Electronically Delivered

August 12, 2026

Licensee
The Lodge Of Howard Lake
445 1st Street East
Howard Lake, MN 55349

RE: Project Number(s) SL29926016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on July 22, 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 . . ."

In accordance with Minn. Stat. § 144G.31 Subd. 4, MDH may assess fines based on the level and scope of the violations; **however, no immediate fines are assessed for this survey of your facility**.

DOCUMENTATION OF ACTION TO COMPLY

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

The correction order documentation should include the following:

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

CORRECTION ORDER RECONSIDERATION PROCESS

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

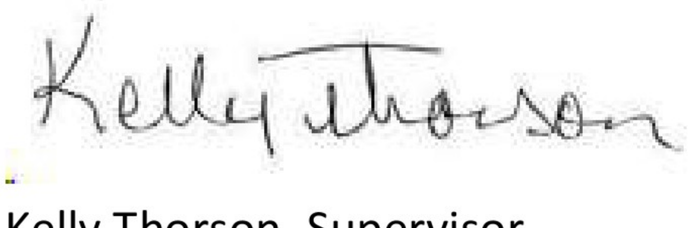
To submit a reconsideration request, please visit:
https://forms.web.health.state.mn.us/form/HRDAppealsForm

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

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,



Kelly Thorson, Supervisor
State Evaluation Team
Email: kelly.thorson@state.mn.us
Telephone: 320-223-7336 Fax: 1-866-890-9290

JMD

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29926	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE OF HOWARD LAKE	445 1ST STREET EAST HOWARD LAKE, MN 55349

(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: SL29926016 On July 20, 2026 through July, 22, 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 18 resident(s); 18 receiving services under the Assisted Living Facility license.	0 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living License Providers. 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 surveyors' 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 subd. 1, 2, and 3.	
0 480 SS=F	144G.41 Subdivision 1 Subd. 1a (a-b) Minimum requirements; required food services (a) Except as provided in paragraph (b), food	0 480		

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0 480	Continued From page 1 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 allowed provided the facility keeps them clean	0 480		

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0 480	Continued From page 2 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 July 20, 2026, for the specific Minnesota Food Code violations. The Inspection Report was provided to the licensee within 24 hours of the inspection. TIME PERIOD FOR CORRECTION: Please refer	0 480		

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0 480	Continued From page 3 to the FBEIR for any compliance dates.	0 480		
0 550 SS=F	144G.41 Subd. 7 Resident grievances; reporting maltreatment All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and email contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center. The notice must also state that if an individual has a complaint about the facility or person providing services, the individual may contact the Office of Health Facility Complaints at the Minnesota Department of Health. This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to post the required information related to the grievance procedure, with all the required content. This had the potential to affect all residents, staff and visitors to the facility. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, 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	0 550		

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0 550	Continued From page 4 portion or all of the residents). The findings include: The licensee lacked a posting to include all the required content about the facility's grievance procedure to include the name, telephone number and email contact information for the individual responsible for handling grievances. On July 20, 2026, at 10:45 a.m.,the surveyor conducted a brief tour of the main entryway, common areas and hallways and found no information regarding the individual responsible for handling facility grievances. On July 21, 2026 at 10:10 a.m., licensed assisted living director (LALD)-A reviewed the posting and confirmed it was lacking contact information. LALD-A stated she was aware of the requirement, and the information must have been missed when the posting was updated. Licensee's undated Grievances, Suggestions or Concerns-Senior Living and Affordable Housing policy indicated the formal grievance procedure would be posted in a public area. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 550		
01290 SS=F	144G.60 Subdivision 1 Background studies required (a) Employees, contractors, and regularly scheduled volunteers of the facility are subject to	01290		

