



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

June 3, 2025

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

RE: CCN: 245055
Cycle Start Date: May 29, 2025
Event ID: H19X11

Dear Administrator

On May 29, 2025, a survey was completed at your facility by the Minnesota Department of Health to investigate a complaint 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. The investigation resulted in no deficiencies being issued.

At the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

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. Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 05/29/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>On 5/28/25 through 5/29/25, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was reviewed: H50554230C(MN112832), H50555247C(MN113129). NO deficiencies were cited.</p> <p>The facility is enrolled in ePOC, therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00276	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/29/2025
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NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATIO	STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH MINNEAPOLIS, MN 55409
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 5/28/25 through 5/29/25, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaints were reviewed: H50554230C(MN112832),</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>H50555247C(MN113129). NO licensing orders were issued.</p> <p>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.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021
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K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/29/2025. At the time of this survey, THE EMERALDS AT FARIBAULT was found NOT in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.</p> <p>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.</p> <p>UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.</p> <p>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:</p> <p>IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 05/16/2025
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K 000	<p>Continued From page 1</p> <p>Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. <p>THE EMERALDS AT FARIBAULT is a 4-story structure with partial basement.</p> <p>The facility was constructed at 5 different times. The original building is a 4-story building with no basement. It was constructed in 1908 and was determined to be of Type I (332) construction, (the 1st and 2nd floor only are used for health care). In 1960 a 1-story addition was constructed and</p>	K 000		

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K 000	Continued From page 2 was determined to be of Type II (111) construction, with no basement. In 1971 a 1-story addition was constructed and was determined to be of Type II (111) construction, with a full basement. In 1990 a 1-story addition was constructed and was determined to be of Type II (111) construction, with no basement. In 1991 an addition was constructed and was determined to be of Type II (111) construction, with no basement. Because the original building and additions are compatible construction types allowed for existing buildings of this height, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, and spaces open to the corridors that are monitored for automatic fire department notification. The facility has a capacity of 109 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 222 SS=C	Egress Doors CFR(s): NFPA 101 Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking	K 222		5/23/25	

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K 222	<p>Continued From page 3</p> <p>arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING</p>	K 222		

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K 222	<p>Continued From page 4</p> <p>ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4</p> <p>ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed provide proper labeling of egress doors having time-delay as identified per NFPA 101 (2012 edition), Life Safety Code, section 19.2, 7.2.1.6, 7.2.1.6.1.1(4) This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that exit doors having delayed egress of 15-seconds were not labeled with identifying signage.</p> <p>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</p>	K 222	<p>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements</p> <p>Immediate Correction: The facility installed signage stating "Push Until Alarm Sounds. Door Can Be Opened In 15 Seconds" on all affected exit doors.</p> <p>The Maintenance Director educated all maintenance and housekeeping staff during the weekly safety huddle about the requirement for delayed egress door signage and associated NFPA Life Safety Code standards.</p> <p>The Maintenance Director or designee will conduct audits of all egress doors daily x2 weeks, weekly x2 weeks then monthly 2 months, to ensure signage remains visible</p>	

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K 222	Continued From page 5	K 222	and intact.		
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4	K 741	QAPI: Findings from audits will be reported to the monthly QAPI meeting for ongoing monitoring and additional recommendations as needed. Responsible Party: Maintenance Director. Completion date 5/23/2025	5/23/25	

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K 741	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to maintain the facility smoking policy per NFPA 101 (2012 edition), Life Safety Code, section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by a review of available documentation that the smoking policy was generic in content not providing guidance as to the approved smoking location(s) for staff, residents, and visitors.</p> <p>An interview with the Maintenance Director verified this deficient finding at the time of discovery.</p>	K 741	<p>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.</p> <p>Immediate Correction: The Administrator revised the facility smoking policy on 05/16/2025 to identify designated smoking areas for residents, staff, and visitors. A copy of the revised policy was posted at all staff bulletin boards and signs posted at doors.</p> <p>Signage & Equipment: Appropriate "NO SMOKING" signage was placed in prohibited areas and smoking signs placed at designated smoking areas. Ashtrays made of non-combustible material and approved disposal containers with self-closing lids were placed in designated areas. Education provided to staff on revised smoking policy, safety procedures, and resident supervision requirements.</p> <p>The Maintenance Director or designee will complete audits daily x2 weeks, weekly x2 weeks and monthly x 2 months to ensure compliance with the policy and correct signage.</p> <p>QAPI: Compliance results will be reviewed during monthly QAPI meetings to ensure continued effectiveness of the policy. Responsible Party: Maintenance Director.</p>	

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K 741	Continued From page 7	K 741	Completion Date 5/23/25	
K 923 SS=F	<p>Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101</p> <p>Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored</p>	K 923		5/23/25

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NAME OF PROVIDER OR SUPPLIER THE EMERALDS AT FARIBAULT LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 500 SOUTHEAST FIRST STREET FARIBAULT, MN 55021		
(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
K 923	<p>Continued From page 8</p> <p>in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.3.2.4, 11.7.3. 11.7.3.2, 5.1.3.3.2, 5.1.3.3.4. These deficient findings could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the North - Med Gas (O2) Room, there was storage of transfill portable tanks and Liquid Oxygen Units. The identified room is not approved for transfilling. 2. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation that the North - Med Gas (O2) Room was found unsecured. 3. On 04/29/2025 between 9:00 AM and 1:30 PM, it was revealed by observation in resident RM 106 that there was a non-plumbed for use liquid oxygen tank which was positioned in the path of egress from the resident room. <p>An interview with the Maintenance Director verified these deficient findings at the time of discovery.</p>	K 923	<p>Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements</p> <p>Immediate Correction: All portable transfill tanks and liquid oxygen units were removed from the unapproved North Med Gas Room. They were relocated to an approved area that meets all ventilation and construction requirements for transfilling operations.</p> <p>The Maintenance Director and DON provided joint education to all clinical and maintenance staff about proper medical gas storage, NFPA 99 regulations, and the risks of unauthorized transfilling.</p> <p>The Maintenance Director or designee will conduct daily audits of all oxygen storage and transfilling areas × 2 weeks, weekly x2 and then monthly × 2 months.</p> <p>QAPI Oversight: Audit results will be presented to QAPI monthly for review, tracking of trends, and further quality improvement actions. Responsible Party: Maintenance Director. Completion date 5/23/25</p>	