

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  06/10/2024
NAME OF PROVIDER OR SUPPLIER  Lakehouse Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  3737 Bryant Avenue South Minneapolis, MN 55409	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44648</b></p> <p>Based on observations, interviews, and record review the facility failed to provide interpretive services for 1 of 3 residents (R1) to ensure the resident was fully informed in his primary language the risks and benefits, treatment plan and alternative options to treat diabetes when he ate snacks and refused insulin therapy.</p> <p>Findings included:</p> <p>During observation on 6/5/24 at 10:37 a.m. witness two staff knock on R1's door and enter his room. Observed the two staff standing with R1 in front of his open closet. Unable to understand what R1 told them. One of the staff members was holding a bag of snacks in a plastic bag and left the room.</p> <p>During observation and interview on 6/5/24 at 11:05 a.m., while talking to NP-A in the hallway R1 exited his room and saw writer talking to NP-A. Unable to understand what he was saying he looked at me and pointed at the LPN-C who was holding the bag of sweets and said, show her. He appeared agitated by pacing back and forth and kept looking at me and telling LPN-C show her. LPN-C and NP-A both looked at him and shook their head up and down as they were nodding and said OK. Nothing further was said to him and R1 went back into his room and shut the door.</p> <p>R1's admission nursing assessment dated [DATE]. Indicated his primary language was Somali. His speech was clear, and another means to communicate was through an interpreter. The assessment determined he understood the staff and the staff understood him.</p> <p>R1's care conference note dated 12/8/23 at 1:21 p.m. Indicated he was able to make his basic needs and preferences known even though his primary language was Somali. His son lived in Somalia, and a nephew lived in the area. His current health condition prevented him from living safely at home.</p> <p>R1's care plan dated 12/18/23 indicated his preferred language was Somali but he could speak some English. No interventions to improve communication was identified.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R1's minimum data set (MDS) dated [DATE], indicated R1 had moderately impaired cognition, cognitive communication deficit (the inability to pay attention to a conversation, stay on topic, and remember the information presented), depression, and rejected cares from staff one to three times a week. Medical history included metabolic encephalopathy (when diabetes caused impaired brain function), diabetes, severe protein calorie malnutrition, adult failure to thrive, dementia with behavioral disturbances. The assessment determined he could speak clearly to communicate his needs and understand others. He was independent with most activities of daily living ( ADL).</p> <p>R1's Adult Psychiatric Clinic note dated 4/2/24, indicated an interpreter was required for every visit related to his language barrier.</p> <p>R1's nurse practitioner (NP)-A's follow-up visit note dated 4/29/24, indicated on the patient information banner at the top of the page was needs interpreter Somali in bold letters.</p> <p>R1's Associated Clinic of Psychology note dated 5/8/24, indicated she was told by the facility staff they were trying to manage his diet by reducing sugar intake. During her assessment with an interpreter, she found R1 was very upset because the facility would not let him eat the food he wanted to eat. She developed ways for the staff to improve communication and build connections with R1.</p> <p>R1's social worker note dated 5/6/24, indicated the nurse practitioner had requested and interpreter for her next visit to two learn why resident was refusing to take insulin.</p> <p>R1's social worker note dated 5/8/24, indicated she needed to schedule an interpreter for his upcoming nurse practitioner and acute care psychiatry visits. Having an interpreter at the meeting would be beneficial to aid their ability to assess his current condition.</p> <p>R1's social worker note dated 5/13/24 indicated and an interpreter was arranged for his I'm coming the upcoming appointment with the medical provider.</p> <p>R1's hospital discharge record dated 5/31/24, indicated he needed a Somali interpreter during his hospital stay.</p> <p>R1's palliative care consult dated 5/31/24, indicated he needed an in-person interpreter for all care conferences or serious medical conversations.</p> <p>During interview on 6/4/24 at 2:32 p.m. SW-B stated when she assessed him, he only spoke a few words but communicated his needs and concerns with the interpreter.</p> <p>During interview and observation on 6/4/24 at 3:09 p.m. R1 stated wait, and he ran out of the room. He was looking for a Somali staff member to help him communicate. With the use of the language line, he stated the facility did not provide him healthy food, and he was very hungry. He had to eat unhealthy snacks found on the unit consequently increasing his blood sugar. R1 only spoke a few words in English and mainly relied on the interpreter to communicate his thoughts and needs.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/4/24 at 4:15 p.m. licensed practical nurse (LPN)-A stated if a resident did not speak English, they would use picture cards. They used interpreters for meetings, care conferences and medical doctor appointments. She would also use a family member to interpret. She stated they did not have access to an interpreter language line and most of the time they could figure out what the resident was trying to say. If they needed an interpreter, she would speak with the social worker (SW) to make the arrangements.</p> <p>During interview on 6/4/24 at 4:30 p.m. the director of nursing (DON) stated she requested ACP with an interpreter to discuss is care. Even when they used his family to help with communication, they had a hard time because of his dialect.</p> <p>During interview with nurse practitioner (NP)-A on 6/5/24 at 11:00 a.m., stated R1 did better with an in-person interpreter and the facility was able to arrange one at a short notice. She could use a language line through her employer and wished the facility staff had access to a language line to decrease R1's confusion caused by his language barrier.