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01290	Continued From page 5 the background study required by section 144.057 and may be disqualified under chapter 245C. Nothing in this subdivision shall be construed to prohibit the facility from requiring self-disclosure of criminal conviction information. (b) Data collected under this subdivision shall be classified as private data on individuals under section 13.02, subdivision 12. (c) Termination of a staff member in good faith reliance on information or records obtained under this section regarding a confirmed conviction does not subject the assisted living facility to civil liability or liability for unemployment benefits. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a background study was affiliated to the current health facility identification (HFID) number for two of two employees (unlicensed personnel (ULP)-G and ULP-H) on the facility provided employee roster. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all the residents). The findings include: On July 20, 2026, at 1:45 p.m., the surveyor reviewed the facility's NETStudy 2.0 roster and compared it to the facility's staff roster and discovered two of the facility's employees were	01290		

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01290	Continued From page 6 affiliated to a sister facility and not to the licensee's HFID 29926. ULP-G began employment on May 5, 2025, to provide direct care services to residents. A background study had not been affiliated to the facility's HFID. ULP-H began employment on November 28, 2023, to provide direct care services to residents. A background study had not been affiliated to the facility's HFID. On July 21, 2026, at 10:00 a.m., licensed assisted living director (LALD)-A stated the two employees missing from the net study roster are affiliated with sister facilities and will get them affiliated with this HFID right away. The licensee's Hiring and Screening policy dated March 28, 2025, indicated Human Resources will conduct background checks on all new employees and transfers prior to beginning employment or transferring to a new position. All offers of employment are contingent upon successful completion of the background check, state-specific background check, professional/personal reference check, health assessment, drug screen, and any other pre-employment requirements. No further information was provided. TIME PERIOD FOR CORRECTION: TWO DAY	01290		
01620 SS=D	144G.70 Subd. 2 (c-e) Initial reviews, assessments, and monitoring (a) Residents who are not receiving any assisted	01620		

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01620	Continued From page 7 living services shall not be required to undergo an initial nursing assessment. (b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery. (c) Resident reassessment and monitoring must be conducted by a registered nurse: (1) no more than 14 calendar days after initiation of services; (2) as needed based on changes in the resident's needs; and (3) at least every 90 calendar days. (d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment. (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90	01620		

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01620	Continued From page 8 calendar days from the date of the last review. (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure a registered nurse (RN) conducted a change of condition assessment for one of one resident (R2) reviewed for change in condition. 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: R2 was admitted to the licensee on November 27, 2025. R2 diagnoses included acquired absence of right leg below knee (below the knee amputation) and benign prostatic hyperplasia (enlarged prostate gland that can lead to difficulty with urination). R2's service plan dated January 1, 2026, indicated R2 was on a level 4 care package, which included medication administration.	01620		

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01620	Continued From page 9 R2's change in condition assessment dated March 17, 2026, indicated R2 does not take controlled medications requiring staff tracking, R2 does not receive assistance from staff with medication administration and management and R2 had a catheter but does not require staff assistance with catheter care. R2's nurse progress note dated April 9, 2026, indicated R2 would need assistance with catheter care and staff assistance with medication administration. R2's uniform assessment review dated April 9, 2026, indicated the nurse completed a comprehensive assessment and R2 had no change in condition or change in care needs, which did not reflect the addition of medication administration or the assistance with catheter care. R2's medication administration record (MAR) for July 2026, indicated Pregabalin (a schedule 5 controlled substance used to treat nerve pain) with a start date of June 18, 2026. R2's uniform assessment review dated July 8, 2026, indicated there had been no changes in the resident's condition since the previous assessment, which did not reflect R2's pregabalin. On July 21, 2026, at 3:10 p.m.clinical nurse supervisor (CNS)-F stated she would complete an assessment when a resident has a change in condition. CNS-F was unsure why she did not complete a change in condition assessment for R2 when services changed to include medication administration and catheter care.	01620		

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01620	Continued From page 10 The licensee's policy for Assessment Requirements - Minnesota dated July 17, 2026, indicated residents must be reassessed or reviewed by a registered nurse as needed based on changes in the residents' needs and cannot exceed 90 calendar days from the last assessment. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01620		
01650 SS=D	144G.70 Subd. 4 (f) Service plan, implementation and revisions to (f) The service plan must include: (1) a description of the services to be provided, the fees for services, and the frequency of each service, according to the resident's current assessment and resident preferences; (2) the identification of staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring assessments of the resident; (4) the schedule and methods of monitoring staff providing services; and (5) a contingency plan that includes: (i) the action to be taken if the scheduled service cannot be provided; (ii) information and a method to contact the facility; (iii) the names and contact information of persons the resident wishes to have notified in an emergency or if there is a significant adverse change in the resident's condition, including identification of and information as to who has authority to sign for the resident in an emergency;	01650		

