STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeside Generations Health Care Center	439 William Avenue East Dassel, MN 55325

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)
F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to transcribe and administer a diuretic medication for 1 of 3 residents (R1) who had a diagnosis of heart failure that required medication management to prevent fluid related complications. The facility's failures resulted in actual harm for R1 when R1 was not administered 13 doses of Furosemide (diuretic) which contributed rapid weight gain, worsening respiratory status, and hospitalization for acute chronic congestive heart failure and hypoxia. The facility implemented corrective action prior to the survey by 2/4/26, therefore citation is issued at past non-compliance (PNC) Findings include: R1's hospital Discharge summary dated [DATE], identified R1's primary diagnoses included chronic hyponatremia, acute on chronic diastolic congestive heart failure and chronic respiratory failure with hypoxia. The discharge summary included an order to administer: Furosemide 20 mg tablet for acute chronic diastolic congestive heart failure. Instruction: Wait to take this until January 17, 2026. Take two tablets (40 mg) by mouth once daily in the morning. R1's comprehensive Minimum Data Set (MDS) dated [DATE], indicated R1 had no cognitive impairment, was receiving a diuretic medication, and required moderate assistance with toileting and transfers. R1's activity of daily living (ADLs) care plan dated 1/14/26, indicated R1 required medications to be administered as ordered. Additionally, it directed staff to monitor R1's fluid restriction and record weights according to the facility policy. R1's facility physician orders that were transcribed into the electronic health record (EHR) did not include the order for Furosemide 20 mg tablets as per the hospital Discharge summary dated [DATE]. The facility admission Checklist and Observation Schedule for admissions procedures dated 2/7/24, required staff to obtain signed hospital discharge orders and initiate applicable order sets, including CHF. In review of R1's record, it was not evident the CHF order set was initiated. R1's progress note dated 1/23/26 at 8:14 a.m., indicated R1 had not been placed on daily weights since admission on [DATE]. The note indicated that staff initiated R1's daily weight on 1/23/26. Review of R1's weight record identified on 1/15/26, R1's weight was 118.4 pounds (lbs.) and on 1/23/26 R1's weight was 124.7 lbs, an increase of 6.3 lbs. Despite the increase in weight there was no indication of a comprehensive assessment/analysis that identified possible etiology of the weight gain. Review of the January 2026 Medication Administration Record (MAR) showed R1 did not receive any doses of furosemide 40 mg from 1/17/26 through 1/29/26 (13 doses) in accordance with the hospital discharge order. R1's medication incident report dated 1/30/26 at 2:35 p.m., indicated R1's medication incident began on 1/17/26 and was identified on 1/30/26. The report identified R1 had gained unexpected weight but did not specify what the weight gain was. The report also indicated R1's vascular provider was notified of the weight gain as well as the medication error and ordered Furosemide to be restarted as prescribed. The report did not identify if the rounding physician and/or medical director of the facility was notified. R1's weight record identified the following weights between 1/15/26 through 2/1/26: On 1/15/26, weight (wt.) 118.4 lbs. On 1/16/26, wt. 118.6 lbs. On 1/17/26, no wt. recorded On (continued on next page)

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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F 0760 Level of Harm - Actual harm Residents Affected - Few	1/18/26, wt. 125.6 lbs. (gain of 7.2 lbs. in 3 days) On 1/19/26, no wt. recorded On 1/20/26, wt. 125.0 lbs. On 1/21/26 and 1/22/26, no weights were recorded On 1/23/26, wt. 124.7 lbs. On 1/24/26, wt. 123.7 lbs. On 1/25/26, wt. 124.0 lbs. On 1/26/26, no wt. was recorded On 1/27/26, wt. was 124.0 lbs. On 1/28/26, wt. was 135.8 lbs. (representing an 11.8 gain in one day and a 17.4 lb. gain in 15 days). On 1/29/26, wt. was 136.4 lbs. On 1/30/26 and 1/31/26 no weights were recorded. On 2/1/26, wt. was 136.1 (gain of 17.7 lbs. in 19 days.) R1's progress note dated 2/2/26 at 12:00 a.m., indicated staff transferred R1 to the hospital due to hypoxic episode with low oxygen saturation and temperature of 101F (Fahrenheit) on 2/1/26 at 9:30 p.m. R1's progress note dated 2/2/26 at 8:24 a.m., indicated R1 was admitted at the hospital with hypoxia, and she had gained 18 pounds since the previous hospitalization on 1/14/26. R1's hospital admission note dated 2/2/26 at 8:04 a.m., identified R1 was admitted at the hospital with worsening weakness, worsening hypoxia, hypertensive and saturating in low to mid 80s on room air with coarse breath sound at bilateral lung bases and x-ray wheeze upper lung fields. The note further identified R1's B-type natriuretic peptide (BNP), a test to measure a hormone produced by the heart to detect or monitor heart failure was markedly elevated at 11,015 consistent with known heart failure and likely volume overload contributing to R1's respiratory distress. The facility Medication Error Summary dated 2/2/26 identified staff failed to transcribe the furosemide order and failed to identify R1's CHF diagnosis or initiate the CHF monitoring order set (daily weights, edema checks, respiratory assessment). ? R1's hospital Discharge summary dated [DATE], identified R1's was hospitalized for an acute on chronic hypoxic respiratory failure secondary to influenza A infection with contributing factors including underlying