Protecting, Maintaining and Improving the Health of All Minnesotans

State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL308381281M
Compliance #: HL308385521C

Date Concluded: April 3, 2026

Name, Address, and County of Licensee Investigated:
Lakewood Pines
1702 Airport Road NE
Staples, MN 56479
Wadena County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Barbara Axness, RN
Special Investigator

Finding: Not Substantiated

Nature of Investigation:
The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

Initial Investigation Allegation(s):
The facility neglected the resident when the alleged perpetrator (AP), an unlicensed personnel (ULP), failed to administer as needed pain medication as prescribed. The ULP failed to notify the registered nurse (RN) and failed to follow up on the resident's complaints of pain.

Investigative Findings and Conclusion:
The Minnesota Department of Health determined neglect was not substantiated. Although the resident did not get as needed pain medication when she requested it, the error was an isolated incident, and no harm occurred to the resident. A nurse followed up with the resident the next morning to assess her pain.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigation included review of the resident record, facility incident report, personnel files, staff schedules, and related facility policy and procedures.

The resident resided in an assisted living facility. The resident's diagnoses included a recent right hip fracture. The resident's service plan included assistance with medication administration. The resident's assessment indicated the facility managed the resident's medications and staff were responsible for administering all medications.

The resident had orders for scheduled Tramadol and an additional as needed/PRN dose. Instructions on the PRN dose read: give 0.5 tablet by mouth every six hours as needed for pain during the day. Instructions on the scheduled dose read: give 0.5 tablet by mouth at bedtime for pain.

The resident's record contained a note from the AP which indicated around 1:10 a.m., the resident requested a PRN Tramadol for pain and after reviewing the MAR, noted she got a Tramadol around 9:30 p.m. and that she had to wait a few more hours before another dose was due again as it had to be six hours apart. The resident became upset/angry and the AP went to recheck the computer and went back and explained what medications the resident had received. The AP told the resident she could have a Tramadol at 3:30 a.m. and she could come back to administer it then. The next morning, a licensed practical nurse (LPN) visited with the resident. The resident told the LPN she had pain rated at a 5 or 6 in her left leg, so she called for help and she "was not offered any ice or pain cream, just told that it was too early to have a PRN medication."

A facility incident report indicated when the resident was interviewed the next morning, the resident stated she had been in pain most of the night and that staff did not return to reassess her pain or follow up after her initial request. The incident report indicated the PRN dose was not required to be given six hours after the scheduled dose, only six hours between PRN administrations.

During an interview, the AP stated she worked alone overnight and when the resident requested pain medication, she misread the MAR and thought the resident couldn't have anything for a few hours. The AP stated shortly after, another resident rang her call light after falling and she became busy with assisting her and calling emergency medical services. During that time, another resident rang her call light to request assistance using the bathroom. The AP stated she checked in with the resident and let her know she'd be back to check on her shortly and she offered the resident ice for her pain, which the resident declined. The AP stated after she got one resident to the bathroom and the other resident sent with emergency medical services, she went back to check on the resident but she was asleep so she didn't wake her to check in on her pain. The AP stated she should have called the nurse to notify her about the pain but had a busy night.

When interviewed, the resident did not recall the incident and stated that she usually got pain medication if she needed it.

In conclusion, the Minnesota Department of Health determined neglect was not substantiated.

“Not Substantiated” means:
An investigatory conclusion indicating the preponderance of evidence shows that an act meeting the definition of maltreatment did not occur.

Neglect: Minnesota Statutes, section 626.5572, subdivision 17
“Neglect” means neglect by a caregiver or self-neglect.
(a) "Caregiver neglect" means the failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
(1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
(2) which is not the result of an accident or therapeutic conduct.

Vulnerable Adult interviewed: Yes
Family/Responsible Party interviewed: Yes
Alleged Perpetrator interviewed: Yes

Action taken by facility:
The facility identified the error and investigated the incident. The incident was reported to MAARC. The AP was retrained.

Action taken by the Minnesota Department of Health:
No further action taken at this time.

cc:
The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	30838	A. BUILDING: _____ B. WING _____	C 03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD PINES	1702 AIRPORT ROAD NE STAPLES, MN 56479

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	Initial Comments On March 20, 2026, the Minnesota Department of Health initiated an investigation of complaint #HL308381281M/ #HL308385521C. No correction orders are issued.	0 000		