Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 12, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

RE: CCN: 245055
Cycle Start Date: March 8, 2024

Dear Administrator:

On April 1, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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March 21, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

RE: CCN: 245055
Cycle Start Date: March 8, 2024

Dear Administrator:

On March 8, 2024, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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:

Annette Winters, Regional Operations Supervisor, Federal Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street North
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 June 8, 2024 (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 September 8, 2024 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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March 21, 2024

Administrator
Lakehouse Healthcare & Rehabilitation Center
3737 Bryant Avenue South
Minneapolis, MN 55409

Re: Event ID: XIL011

Dear Administrator:

The above facility survey was completed on March 8, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. BUILDING _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(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
F 000	INITIAL COMMENTS On 3/8/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H50551416C (MN99528) The following complaints were reviewed. H50551476C (MN101402) with a deficiency issued at F558 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 that substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 558	This provider submits the following plan	3/29/24

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

Electronically Signed | 03/22/2024

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 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.

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F 558	Continued From page 1 review the facility failed to ensure a resident's right to reasonable needs and preferences for 1 of 3 (R1) residents reviewed. R1's remote control for her bed was taken away leaving her dependent on staff for bed mobility. This practice limited R1 in achieving independent functioning and impaired her dignity. R1 was her own decision maker. Finding include: Upon observation and interview on 3/8/24 at 9:37 a.m. R1 was seated in her wheelchair fully dressed and groomed. R1 stated, the staff took her bed remote control away. R1 stated she had never fallen at the facility and was able to use the remote appropriately. Nursing assistant (NA)-A gave R1 her television remote control. R1 turned on her television, changed the channels and used the volume button appropriately. R1 stated she can use the bed remote just as she is able to use the television remote. R1 stated she needed to have the bed remote due to back pain because she liked to lift the head of her bed up and reposition her legs while she is in bed. She stated she does not like sleeping "inches" off the floor and prefers her bed in a higher position. She stated she liked to have her bed at an even level with her television for comfortable viewing. She also liked to sit-up in bed to use her phone and her computer at a comfortable level where she could also reach her phone and computer from her bedside table on her own. R1 stated that even at the highest position the bed is not a dangerous level. "I shouldn't have to wait for staff when I can do it myself." Upon observation on 3/8/24 at 12:59 p.m. NA-A laid R1 down in bed using the EZ-stand	F 558	of correction in good faith and to comply with Federal and State Law. This plan is not an admission of wrongdoing, nor does it reflect agreement with the facts and conclusions stated in the statement of Resident has her requests met as per regulations Individual Resident: R1 requests are now met. Identification of other residents: The facility will identify other residents who are making decisions that have the potential to be affected by the same deficient practice. Staff development/designee will re-educate facility licensed staff on resident rights and making reasonable accommodations to ensure residents preferences are met in a reasonable manner Date of completion: March 29th, 2024. To ensure correction is achieved and sustained, Audits will be conducted by the IDT team or designee to ensure that residents requests that are not safe are being addressed weekly for 4 weeks and then monthly for two months. Audit results will be reviewed at the QAPI meeting to review and make recommendations for ongoing monitoring.	

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F 558	Continued From page 2	F 558		

mechanical lift. During the transfer R1's bed was lifted to the highest position which was approximately three feet off the ground.

R1's progress notes dated 8/30/23- 3/4/24 did not indicate R1 had any falls or had any difficulty with using her bed remote control.

R1's nursing assessment dated 2/25/24 indicated R1 had clear speech, was able to use her call light, was able to make herself understood, was able to understand others, was consistent and reasonable with decision making, had a pleasant mood, had a good attitude and no obvious behavior problems.

R1's quarterly Minimum Data Set (MDS) dated 2/27/24 indicated R1 had a Brief Inventory of Mental Status (BIMs) score of 15 indicating she was cognitively intact. R1 did not exhibit any behaviors nor refused cares. R1 had limited range-of-motion on her left upper and lower extremities. R1 was dependent with toileting hygiene, showering, dressing, and transferring. R1's pertinent diagnoses were hemiplegia following cerebral infarction affecting left nondominant side (stroke), acute respiratory failure and morbid obesity. R1 had no falls since admission of 8/30/23.

R1's progress note dated 3/5/24 at 6:53 a.m. indicated during rounds at 4:00 a.m. the writer observed R1 had her bed elevated almost twelve feet above ground and asked the resident to bring the bed down, but R1 refused and stated, "I like my bed very high." Writer reapproached, but to no avail. Writer educated R1 on the safety of lowing bed when asleep. The nurse manager was informed and will update the incoming a.m.

