

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  01/02/2025
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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44648</b></p> <p>Based on interview and document review the facility failed to accurately document new or changed medication orders for 2 out of 3 residents (R1, R2) reviewed for medical records. R1's seizure medication was changed from tablet form to oral solution, but the tablet form was not discontinued, which resulted in R1 being administered two doses. In addition, R2 did not receive three medications when he returned from a hospitalization resulting in missed doses of medication required for his liver disease and diabetes.</p> <p>Findings include:</p> <p>R1's medication order dated 12/14/24, indicated Levetiracetam 1000 milligram (mg) tablet two times a day.</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], indicated he had prostate cancer, high blood pressure, diabetes, dementia, impaired cognition related to a stroke and epilepsy. He required staff assistance with all activities of daily living (ADLS). He was admitted for Hospice (end of life care) respite (short stay when their caregiver was unable to care for them) care from 12/13/24 through 12/23/24.</p> <p>R1's medication order dated 12/21/24, indicated a change to the Levetiracetam from tablet form to an oral solution. R1 received four doses of the oral solution from 12/21/24 through 12/23/24, in addition to the tablet form. R1 received 2000 mg two times a day.</p> <p>R1's medication administration record dated 12/1/24 through 12/31/24, indicated: RN-A gave three additional doses of Levetiracetam from 12/21/24 through 12/22/24, and RN-B gave one extra dose on 12/23/24. The error was not found by the facility at the time of discharge on 12/23/24 when the resident discharged back to his home.</p> <p>During interview on 12/30/24 at 12:55 p.m., registered nurse (RN)-A stated new medication orders are processed by the nursing staff. If he found two orders for the same medication one in a tablet form and the other in an oral solution, he would call the medical provider and then the pharmacy to clarify the order. He said he was not working at that time, and the initials on the MAR were not his.</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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 12/30/24 at 1:08 p.m., RN-B stated if he found two orders for the same medication one in a tablet form and the other in an oral solution, he would clarify the order. He stated on 12/23/24, he did not realize he gave the same medication with the same dosage in both tablet and liquid form. When he realized the mistake, he spoke to the nursing staff. The dosage he gave was the last double dose before R1 was discharged to home.</p> <p>During interview on 12/30/24 at 2:38 p.m., licensed practical nurse (LPN)-A stated she processed the Levetiracetam order changed on 12/21/24. She was not sure why she did not discontinue the tablet form. LPN-A stated the third floor served a difficult population of residence to include memory loss and behaviors. She felt while she was transcribing the order she must have gotten interrupted and when she went back to finish the documentation, she forgot to discontinue the tablet form. She stated moving forward she planned to discontinue the old order before she processed the new one.</p> <p>During interview on 12/30/24 at 3:43 p.m., third floor manager RN-C stated recently in the last few months they no longer needed a second nurse to verify a new order was completed accurately. Prior to this decision they always had a second nurse make sure the order was correct and the electronic medical record would not let them click on the order until it was reconciled.</p> <p>During interview on 12/31/24 at 9:30 a.m., RN-A stated the facility contacted him about the medication error, and he did not realize he was the nurse that gave the medication. He said if there were both an oral solution and tablet form for the same medication, he would not give it, and the MAR entries were a clicking problem.</p> <p>During interview on 1/2/25 at 1:20 p.m., director of nursing g (DON) stated the facility leadership changed the order process one to two months ago. The new process eliminated another nurse to verify each new order was transcribed correctly.</p> <p>R2's admission Minimum Data Set (MDS) dated [DATE], indicated Metabolic and Hepatic Encephalopathy (when a diseased liver could no longer filter the body's waste from the blood stream leading to a buildup of toxins in the brain and abdomen), diabetes, and depression. He had normal cognition and made his own decisions except when his brain built up toxins leading to memory loss and confusion.</p> <p>R2's hospital discharge instructions dated 12/26/24, indicated to administer:</p> <ul style="list-style-type: none"> <li>-Rifaximin (medication to reduce the buildup of toxins in the brain.) The order was for 550 mg two times a day. He should have received a dose on 12/26/24 at 8:00 p.m., He missed a total of six doses. In addition, the order was not processed until 12/29/24, when he was already back in the hospital.</li> <li>- Glargine insulin (diabetic medication) was increase to 70 units at bedtime. He did not receive a dose at 9:00 p.m. on 12/26/24, 12/27/24, and 12/28/24. In addition, the order was not processed until 12/29/24, when he was already back in the hospital.</li> <li>-Metformin (diabetic medication) 500 mg two times a day should have started on 12/26/24 at 5:00 p.m., but he never received the medication. In addition, the order was not processed until 12/30/24 when he was already back in the hospital.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R2's blood sugar levels dated 12/26/24 when he returned to the facility was 240. From 12/26/24 at 4:12 p.m. through 12/29/24 at 12:30 p.m., his lowest blood sugar was 140, and his highest was 356. Normal blood sugar levels are 70 to 100.</p> <p>During interview on 1/2/24 at 1:20 p.m., the DON stated even though R2 came back from the hospital on 12/26/24 at 4:00 p.m., the Rifaximin, Glargine, and Metformin's start date was when he was already back in the hospital. She did not realize the missed doses until 12/29/24 and 12/30/24, when she entered the order into the MAR. She stated recently they stopped requiring two nurses to review new orders for accuracy. She was unhappy with the change and will reinstitute the practice.</p> <p>Facility policy Medication Orders dated 12/24, when processing new order, the staff will discontinue the previous order before entering the new order. When an order comes from the hospital after discharge the nurse would verify an appropriate signature of the ordering position. Any unsigned order would need validation from the facility provider before giving.</p>		