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01650	Continued From page 11 and (iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the resident under those chapters. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to include a signature or other authentication by the facility and by the resident documenting agreement to any changes to the services to be provided for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: R2 was admitted to the licensee on November 27, 2025. R2 diagnoses included acquired absence of right leg below knee (below the knee amputation) and benign prostatic hyperplasia (enlarged prostate gland that can lead to difficulty with urination). R2's service plan dated January 1, 2026, included R2 was on a level 4 care package, which included medication administration.	01650		

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01650	Continued From page 12 R2's change in condition assessment dated March 17, 2026, indicated R2 did not take controlled medications requiring staff tracking, R2 did not receive assistance from staff with medication administration and management and R2 had a catheter but does not require staff assistance with catheter care. R2's nurse progress notes dated April 9, 2026, indicated R2 would need assistance with catheter care and staff assistance with medication administration. R2's record failed to include an updated service plan to reflect the addition of services. On July 21, 2026 at 10:00 a.m., licensed assisted living director (LALD)-A stated R2 did not sign a new service agreement when services changed in April 2026 because his total costs did not change. LALD-A stated she was aware of the requirment to have a new service agreement signed when services changed. Licensee did not provide a policy for service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01650		
01710 SS=D	144G.71 Subd. 3 Individualized medication monitoring and reas A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the	01710		

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01710	Continued From page 13 resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure an accurate medication management assessment was completed for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: R2 was admitted to the licensee on November 27, 2025. R2's service plan dated January 1, 2026, indicated R2 was on a level 4 care package, which included medication administration. On July 20, 2026, at 12:45 p.m. the surveyor observed unlicensed personnel (ULP)-E administer medication for R2. R2 had a change in condition assessment dated March 17, 2026. Assessment indicated R2 did not take controlled medications requiring staff	01710		

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01710	Continued From page 14 tracking, R2 did not receive assistance from staff with medication administration and management. R2's self-administration of medication evaluation dated March 23, 2026, indicated the resident was capable of self-administering medications and family would assist with filling pill boxes and refilling medications. R2's nurse progress note dated April 9, 2026, indicated R2 would need staff assistance with medication administration. No additional medication administration assessments were in R2's medical record. On July 21, 2026, at 10:02 a.m. licensed assisted living director (LALD)-A confirmed the facility started administering medication's for R2 in April 2026 and there was not an additional assessment completed to reflect the change to services. The licensee's policy for Assessment Requirements - Minnesota dated July 17, 2026, indicated residents must be reassessed or reviewed by a registered nurse as needed based on changes in the residents' needs. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01710		
01730 SS=D	144G.71 Subd. 5 Individualized medication management plan (a) For each resident receiving medication management services, a registered nurse,	01730		

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01730	Continued From page 15 advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific resident instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing	01730		

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01730	Continued From page 16 medication management. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to update the medication management plan for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: R2 was admitted to the licensee on November 27, 2025. R2's service plan dated January 1, 2026, indicated R2 was on a level 4 care package, which included medication administration. On July 20, 2026, at 12:45 p.m. the surveyor observed unlicensed personnel (ULP)-E administer medication for R2. R2's change in condition assessment dated March 17, 2026,indicated R2 did not take controlled medications requiring staff tracking and did not receive assistance from staff with medication administration and management. R2's self-administration of medication evaluation	01730		