</p> <p>During interview on 6/5/24 at 11:15 a.m. with the use of an interpreter R1 stated sometimes an employee worked at the facility who spoke Somali and helped him communicate with the staff. He said most of the time he did not understand what the staff was saying. He could not read the printed activity schedule and menu because it was written in English.</p> <p>During interview on 6/5/24 at 2:32 p.m. trained medication aid (TMA)-A stated when caring for a resident whose primary language was not English, he would find someone working to help interpret. He would know if the resident understood him by their body language. He said if they could not find someone to help interpret, he would do his best. He stated there was no access to an interpretive line to add in communication.</p> <p>During interview on 6/4/24 at 3:00 p.m., nursing assistant (NA)-B stated if she could not understand a resident related to a language barrier, she would use a communication board or tell the nurse to arrange for an interpreter.</p> <p>During interview on 6/4/24 at 3:15 p.m., the administrator stated they had signs posted at the nursing station how to use an interpreter line at any time. She showed me the signs on the seventh floor.</p> <p>During interview on 6/5/24 at 11:00 a.m., NP-A stated it was easier to interview R1 with an in-person interpreter and had one for last visit. The facility was able to schedule interpreter on a short notice and it worked best for communication regarding his condition.</p> <p>During interview on 6/5/24 at 11:15 a.m., with an interpreter using the language line, R1 He said the NP-A and LPN-C came into his room and took his snacks. He said there was Somalia employees who interpreted for him when they worked. He stated most of the time he did not understand what the staff told him. He said he did not understand what the menu and activity calendar on his desk was.</p> <p>During interview on 6/5/24 at 3:24 p.m., the Don stated when NP-A and LPN-C went into R1's room to search for snacks, they did not require an interpreter.</p> <p>(continued on next page)</p>		

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<p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview 6/6/24 at 11:43 a.m., SW-A stated R1 had some cognitive impairment and even when they use an interpreter, it was unclear whether he retained the information provide it to him. In the past, they have used family such as his nephew or son on the phone to discuss matters. An interpreter can be arranged at any time when it is required for in-depth conversations about medical care.</p> <p>During interview on 6/6/24 at 12:15 p.m., MD-A the facility's medical director stated he was unsure how much R1 retained the diabetes education. Even with an interpreter on site every day to refresh his memory he was unable to say if it would help.</p> <p>During interview on 6/6/24 at 1:00 p.m., Doctor of Psychology DP-A stated she felt he could not communicate accurately without an interpreter. He had very little support here and she looked for ways for the staff to communicate with him in meaningful ways. She attempted to find ways for R1 to eat better and follow medical protocols in a way he did not feel like he was being ganged up on by the staff and medical providers.</p> <p>During interview on 6/6/24 at 4:30 p.m., R4's family member (FM)-A said R1 spoke very little English and when he tried to talk to the staff, he would call his son or daughter on the phone to interpret for him. The lack of communication caused R1 to become frustrated because he could not tell the staff what he really wanted.</p> <p>During interview on 6/6/24 at 3:30 p.m. LPN-D stated there was one resident on the floor who did not speak any English. He said the resident's family was very involved with the care and they would interpret for him on the phone.</p> <p>Facility policy Interpreter Services dated 1/1/24, indicated facility staff would provide meaningful conversations to their non-English speaking residence along with the opportunity to participate in activities, programs, and services. Interpreters would be used anytime a resident's medical condition and treatment plans were being discussed. Documents such as waivers and consent forms would also be interpreted for the resident. The social service's department was responsible for arranging the interpreter.</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44648</b></p> <p>Based on observations interviews and record review the facility failed to use an interpreter during the admission process when the resident's bill of rights was presented for 1 of 3 residents (R1). Staff identified a resident's code status was a factor to let a resident exercise their right to refuse care.</p> <p>Findings included:</p> <p>R1's care plan dated 12/18/23 indicated his preferred language was Somali but he could speak some English. No interventions to improve communication was listed.</p> <p>R1's minimum data set (MDS) dated [DATE], indicated R1 had moderately impaired cognition, cognitive communication deficit (the inability to pay attention to a conversation, stay on topic, and remember the information presented), depression, and rejected cares from staff one to three times a week. Medical history included metabolic encephalopathy (when diabetes caused impaired brain function), diabetes, severe protein calorie malnutrition, adult failure to thrive, dementia with behavioral disturbances. The assessment determined he could speak clearly to communicate his needs and understand others. He was independent with most activities of daily living ( ADL).</p> <p>During interview on 6/5/24 at 3:24 p.m. the director of nursing (DON) stated R1 had told staff members he was ok with dying but he continues to be a full code. As a nurse they are supposed to do health teaching about the benefits of taking their medication and eating a proper diet. She said if he were a do not resuscitate (DNR) they would be more accepting of his wishes to eat the food he wanted to and refuse to take insulin. She said everyone has the right to make their own decisions but when they are a full code, he needed to take his diabetes more seriously and it was the nurse's responsibility to educate.