heart failure with pleural effusions. R1's new physician orders dated 2/3/26 included: Auscultate lung sounds, make progress note if abnormal lung sounds are present. Check for edema and respiratory effort. Notify provider if indicated. During an interview on 2/11/26 at 3:09 p.m., R1 stated she felt miserable on 2/1/26 due to fever and shortness of breath, so she started screaming to get the nurse who came when she called 911 to go the hospital. R1 reported being diagnosed with heat failure and taking Furosemide to prevent fluid buildup around her heart. During an interview on 2/12/26 at 12:37 p.m., a licensed practical nurse (LPN)-A indicated when R1 was admitted on [DATE], she was the one who transcribed medication orders into R1's record. LPN-A reported there were distractions during order transcription which contributed to missing the Furosemide order and missing CHF diagnosis in order to initiate the CHF order set. ?LPN-A explained they found out about the medication incident because R1 had weight gain. LPN-A stated it was a system failure because RN-A double checked the orders, did not identify CHF diagnosis with furosemide order, and nurses on the cart did not raise any concerns regarding R1's CHF diagnosis either. LPN-A indicated she did not know R1 had CHF otherwise she would have made sure daily weight, edema, and lungs sounds were monitored. During an interview on 2/11/26 at 1:50 p.m., a registered nurse (RN)-A stated she was the second nurse who verified R1's admission orders but failed to identify the Furosemide order and CHF diagnosis to initiate the order set. ?RN-A explained she did not have any excuses for this failure and had since received re-education on CHF admissions, what to look for like weight gain, lungs sounds, edema, and fluid overload. During an interview on 2/12/26 at 11:38 a.m., RN-B indicated on 1/30/26, R1's vascular clinic had called the facility for R1's medication administrations and his weights for routine follow-up monitoring post hospitalization; it was the vascular clinic who identified R1 had not received the Furosemide per physician orders. RN-B then reviewed the hospital Discharge summary dated [DATE], in which she confirmed the furosemide order, nor the CHF order set was not represented in the facility's physician orders for administration and treatment. RN-B stated she assessed R1, restarted furosemide 40 mg daily, initiate daily weights, and (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	monitor R1's symptoms. RN-B indicated she had not notified the facility physician of R1's medication error or the weight gain. RN-B explained R1 not receiving furosemide 40 mg per physician order could result in heart failure exacerbation, weight gain, edema and shortness of breath. During an interview on 2/12/26 at 2:43 p.m., a physician assistant (PA)-A asserted she did not have any record about the facility notification regarding any missing or unavailable medication. PA-A stated she was not aware of R1 not receiving her furosemide 40 mg daily from 1/17/26 through 1/29/26. PA-A explained the potential complication for R1 with CHF diagnosis not receiving her furosemide 40 mg for 13 days could result with fluid overload, weight gain, edema, respiratory and heart failures. PA-A reported staff called on 2/1/26 requesting to send R1 to the hospital due to low oxygen saturation. PA-A stated she expected nursing staff to notify the medical team when there is a medication error for further instructions. During an interview on 2/11/26 at 2:55 p.m., a pharmacist (PH)-A explained that a resident who missed furosemide 40 mg daily should be monitored for fluid overload, weight increased, edema, and respiratory failure. PH-A emphasized the importance of furosemide for residents with CHF. During an interview on 2/12/26 at 3:50 p.m., RN-C, the regional clinical director stated she became aware of the medication error on Monday 2/2/26. RN-C confirmed staff failed to identify the CHF diagnosis, did not initiate the CHF order set, and did not transcribe the furosemide order. RN-C explained when R1 was not administered physician prescribed furosemide 40 mg, this could lead to heart failure exacerbation, rapid weight gain, fluid overload, and respiratory distress. During an interview on 2/12/26 at 3:02 p.m., the medical director (MD)-A stated the incident was self-reported and he provided CHF care education to the nursing staff after the incident. MD-A reported he was not aware R1 had CHF as primary diagnosis at the admission. MD-A explained R1 not having furosemide 40 mg as prescribed could lead to CHF exacerbation, shortness of breath, rapid weight gain, edema, and respiratory distress. The facility Medication management Policy dated 7/18/18 and reviewed 9/30/25, required medications to be administered to residents as prescribed by the primary MD/NP/PA and to be transcribed as received per policy. The facility put the following corrective measures in place and was verified as completed by 2/4/26: -LPN-A was suspended pending investigation and re-education was provided on 2/2/26. ?-The facility reviewed and revised site admission checklist. Once completed, start education and ??auditing use of admission checklist on 2/3/26. -The facility audited charts of all residents with CHF diagnosis to ensure order set is in place. Order set added if not currently scheduled on 2/3/26. Education for direct care staff regarding CHF Management by Medical Director (Teach the teacher to continue education for all new hires and on routine basis by facility staff) on 2/4/26. On 2/11/26 through 2/12/26, staff were interviewed and were able to articulate the ordering and the admission procedures for CHF residents. This deficient practice is being cited at past Non-compliance.