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01730	Continued From page 17 dated March 23, 2026, indicated the resident was capable of self-administering medications and family would assist with filling pill boxes and refilling medications. R2's nurse progress note dated April 9, 2026, indicated R2 would need staff assistance with medication administration. R2's service plan report dated July 21, 2026, indicated the following: - Medication-trained staff to administer medications per provider orders - Medication-trained staff to manage medication storage and security - Medication-trained staff to coordinate all refills and communicate with pharmacy - Family - daughter will assist with medication management including (ordering, assisting with setup in pill box). Resident can administer own medications using the pill box. Resident also assists with pill box set up with daughter. Daughter works at pharmacy and will refill the resident's medications. On July 21, 2026, at 10:02 a.m. licensed assisted living director (LALD)-A confirmed the facility started administering medication's for R2 in April 2026 and there was not an additional assessment or change to medication plan to reflect the change to services. The licensee's Assessment Requirements - Minnesota policy dated July 17, 2026, indicated residents must be reassessed or reviewed by a registered nurse as needed based on changes in the residents' needs. No further information was provided.	01730		

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01730	Continued From page 18 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01730		
01880 SS=D	144G.71 Subd. 19 Storage of medications An assisted living facility must store all prescription medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure all medications were securely locked in substantially constructed compartments permitted only authorized personnel to access. 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: On July 21, 2026 at 1:15 p.m., the surveyor observed the third drawer not being completely and securely closed on a medication cart that was placed in a hallway and was accessible to residents, staff and visitors. The unsecured drawer was able to be completely opened and did contain resident medications.	01880		

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01880	Continued From page 19 On July 21, 2026 at 1:30 p.m., unlicensed personnel (ULP)-D stated she had recently completed a medication pass with the medication cart and had thought she left the cart with all drawers securely closed. ULP-D confirmed the third drawer was not completely closed and secured. The licensee Medication Administration and Storage policy dated July 22, 2026, indicated all medications would be stored in a locked cabinet when not in full view of staff. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01880		
01890 SS=D	144G.71 Subd. 20 Prescription drugs A prescription drug, prior to being set up for immediate or later administration, must be kept in the original container in which it was dispensed by the pharmacy bearing the original prescription label with legible information including the expiration or beyond-use date of a time-dated drug. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to monitor for expired medications. This had the potential to affect all residents who received medications administration and management. This practice resulted in a level two violation (a	01890		

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01890	Continued From page 20 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: On July 21, 2026 at 8:45 a.m., the surveyor observed unlicensed personnel (ULP)-C administer medications for R4 which included a cranberry capsule 4200 milligrams (mg) once a day for urinary health. ULP-C took one capsule from the bottle and placed it in the medication cup for administration. Expiration date on cranberry supplement was June 2026. On July 21, 2026 at 8:45 a.m., ULP-C confirmed the bottle of cranberry supplement had expired and that she had not checked the date prior to preparing the medication for administration. ULP-C stated it was the job of the staff administering medication and the nurse to monitor medication expiration dates. On July 21, 2026 at 8:45 a.m., the surveyor observed the medication cart. The surveyor found a tube of diclofenac sodium 1% gel for R5 that expired in April 2026. R5's medication administration record for July 2026, indicated R5 received diclofenac sodium as needed up to four times daily and had not received any doses during the month of July. ULP-C confirmed the tube was expired and stated R5 did not regularly receive diclofenac sodium.	01890		

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01890	Continued From page 21 On July 21, 2026 at 3:10 p.m., clinical nurse supervisor (CNS)-F stated staff should be routinely checking the expiration dates on medications to make sure they have not expired. CNS-F stated she also checks medication carts regularly for expired medications. The licensee's Medications Acquisition, Receiving, Packaging, and Storage policy dated October 30, 2025, indicated the licensee would routinely check for expired medications and dispose of them in accordance with state and pharmacy regulations. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01890		
01940 SS=D	144G.72 Subd. 3 Individualized treatment or therapy managemen For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following: (1) a statement of the type of services that will be provided; (2) documentation of specific resident instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that	01940		

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01940	Continued From page 22 will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instruction for each resident treatment and documented those instructions in the resident's record for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: R2 was admitted to the licensee on November 27, 2025. R2 diagnoses included acquired absence of right	01940		

