an interview on 2/19/26 at 12:44 p.m., director of nursing (DON) confirmed the ombudsman had not been notified of R87's discharge. DON indicated the usual facility practice was not to notify the ombudsman of planned discharges. DON stated it would be important to notify the ombudsman if any concerns, so they could follow up with them for any unmet needs. A facility policy was requested, but not provided.	F0628		
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to provide routine shaving for 1 of 1 residents (R39) who was dependent on staff for assistance with personal hygiene.	F0677	1. Corrective Action for Resident Affected R39 was provided shaving and grooming care immediately upon identification of the concern. The resident’s care plan and CNA assignment sheet were reviewed to ensure shaving needs and frequency were clearly documented. Nursing staff were reminded to follow the resident’s care plan and preferences related to grooming and personal hygiene. Nursing staff interviewed report that resident had refused this already today and often does, just depending on the day, his preferences change. 2. Measures Put into Place to Ensure the Practice Will Not Recur	03/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Health System	401 PRAIRIE AVENUE NORTHEAST , STAPLES, Minnesota, 56479

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F0677 SS = D	Continued from page 8 Findings Include: R39's quarterly Minimum Data Set (MDS) dated 12/8/25, identified R39 had moderate cognitive impairment and diagnoses which included; paraplegia (paralysis of lower body), Alzheimer's disease and multiple sclerosis (chronic neurological disorder that affects the nerve cell coverings and may cause numbness, weakness, vision changes and fatigue). R39's MDS identified R39 required substantial/maximal assistance with personal hygiene. R39's Functional Abilities Care Area Assessment (CAA) dated 6/27/25, identified R39 required substantial/maximal assistance with personal hygiene. R39's CAA identified R39 was able to verbalize, but staff also had to anticipate his needs. R39 needed and received staff assistance with all activities of daily living (ADL) tasks. R39's comprehensive care plan revised 12/10/25, identified R39 had an ADL self-care performance deficit related to impaired balance related to multiple sclerosis. R39's care plan interventions included touching assistance from wheelchair level for oral care and shaving. R39's medical record lacked documentation of R39 refusal of shaving. During an observation on 2/17/26 at 2:14 p.m., R39 had approximately one quarter inch long white facial hair across his lower face and neck area. At 4:53 p.m., R39 stated he would like to be shaven daily, but was unable to determine the last time he was shaved. During a phone interview on 2/17/26 at 5:31 p.m., family member (FM)-A stated R39 would like to be shaved every day but was not sure if the staff had the time to shave R39. During an observation on 2/18/26 at 9:15 a.m., R39 was seated in his wheelchair in the activity room doing exercises with other residents and staff. R39 continued to have white facial hair present across his lower face and neck. At 10:56 a.m., R39 was in wheelchair in sitting area with other residents, while they were watching television. R39 continued to have facial hair. R39 informed surveyor he needed to be shaved. During an interview on 2/18/26 at 11:06 a.m., nursing assistant (NA)-A indicated she had completed morning cares with R39, and R39 had whiskers today. NA-A stated the bath aides usually shaved R39 on Mondays. NA-A indicated she had offered to shave R39 at times, but did not offer to shave R39 today. NA-A stated her usual practice was to offer shaving to residents if facial hair was present and if refused to let the nurse know. During an interview on 2/18/26 at 1:37 p.m., licensed practical nurse (LPN)-A confirmed R39 had whiskers today, and stated she had shaved R39 about twenty minutes ago, because he needed to be shaved. LPN-A stated the nursing assistants were responsible to shave residents. LPN-A stated they did have a few residents the nurses were to document on the treatment administration records (TAR) that they were specifically shaved. LPN-A indicated she was unaware	F0677	Continued from page 8 The Director of Nursing or designee reviewed the care plans, interviewed each resident in facility, and CNA task documentation for residents now includes specifically shaving and facial hair grooming to ensure it is offered daily then documented with resident response. Education provided to facility staff regarding: Following resident care plans for personal hygiene and grooming Ensuring routine shaving is completed according to resident preferences and care plan instructions Reporting when grooming supplies are not available Document findings accurately after cares are offered The facility will reinforce expectations that all personal hygiene cares, including shaving, must be completed and documented according to the resident's care plan. 3. Monitoring to Ensure Ongoing Compliance The Director of Nursing or designee will complete weekly audits of residents who require assistance with shaving to ensure grooming needs are being met according to the care plan and resident preference. Audit results will be reviewed during Quality Assurance and Performance Improvement (QAPI) meetings to ensure continued compliance and reassess ongoing need for audits including frequency. 4. Date of Compliance The facility will achieve compliance by March 6, 2026.	

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F0677 SS = D	Continued from page 9 R39 wanted to be shaved daily, but would discuss with unit manager to possibly add R39 to the TAR to assure they offered R39 to be shaved daily. During an interview on 2/18/26 at 1:41 p.m., director of nursing (DON) indicated her expectation was to offer shaving daily, unless otherwise care planned. DON stated it was important to offer to shave residents to make them feel neat and clean, and possibly for infection prevention. On 2/18/26 at 3:48 p.m., DON e-mailed indicating the facility did not have a policy for shaving residents, but nursing staff were taught to offer shaving daily per resident preference.	F0677		

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		A. BUILDING **NN - LAKEWOOD NURSIN.** B. WING	**02/19/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Health System	**401 PRAIRIE AVENUE NORTHEAST , STAPLES, Minnesota, 56479**

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K0000	INITIAL COMMENTS An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/19/2026. At the time of this survey, Lakewood Health System Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action	K0000		03/06/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING NN - LAKEWOOD NURS B. WING	(X3) DATE SURVEY COMPLETED N.02/19/2026

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K0000	Continued from page 1 taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakewood Health Systems Care Center is a 1-story building with a partial basement. The building was constructed in 1976, was determined to be of Type II (000) construction. A dining room addition was constructed in 1992 to the south east, is one story, without a basement and was determined to be Type II (000) construction. The 1965 old hospital building, which is separated from the 1976 building with a 2-hour fire barrier, has a partial basement, is a Type II (000) construction, has been remodeled and part of it is part of the Lakewood Health System Care Center. The building is fully sprinkler protected and has a manual fire alarm system with smoke detection in the sleeping rooms, corridors and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 87 beds and had a census of 82 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0345 SS = F Bldg. NN	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This STANDARD is NOT MET as evidenced by:	K0345	The fire system was tested and completed as of 3/2/26. All aspects of the life safety will be integrated via brightly software are online tracking program The Worx Hub. From here on out it will notify the maintenance team 3 weeks prior to the expected completion date.	03/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING NN - LAKEWOOD NURS B. WING	(X3) DATE SURVEY COMPLETED N. 02/19/2026

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K0345 SS = F Bldg. NN	Continued from page 2 Based on a review of available documentation, and staff interview, the facility failed to maintain and test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1, 9.6.1.3 and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, section 14.3.1, 14.4.5, 14.4.5.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 02/19/2026 at 10:30 AM, it was revealed during a review of available documentation that the facility could not provide a annual fire alarm report, the last report that could be provided was dated 01/28/2025. 2. On 02/19/2026 at 10:31 AM, it was revealed during a review of available documentation that the the facility could not provide a semi-annual fire alarm report. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K0345		