

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 06/13/2025
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 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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to timely change end of life wishes in the medical record to ensure the advanced directive (a written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) was followed for 1 of 3 resident's (R1) reviewed for advanced directives.</p> <p>Findings include:</p> <p>R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 had severe cognitive impairment and diagnoses that included acute respiratory failure, diabetes, malnutrition, intellectual disabilities, and adult failure to thrive.</p> <p>R1's care plan dated [DATE], indicated R1 required assistance with all decision making, and was signed by R1's legal guardian and R1's physician.</p> <p>R1's Provider Orders for Life Sustaining Treatment (POLST) form dated [DATE], indicated full code (receive all possible life-saving measures in the event of the event the resident stops breathing or heart stops) and was signed by R1's legal guardian. On [DATE], R1's POLST form was signed by his legal guardian, and directed do not attempt resuscitation (DNR), allow natural death. The POLST form further indicated comfort-focused treatment (allow natural death), and patient prefers no transfer to hospital for life-sustaining treatments.</p> <p>R1's Provider Orders dated [DATE], indicated R1's code status (patient's instruction to the medical team regarding what treatments they wish to receive or not receive if their heart of breathing stops) indicated cardiopulmonary resuscitation (CPR)/attempt resuscitation.</p> <p>R1's progress notes dated [DATE] at 3:29 a.m., indicated R1 was found unresponsive at about 1:00 a.m., R1's provider was notified, and ordered transfer to the hospital.</p> <p>On [DATE], at 8:25 a.m., R1's legal guardian (G)-A stated R1 had a legal guardian for approximately 75 years, due to intellectual disabilities. R1 had recent health changes, and a new POLST, signed by G-A, was provided by email to the social worker (SW)-A on [DATE] at 2:52 p.m. SW-A acknowledged the new POLST was received.</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
---	-------	-----------

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 06/13/2025
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On [DATE] at 9:09 a.m., SW-A stated he received the email from G-A on [DATE] at approximately 3:30 p.m. The facility's process was for the provider to sign a POLST, in order to complete the POLST process. The signed POLST with R1's wishes for DNR status was not valid because his physician had not signed it.</p> <p>On [DATE] at 1:14 p.m., registered nurse (RN)-B stated when R1 was sent to the hospital on [DATE] at 2:40 a.m., R1's medical record indicated full code resuscitation status, not DNR, and didn't indicate R1 should not go to the hospital.</p> <p>On [DATE] at 2:06 p.m., the director of nursing (DON) stated when a resident or representative requested a change in code status, the facility's process was to complete a new POLST form, and the provider signed it. The orders and banner (top of the medical record that contained information about code status) were changed with the new code status after the provider order was obtained. The facility was aware G-A requested the code status change on [DATE].</p> <p>On [DATE] at 2:22 p.m., the medical director (MD)-A stated R1's POLST was not signed, and there was no copy of the new POLST in the medical record when R1 was sent to the hospital. The expectation in Minnesota was advanced directives contain a POLST, and there was a physician's order to adhere to the advanced directive. Further, the facility allowed a week for the POLST to be signed by a physician.</p> <p>The Advanced Directive policy dated 6/05, directed it was the policy of the facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment, and to formulate advanced directives.</p>