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01940	Continued From page 23 leg below knee (below the knee amputation) benign prostatic hyperplasia (enlarged prostate gland that can lead to difficulty with urination). On July 20, 2026, at 12:45 p.m., the surveyor observed unlicensed personnel (ULP)-E assist R2 with emptying his catheter drainage bag. ULP-E stated they assist him a few times a day with emptying the drainage bag. On July 21, 2026, at 9:00 a.m., ULP-C stated the staff help R2 with putting on his prosthetic leg and the only instruction they had were in the task section of his record. R2's task schedule for July 2026, included - assist with emptying catheter bag four times a daily - AM- assist resident with sock, tubigrip, Velcro wrap, shoes and leg. PM- take off shoe, wrap, and sock. Take off leg. Encourage resident to sleep in bed instead of chair. R2's service plan report dated July 21, 2026, indicated R2 needed assistance in applying and removing right lower leg prosthesis and required assistance applying and removing sock, wrap, shoe. R2's record lacked specific documentation, written instructions and evidence the instructions were communicated with the ULP about the individual needs of the resident. On July 21, 2026, at 3:10 p.m., clinical nurse supervisor (CNS)-F stated she did train staff on treatments and therapies for residents. CNS-F stated she provided verbal instructions on application of R2's prosthetic leg and stated he also knew the steps and could help staff if	01940		

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01940	Continued From page 24 needed. CNS-F confirmed there were not written instructions on how to apply R2's prosthetic leg. The licensee's Treatment And Therapy Management Services policy dated December 3, 2025, included the assisted living provider must ensure all delegated treatments and therapies must have written, specific instructions for each resident and have documented those instructions in the resident's record. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01940		
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: (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	01950		

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01950	Continued From page 25 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the registered nurse (RN) specified, in writing, specific instruction for each resident treatment and documented those instructions in the resident's record and unlicensed personal (ULP) has demonstrated competency for one of two residents (R2). This practice resulted in a level two violation (a violation that did not harm a resident's health or 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: R2 was admitted to the licensee on November 27, 2025. R2 diagnoses included acquired absence of right leg below knee (below the knee amputation). On July 21, 2026 at 9:00 a.m., ULP-C stated the staff help R2 with putting on his prosthetic leg and the only instruction they have is in the task section of his record. R2's task schedule for July 2026, included - AM- assist resident with sock, tubigrip, Velcro wrap, shoes and leg. PM- take off shoe, wrap, and sock. Take off leg. Encourage resident to sleep in bed instead of chair. R2's service plan report dated July 21, 2026,	01950		

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01950	Continued From page 26 indicated R2 needed assistance in applying and removing right lower leg prosthesis and required assistance applying and removing sock, wrap, shoe. On July 21, 2026 at 3:10 p.m., clinical nurse supervisor (CNS)-F stated she did train staff on treatments and therapies for residents. CNS-F stated she provided verbal instructions on the application of R2's prosthetic leg and stated he also knew the steps and could help staff if needed. CNS-F confirmed there were not written instructions on how to apply R2's prosthetic leg and she had not completed comptentancy testing on application of the prosthetic leg. Licensee's Treatment And Therapy Management Services policy dated December 3, 2025, indicated the assisted living provider must ensure all delegated treatments and therapies must have instructed the ULP in proper methods with respect to each resident and the ULP has demonstrated the ability to competently follow the procedure. TIME PERIOD FOR CORRECTION: Seven (7) days	01950		
03090 SS=C	144.6502, Subd. 8 Notice to Visitors (a) A facility must post a sign at each facility entrance accessible to visitors that states: "Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities." (b) The facility is responsible for installing and maintaining the signage required in this subdivision.	03090		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE OF HOWARD LAKE	445 1ST STREET EAST HOWARD LAKE, MN 55349

