Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 10, 2025

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

RE: CCN: 245055
Cycle Start Date: July 18, 2025

Dear Administrator:

On September 3, 2025, 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 immediate jeopardy (Level J). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On August 29, 2025, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343; has been subject to a denial of payment, the appointment of a temporary manager

or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 3, 2025. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, LAKEHOUSE HEALTHCARE & REHABILITATION CENTER is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 3, 2025. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

LeAnn Huseth, RN, Regional Operations Supervisor, Rapid Response
Fergus Falls District Office
Health Regulation Division
Minnesota Department of Health
2312 College Way
Fergus Falls, 56537
Email: leann.huseth@state.mn.us
Office: (218) 332-5140 Mobile: (218) 403-1100

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

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: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0000	INITIAL COMMENTS On 9/2/25 through 9/3/25, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was not found NOT to be in compliance with the requirements of 42 CFR Part 483, Subpart B, requirements for Long Term Care Facilities. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at F678 began on 8/28/25, when R1 was found unresponsive with an absence of pulse and respirations, CPR was not initiated, and R1 passed away. The administrator, and director of nursing (DON) were notified of the IJ on 9/3/2025 at 2:50 p.m. The facility implemented immediate corrective action on 8/29/25 to prevent recurrence, therefore, the IJ was issued at past non-compliance. The following complaint was reviewed: H50553320C (2604193) with a deficiency cited at F678. 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.	F0000		
F0678 SS = SQC-J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency	F0678	"Past Noncompliance - no plan of correction required"	

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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F0678 SS = SQC-J	Continued from page 1 care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST) to provide cardiopulmonary resuscitation (CPR) for 1 of 3 residents (R1), who wished to have CPR in the event of cardiopulmonary arrest (absence of pulse and respirations). This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found absent of pulse and respirations, no CPR was initiated, and R1 passed away. The facility implemented corrective action prior to survey; therefore, the deficient practice was issued at past non-compliance. The IJ began on 8/28/25, when R1 was found unresponsive with an absence of pulse and respirations, CPR was not initiated, and R1 passed away. The facility administrator and director of nursing (DON) were notified of the IJ on 9/3/2025 at 2:50 p.m. which was identified at the scope and severity of and isolated IJ. The facility implemented immediate corrective action on 8/29/25 to prevent recurrence, therefore, the IJ was issued at past non-compliance. Findings include: A nursing note written by licensed practical nurse (LPN)-A dated 8/28/25, indicated when LPN-A checked on R1 Cheyne-Stokes breathing (an abnormal breathing pattern of deep breathing, shallow breathing and no breathing followed by a gasp, commonly seen during the dying process) was observed. LPN-A requested assistance from another facility nurse and R1's hospice nurse who was in the building. When the nurses returned to R1's room, he was not breathing. The nurses checked for a pulse, finding none. Time of death was called at 2:20 p.m. The nurses cleaned R1's body to prepare for the mortuary to pick up. R1's progress note lacked documentation regarding checking R1's code status and initiation of CPR. R1's admission Minimum Data Set (MDS) dated 8/18/25, indicated intact cognition with diagnoses that included metabolic encephalopathy, type 2 diabetes, and end	F0678		

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F0678 SS = SQC-J	Continued from page 2 stage renal disease. R1's POLST dated 8/13/25, identified R1's wishes were to attempt CPR (full code) with full treatment including intubation, advanced airway interventions, mechanical ventilation and transfer to the hospital if indicated. A Care Conference Summary, locked 8/19/25, identified R1 was a full code and wished to remain as such. A provider visit note, dated 8/22/25, identified R1 was seen by nurse practitioner (NP)-A. The note identified R1's advance directive as full code. A provider order dated 8/13/25, indicated code status as CPR/attempt resuscitation. R1's electronic health record (EHR) indicated R1 elected hospice care on 8/13/25. During an interview on 9/2/2025 at 12:52 p.m., LPN-B stated when a resident was found unresponsive and not breathing, a nurse STAT (an emergency page overhead that calls nurses to a specific location) should be called and the resident's chart should be checked for code status. LPN-B stated CPR would be performed if consistent with the resident's wishes. LPN-B confirmed code status would be checked for a resident who had elected hospice care since hospice care did not automatically mean a resident's code status was do not resuscitate (DNR. Allow natural death). During an interview on 9/2/2025 at 1:29 p.m., LPN-C stated a resident's code status needed to be checked for all residents who were found unresponsive and not breathing. LPN-C stated CPR would be performed if consistent with resident's wishes. During an interview on 9/2/2025 at 2:29 p.m., DON confirmed R1's code status was full code, his code status had not checked when he was found unresponsive, and CPR had not been performed. During an interview on 9/3/2025 at 12:18 p.m., Hospice	F0678		

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F0678 SS = SQC-J	Continued from page 3 registered nurse (HRN) stated she was at the facility to see R1 on 8/28/25, because he was having increased pain. When she assessed R1, he was a little confused however, was able to answer basic questions. HRN left the room to call the provider. LPN-A asked HRN to go to R1's room because his breathing was different. When HRN and LPN-A returned to R1's room, he was not responding and was not breathing. HRN checked for a pulse while LPN-A checked for breathing. Finding no pulse and no breaths, time of death was called. HRN did not check the resident's code status, and LPN-A did not leave the room until after time of death was called. HRN confirmed CPR had not been initiated on R1. During an interview on 9/3/2025 at 1:49 p.m., registered nurse (RN)-A stated a nurse STAT page alerted all nurses to respond to a specific location for an emergency. Each nurse would bring equipment based on the location they were working on. Equipment included a crash cart (included supplies needed to perform CPR), vital signs machine, and automated external defibrillator (AED). If a resident was found unresponsive and not breathing, a nurse should check the POLST of the resident and if the resident was full code, CPR should be started immediately. RN-A stated there was no reason CPR would not be started on a resident who elected full code status. During a follow-up interview on 9/3/2025 2:16 p.m., the DON stated if a resident was found not responding and not breathing, a nurse should check the resident's code status on the POLST. If the resident was full code, the nurse would do chest compressions, give respirations, and use the AED. 911 would also be called. If a resident's code status was DNR, CPR would not be started. DON stated there were reasons CPR would not be started listed in the CPR policy however, those signs take 4-6 hours to develop, and staff would be checking on residents before the signs had time to develop. 3 attempts were made to contact LPN-A with no return phone call. Review of the facility's CPR policy dated August 2024, instructed staff when a resident experienced a cardiac arrest, to provide basic left support, including CPR in accordance with the resident's advance directives. And if the resident did not show obvious signs of clinical death (e.g. rigor mortis [body limb stiffening], dependent lividity [purplish red discoloration to the	F0678		

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F0678 SS = SQC-J	Continued from page 4 skin], decapitation, transection, or decomposition). The facility implemented the following actions prior to the survey which were verified through interview and document review and therefore the IJ was issued at past non-compliance: -LPN-A was immediately suspended and communication with hospice company occurred. -House-wide nurse education started including the importance of checking a resident's code status when they were found unresponsive and not breathing, including residents who had elected hospice care. Education completed 8/29/25. -Nurse STAT (Code Blue) drills started 8/29/25. Drills included residents who were full code, DNR, and hospice residents.	F0678		

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September 10, 2025

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

Re: Event ID: 1D598A-H1

Dear Administrator:

The above facility survey was completed on September 3, 2025 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,

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

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20000	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 9/2/25 through 9/3/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with MN State Licensure. The following complaint was reviewed: H50553320C (2604193). NO licensing orders were issued.	20000		

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

Minnesota State Department of Health

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20000	Continued from page 1 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.	20000		