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F 558	Continued From page 3 nurse. Will continue to monitor. R1's progress note dated 3/5/24 at 1:38 p.m. indicated a call was placed to R1's family member (FM)-A regarding the behaviors of raising the bed height. For safety bed control removed from the bed, staff will use footboard controls to adjust as needed. R1's care plan dated 3/5/24 indicated the focus was behavior: R1 was resistive to care, self-determination in managing own choices. Can be verbally and physically aggressive towards others, will throw food, liquid utensils, and dishes at others, call 911 frequently, can be resistive with cares and toileting. Makes accusations against others that are unfounded. Used bed control to bed in the highest position. The goal: R1 will have no behavior outbursts or call to 911. The interventions: Allow R1 to make decisions about treatment regimen, to provide sense of control. The bed hand control removed for safety. The care plan interventions did not provide any education to the resident about using the bed remote to how the facility would prefer. There were not any changes to R1's room to accommodate her preference of not having the bed so low to the floor, interventions for another method to reposition herself for back pain, have the bed at a height where R1 could reach her phone and laptop or have a straight view of her television while in bed. A risk and benefit form dated 3/5/24 indicated care of treatment refused: R1 refused to keep bed height at a low or neutral position. Explanation of risk: The risk was a fall risk which could result in jury such as but not limited to fractures or death. Explanation of benefit: To	F 558		

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F 558	Continued From page 4	F 558		

have a safe environment when in bed and to prevent any injury. Under signature of resident/responsible part and relationship indicated it was verbally given with resident and spoke with FM-A over the phone. The form did not indicate any alternatives rather than removing the remote from R1.

R1's progress note dated 3/6/24 at 3:52 a.m. indicated R1 kept yelling and crying for her bed control/remote. According to her the bed control was removed from her bed without permission.

R1's progress note dated 3/6/24 at 1:40 p.m. indicated a message was left for FM-A to update regarding bed controls removed for safety. Will return wait for return call.

R1's progress note dated 3/7/24 at 1:41 p.m. indicated licensed practical nurse (LPN)-A nurse manage spoke with FM-A and updated him regarding the bed controls were removed. FM-A stated he spoke with R1 yesterday evening when he was visiting and stated he was in agreement for her safety to remove the hand control.

R1's client resident profile dated 3/8/24 indicated R1 was the responsible party for herself. FM-A was the first emergency contact, the care conference person and had financial responsibility.

Upon interview on 3/7/24 at 3:24 p.m. FM-A stated he was not R1's guardian, he stated he is an emergency contact and visits her often. FM-A stated the facility took away R1's bed remote control. He stated the nurse informed him that they took it for her safety because she elevated it up to twelve feet in the air. "I don't want her to fall

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F 558	Continued From page 5	F 558		

from twelve feet, but why would they have a bed go so high?" FM-A stated he had never heard that she struggled with using the bed on her own. He stated he is aware R1 used the bed remote to lift the head of the bed up and her legs up or down to reduce of back pain. She would elevate the head of the bed to use her phone, laptop, and watch television.

Upon interview on 3/8/24 at 10:09 a.m. occupation therapist (OT)-A stated he was not aware that the nursing had removed R1's bed remote controller from her room. He stated therapy could work with R1 on the concerns the nursing department has to assist R1 with her independence.

Upon interview on 2/8/24 at 11:18 a.m. trained medication assistant (TMA)-A stated she worked with R1 often as a TMA and as an NA. She stated she was "surprised" that R1's remote was removed from her. She stated R1 used it appropriately and was capable of lifting the head and feet of her bed up to reposition herself and assist with her pain.

Upon interview on 3/8/24 at 12:48 p.m. LPN-A (unit manager) stated a few nights ago R1 put her bed in a high position and the facility "can't have that." She stated the remote was taken from R1 the following morning and FM-A was called. She stated FM-A spoke with R1 and told her that she could not put her bed up like that. LPN-A stated FM-A was not R1's power of attorney (POA) or guardian. She stated R1 does have a BIMs score of 15 however she makes poor choices. An example was R1 is on a fluid restriction, and she does not follow the restriction. LPN-A stated to keep R1 safe she could not have the remote in

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F 558	Continued From page 6 case she was to fall out of bed. LPN-A denied any falls since admission on 8/30/23 but stated if she would fall due to putting her bed in the high position the facility would be liable. LPN-A stated R1 can use her call light and could call staff when she wanted to be repositioned in bed. LPN-A denied any formal assessments completed or education with R1 prior to removing the remote from her room. Upon interview on 3/8/24 at 1:18 p.m. the director of nursing (DON) stated she was aware that R1 had her bed remote control taken away. She stated even though R1 had a BIMs of 15 she had cognitive issues, stating she would tell stories that were not true. The DON stated she believed R1 had multiple falls at the facility. The fall reports were requested, and the DON rescinded her statement after she completed a record review and not finding any falls. The DON stated she stands behind the decision to keep the remote away from R1 because the facility has an obligation to keep R1 safe. The DON believed a risk vs. benefit form was discussed with R1 and FM-A however was unable to obtain the report. Upon interview on 3/8/24 at 1:40 p.m. the Administrator stated she was aware that there was talk that R1 had raised her twelve feet. She stated she was not certain how high a bed went but was certain it was not twelve feet. She stated from the perspective of the facility the staff was acting in R1's best interest to keep her safe from falls. She stated, "The facility would be in more trouble if she did fall and obtained a fracture." The administrator was not certain which specific assessments were completed on R1 or any other interventions or education attempted to resolve the concern before removing the bed remote.	F 558		

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F 558	Continued From page 7 A facility policy on residents' rights was requested however none received.	F 558		

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	00276	A. BUILDING: _____ B. WING _____	C 03/08/2024

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LAKEHOUSE HEALTHCARE & REHABILITATION CEN	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 3/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey. H50551476C (MN101402) &	2 000		

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

Electronically Signed | 03/22/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00276	A. BUILDING: _____ B. WING _____	C 03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CEN	3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409

(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
2 000	Continued From page 1 H50551416C (MN99528) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		