(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
03090	Continued From page 27 This MN Requirement is not met as evidenced by: Based on observation and interview, the licensee failed to ensure the required notice was posted at the main entryway of the facility to display statutory language to disclose electronic monitoring activity, potentially affecting all current residents in the assisted living facility, staff, and any visitors of the licensee. This practice resulted in a level one violation (a violation that will cause only minimal impact on the resident and does not affect health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents). The findings include: On July 20, 2026, at 10:45 a.m., the surveyor observed the lack of signage posted regarding electronic monitoring. On July 21, 2026 at 10:10 a.m., licensed assisted living director (LALD)-A stated the sign used to be posted in the entryway and was not sure where it went. The licensee's Electronic Monitoring in Resident/Client/Patient Rooms policy dated May 18, 2026, indicated a sign shall be posted at each publicly available entrance stating the following: Electronic monitoring devices, including security cameras and audio devices, may be present to record persons and activities. No further information was provided.	03090		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	29926	A. BUILDING: _____ B. WING _____	07/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LODGE OF HOWARD LAKE	445 1ST STREET EAST HOWARD LAKE, MN 55349

(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
03090	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	03090		

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

Establishment Info

THE LODGE OF HOWARD LAKE
445 1st St E
Howard Lake, MN
Wright County
Parcel:

Phone:

License Info

License: HFID 29926

Risk:
License:
Expires on:
CFPM: Zachary Bach
CFPM #: 124173; Exp: 01/31/2027

Inspection Info

Report Number: F1051261185
Inspection Type: Full - Single
Date: 7/20/2026 Time: 11:00:00 AM
Duration: 30 minutes
Announced Inspection: No
Total Priority 1 Orders: 0
Total Priority 2 Orders: 1
Total Priority 3 Orders: 0
Delivery: Emailed

New Order: 4-300 Equipment Numbers and Capacities
4-302.14 *Priority Level: Priority 2 CFP#: 48*
MN Rule 4626.0715 Provide an appropriate test kit to accurately measure sanitizing solutions.
COMMENT:
THE SINK AND SURFACE TEST STRIPS USED FOR SANITATION EXPIRED IN APRIL 2024. PROVIDE A CURRENT TESTING KIT.
Comply By: 7/27/2026 Originally Issued On: 7/20/2026

Food & Beverage General Comment

MET WITH THE NURSE EVALUATOR, WENDY ROBARGE.

DISCUSSED THE FOLLOWING WITH THE HOUSING DIRECTOR, KARLA, & FOOD SERVICE DIRECTOR, ANGIE:

EMPLOYEE ILLNESS LOG
VOMIT CLEAN-UP PROCEDURES
HANDWASHING & GLOVE USE/DISPOSAL
NOROVIRUS
DATE MARKING & DISPOSITION OF TCS FOOD ITEMS
TESTING KIT FOR SANITIZERS

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 F1051261185 from 7/20/2026

Karla
Housing Director

Kai Yang,
Public Health Sanitarian 1
320-640-3532
kai.yang@state.mn.us

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

Temperature Observations/Recordings

Establishment Info

THE LODGE OF HOWARD LAKE
Howard Lake
County/Group: Wright County

Inspection Info

Report Number: F1051261185
Inspection Type: Full
Date: 7/20/2026
Time: 11:00:00 AM

Food Temperature: Product/Item/Unit: COLESLAW**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 36 Degrees F.
Comment: KITCHEN
Violation Issued?: No

Food Temperature: Product/Item/Unit: SLICED TURKEY**; Temperature Process:** Cold-Holding
Location: Upright Cooler at 38 Degrees F.
Comment: KITCHEN
Violation Issued?: No

Equipment Temperature: Product/Item/Unit: AMBIENT**; Temperature Process:** Ambient Air
Location: Upright Cooler at 36 Degrees F.
Comment: DINING AREA
Violation Issued?: No

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

Sanitizer Observations/Recordings

Establishment Info

THE LODGE OF HOWARD LAKE
Howard Lake
County/Group: Wright County

Inspection Info

Report Number: F1051261185
Inspection Type: Full
Date: 7/20/2026
Time: 11:00:00 AM

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Spray Bottle
Location: Kitchen **Equal To** 1875 PPM
Comment:
Violation Issued?: No

Sanitizing Equipment: **Product:** Hot Water**; Sanitizing Process:** Dish Machine
Location: Kitchen **Equal To** 165 Degrees F.
Comment:
Violation Issued?: No

Sanitizing Chemical: **Product:** Sink and Surface**; Sanitizing Process:** Wiping Cloth Bucket
Location: Front **Equal To** 1875 PPM
Comment:
Violation Issued?: No