</p> <p>During interview on 6/6/24, at 11:43 a.m., social worker (SW)-A said that the resident received documentation regarding patient rights upon admission to the facility. She said if requested they could print the rights in their preferred language. She confirmed R1 did not have an interpreter during the admission process. She added a resident's code status had no bearing whether a resident had the right to refuse treatment.</p> <p>During interview on 6/6/24 at 12:05 p.m., the administrator stated the facility's admission staff provided the [NAME] of Rights. She said medical providers often want to give the residents proper care and have a hard time letting them refuse when they know it would be against their medical advice. She felt the incident on 6/5/24 at 11:00 a.m., when the nurse practitioner (NP)-A went into R1's room to remove the sweets he had stored in his closet was inappropriate and interfered with his right to eat what he wanted to eat. Lastly, she stated a resident's code status did not affect their ability to refuse treatment.</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/6/24 at 12:15 p.m. medical doctor (MD)-A stated if R1 continue to refuse to manage his diabetes would decrease his life expectancy. If R1 wanted to refuse care, then he should reconsider his code status to be a do not resuscitate (DNR). In this situation, the facility should do a risk benefit with an interpreter. In addition, the facility should try to provide healthy snacks for him when he is hungry.</p> <p>Facility policy Resident Rights Guideline dated 4/10/24, indicated the facility would protect and promote a resident's right regardless of diagnosis, severity of condition, or payment source. Each residents had the right to refuse treatment and medical care.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44648</b></p> <p>Based on observations, interviews, and record review the facility failed to develop a comprehensive care plan to understand cultural practice, medical history, and diabetic goals for 1-3 residents (R1) when he refused to follow a diabetic diet and develop strategies to encourage him to take insulin for elevated blood sugar levels.</p> <p>Findings included:</p> <p>R1's care plan dated 12/18/23, indicated his preferred language was Somali and he could speak some English. The facility failed to identify staff interventions to enhance his understanding the medical provider's current diabetic treatment plan along with strategies to encourage compliance.</p> <p>R1's minimum data set (MDS) dated [DATE], indicated R1 had moderately impaired cognition, depression, and rejected cares from staff one to three times a week. Medical history included cognitive communication deficit (the inability to pay attention to a conversation, stay on topic, and remember the information presented, ) metabolic encephalopathy (when diabetes caused impaired brain function), diabetes, severe protein calorie malnutrition, adult failure to thrive, and dementia with behavioral disturbances. His speech was clear, and he was able to communicate his needs and understand others. He was independent with most activities of daily living (ADL).</p> <p>R1's Doctor of Psychology (DP)-A note dated 5/8/24, indicated he moved from Somalia to the United States eight years ago. In Somalia he was a government worker and left because of the war. He followed the Muslim faith and lived in apartment in Minneapolis until he was hospitalized for elevated blood sugar levels. She found R1 had a strong personality and was upset staff would not let him eat the food he liked. She felt if the staff would let him eat the food he wanted, he might be inclined to take the insulin. She developed strategies such as not removing food in his presence, or talking about soccer as an ice breaker when he refused treatment.</p> <p>Clinical dietician note dated 5/22/24, indicated at a young age his traditional beliefs and habits taught him to limit the amount of food he ate. R1 preferred to eat sweet snacks in the evening. As a result, the nurses locked the unit refrigerator door.</p> <p>R1's care plan note dated 5/30/24, indicated staff would explain and reinforce the importance of following a diabetic diet without specific interventions such as identified in DP-A's note dated 5/8/24,</p> <p>During interview on 6/4/24 at 3:09 p.m., with the use of an interpreter R1 stated the facility would not let him eat what he wanted to eat. He said he was so hungry he had to eat the unhealthy food he found around the unit causing his blood sugar to go high.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 6/6/24 at 11:43 a.m., social worker (SW)-A stated she reviewed all the psychology notes along with the director of nursing (DON). After reviewing the notes and recommendations they would add them to the resident's care plan. She did not feel DP-A's note dated 5/8/24, regarding power struggles and the love of soccer would help the staff provide his care. She said as far as power struggles, they encourage staff to never have a power struggle with a resident. She added what would him liking the game of soccer provide any benefit to his care.</p> <p>During interview on 6/6/24 at 12:41 p.m., DP-A said R1 had very little support in the United States and her goal was to look for ways for the staff to communicate with him in a meaningful way. She found he loved soccer. He played soccer when he was young and felt if the staff engaged with him talking about soccer it might help build connections. She expected the staff to review her recommendations and place them in the care plan so she could later see if the plan were successful. She focused on trying to find strategies for him to eat better, follow medical advice, and not feel like he was being ganged up on. She wanted to help the staff form relationships that would mitigate his stress.</p> <p>The facility policy Care Planning dated 10/20/23, indicated the staff would develop a person-centered care plan for each resident. The care plan would include cultural preferences involving the residence's beliefs, norms, and values. Nursing staff would identify the residents needs and develop appropriate goals. The information would help the staff provide care necessary to meet the resident's needs.</p>		