Minnesota (MDH) Version
EH Manager; RPT: F1051261185

Food Establishment Inspection Report

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

No. of Risk Factor/Intervention/Violations	0	Date: 7/20/2026
No. of Repeat Risk Factor/Intervention/Violations		Time: 11:00 AM
Score (optional)		Dur: 30 min

Establishment:	Address:	City/State:	Zip:	Phone:
THE LODGE OF HOWARD LAKE	445 1st St E	Howard Lake, MN		
License/Permit #:	**Permit Holder:**	**Purpose of Inspection:**	**Est. Type:**	**Risk Category:**
HFID 29926		Full		

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Designated compliance status (IN, OUT, N/O, N/A) for each numbered item

IN=in compliance **OUT**=not in compliance **N/O**=not observed **N/A**=not applicable

Mark "X" in appropriate box for COS and/or R

COS=corrected on-site during inspection **R**=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN	Person in charge present, demonstrate knowledge and performs duties		
2	IN	Certified Food Protection Manager		
	Employee Health			
3	IN	knowledge, responsibiities, and reporting		
4	IN	Proper use of restriction and exclusion		
5	IN	Response to vomiting, diarrheal events		
	Good Hygienic Practices			
6	IN	Proper eating, tasting, drinking, tobacco use		
7	IN	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN	Hands clean and properly washed		
9	IN	No bare hand contact with RTE foods, alternatives		
10	IN	Adequate handwashing sinks supplied and access		
	Approved Source			
11	IN	Food obtained from approved source		
12	N/O	Food Received at proper temperature		
13	IN	Food in good condition, safe & unadulterated		
14	N/A	Records available: shellstock tags, parasite dest.		
	Protection From Contamination			
15	IN	Food separated and protected		
16	IN	Food-contact surfaces; cleaned & sanitized		
17	IN	Proper Disposition of returned, previously served, reconditioned,& unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	N/O	Proper cooking time & temperatures		
19	N/O	Proper reheating procedures for hot holding		
20	N/O	Proper cooling time and temperature		
21	N/O	Proper hot holding temperatures		
22	IN	Proper cold holding temperatures		
23	IN	Proper date marking & disposition		
24	N/A	Time as public health control;procedures & record		
	Consumer Advisory			
25	N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	N/A	Food additives; approved & properly used		
28	N/A	Toxic substances properly identified;stored;used		
	Conformance with Approved Procedures			
29	N/A	Compliance with variance, specialized processes & HACCP plan		

Risk factors are improper practices or procedures identified as the most prevalent contributing factors of foodborne illness or injury. Public Health Interventions are control measures to prevent foodborne illness or injury

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the addition of pathogens, chemicals, and physical objects into foods.

Mark "X" or OUT in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R **COS**=corrected on-site during inspection **R**=repeat violation

			COS	R
		Safe Food and Water		
30	IN	Pasteurized eggs used where required		
31		Water & ice from approved source		
32	N/A	Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34	N/O	Plant food properly cooked for hot holding		
35	N/O	Approved thawing methods used		
36		Thermometers provided & accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, & animals not present; no unauthorized person		
39		Contamination prevented during food prep, storage, & display		
40		Personal cleanliness		
41		Wiping cloths: properly used & stored		
42		Washing fruits & vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils; Properly stored		
44		Utensils, equipment & linens; properly stored, dried, handled		
45		Single-use & single-service articles, properly stored and used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47		Food & non-food contact surfaces cleanable, properly designed, constructed, & used		
48	X	Warewashing facilities: installed, maintained, used; test strips		
49		Non-food contact surfaces clean		
		Physical Facilities		
50		Hot & cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage & waste water properly disposed		
53		Toilet facilities; properly constructed, supplied & cleaned		
54		Garbage & refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained & clean		
56		Adequate ventilation & lighting; designated areas used		
57		Compliance with MCIAA		
58		Compliance with licensing and plan review		

Person in Charge (signature)

Inspector (signature) Blai Yang

Follow-up: Follow-up Date: