



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 18, 2025

Administrator
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER
3737 BRYANT AVENUE SOUTH
MINNEAPOLIS, MN 55409

RE: CCN: 245055

Cycle Start Date: July 18, 2025

Dear Administrator:

On August 29, 2025, we notified you a remedy was imposed. On November 3, 2025 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 2, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 18, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of September 10, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I) (b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 3, 2025. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 29, 2025

Administrator
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER
3737 BRYANT AVENUE SOUTH
MINNEAPOLIS, MN 55409

RE: CCN: 245055
Cycle Start Date: July 18, 2025

Dear Administrator:

On August 6, 2025, we informed you that we may impose enforcement remedies.

On August 15, 2025, the Minnesota Departments of Health and Public Safety completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 18, 2025.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 18, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 18, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 18, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, LAKEHOUSE HEALTHCARE & REHABILITATION CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 18, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

**Stefanie Salberg, Regional Operations Supervisor
Metro C District Office
Health Regulation Division**

**Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: stefanie.salberg@state.mn.us
Office: 651-201-4393 Mobile: 651-279-5602**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 18, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the

CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag) i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
E0000	Initial Comments On 8/11/25 - 8/15/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and 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, it is required that the facility acknowledge receipt of the electronic documents.		E0000			10/02/2025	
F0000	INITIAL COMMENTS On 8/11/25 through 8/15/25, a standard recertification survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued: 1027370 H50551691C (MN00105770) 1027379 H50551690C (MN00106284) 1027382 H50551689C (MN00106360) 1030391 H50551685C (MN00107008) 1030396 H50551684C (MN00107529) 1030398 H50551683C (MN00107801) 1027371 H50551692C (MN00105793) 1027381 H50557945C (MN00106372) 1027384 H50551688C (MN00106696)		F0000			10/02/2025	

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0000	Continued from page 1 1027385 H50551687C (MN00106748) 1030389 H50551686C (MN00106952) 1030401 H50551801C (MN00107980) 1030405 H50551682C (MN00108144) 1030411 H50551681C (MN00108674) AND The following complaints were reviewed: 2587702 H50552200C with a deficiency issued at F921 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.		F0000				
F0550 SS = E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.		F0550	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. – Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No resident has had an adverse event from the deficient practice. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0550 SS = E	Continued from page 2 §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure all staff knocked on individual resident bedroom doors, introduced themselves, and waited for permission to enter room prior to entry for 9 of 9 residents (R69, R77, R106, R119, R146, R167, R178, R196, R252) reviewed for dignity. Findings include: R69's quarter Minimum Data Set (MDS) dated 8/9/25, identified R69 with intact cognition. R146's quarterly MDS dated 5/30/25, identified R146 with intact cognition. R252's quarterly MDS dated 8/11/25, identified R252 with impaired cognition. During observation on 8/11/25 at 1:15 p.m., staff entered R252's room after one knock and did not introduce self or wait for a response or permission to enter. Once the staff entered the room, she looked at surveyor and turned around and left the room without a word. R252 stated, "they do that a lot. Don't wait to let me answer or tell me who they are and what they want. I don't like that at all. I think it is rude." During interview with R146 on 8/12/25 at 9:01 a.m., R146 stated, "I want people to knock and say who they are before barging into my room. Some of the staff just			F0550	Continued from page 2 The community strives to promote dignity for all residents we serve. All residents who are in need of assistance could be impacted. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Staff will be educated on the importance of knocking with introduction and waiting for a response as appropriate before entering the resident's room. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting NHA/designee will conduct an audit of 5 residents per week for 4 weeks to verify community staff are waiting for a response prior to entering a resident's room. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0550 SS = E	Continued from page 3 walk in and I don't like it. I expect them to respect my privacy and ask permission to enter my room." During observation on 8/13/25 at 8:15 a.m., two staff members entered shared resident room of R106 and R178 without knocking and announcing who they were. During interview with licensed practical nurse (LPN)-A on 8/13/25 at 8:21 a.m., LPN-A stated expectation of staff to knock, introduce themselves, and wait for permission to enter the resident room, "for privacy [sic] dignity it is their home, and you do not just enter." During interview with registered nurse (RN)-A on 8/13/25 at 8:35 a.m., RN-A stated expectation of staff to knock and "wait for response" before entering a resident room. "If I don't knock before entering it is rude because of dignity and privacy. I would not be happy if someone just walked into my house without knocking or introducing themselves. This is their home, and we need to remember to treat it as such." During observation and interview with nursing assistant (NA)-A on 8/13/25 at 9:01 a.m., NA-A entered R196 room after knocking but did not announce self or wait for response before entering the room. NA-A stated, "I should have waited for [R196] to respond before I entered the room." During observation and interview with licensed practical nurse (LPN)-B on 8/13/25 at 9:29 a.m., LPN-B knocked on door of shared room for R167 and R119 but did not wait for a response before entering the room. At 9:36 a.m., LPN-B exited the room and stated, "I did not wait for a response before entering. It [sic] important to wait for response due to privacy." During interview with director of nursing (DON) on 8/13/25 at 1:55 p.m., DON stated expectation of staff to knock on the resident door and wait for a response and permission to enter the resident room. "They [staff] should be waiting for an invite or at least knock wait and then introduce self before walking in". During interview with NA-C on 8/14/25 at 8:23 a.m., NA-C stated expectation of all staff to introduce themselves after knocking on resident's door and "wait for them to give permission to enter their room". During interview with NA-D on 8/14/25 at 8:37 a.m., NA-D stated expectation of all staff to introduce themselves and "tell them [resident] what I am there for".			F0550			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0550 SS = E	Continued from page 4 During observation and interview on 8/14/25 at 8:46 a.m., NA-E entered shared room for R69 and R77 without knocking or introducing self and waiting for permission to enter. NA-E stated, "I did not do that. It is important". During interview with R69 at 8:51 a.m., R69 stated staff "do not always knock and introduce themselves waiting for me to give permission to enter. I had an incident with an aide that walked in on me with my pants down while I was taking care of my catheter. I asked her to not do that anymore. I am adjusting to my loss of independence since my admission here. I don't like anyone coming into my room while I am naked. It is a respect thing." During observation and interview on 8/14/25 at 9:07 a.m., NA-F entered resident room without knocking and waiting for permission to enter. NA-F stated, "I did not introduce myself. We are to knock and wait for answer before entering room. For privacy." Facility policy titled Resident Rights, dated July 2025, state, "The resident has a right to personal privacy and confidentiality of his or her personal and medical records. A. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care".		F0550				
F0583 SS = D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered		F0583	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No resident has had an adverse event from the deficient practice. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice The community complies with HIPAA regulations for all residents we serve. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The community will educate Nurses, NARs, staff that resident information including NAR guides, nurses' sheets, and computer screens must be kept private when		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0583 SS = D	Continued from page 5 through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is NOT MET as evidenced by: During observation and interview, the facility failed to implement interventions to ensure residents' personal care information was kept secured and out of public view when stored on 3 of 7 facility units with mobile medication/treatment carts. This had the potential to affect 9 residents on the 2nd floor, 8 residents on the 5th floor, and 11 residents on the 7th floor whose personal information was listed on unattended care sheets. Findings include: During observation and interview starting on 8/13/25 at 8:21 a.m., licensed practical nurse (LPN)-A left an unattended resident care sheet including thirteen resident names, room numbers, information on how they take their medications, bath information, and diagnoses and information on pressure ulcer status, assistance required for transfers and applying ordered adaptive equipment and infection control precautions. The form titled 7G ODD Nurse Census Sheet was left unattended on medication cart while two residents in wheelchairs were pushed past the cart by other staff members. LPN-A returned to cart and stated, "[I] left the paper unattended on the med cart. I should flip it over so info [cannot be seen]". During interview with registered nurse (RN)-A on 8/13/25 at 8:35 a.m., RN-A stated expectation of staff to "protect [resident] information. Because of HIPAA." During interview with LPN-B on 8/13/25 at 9:36 a.m., LPN-B stated expectation of staff, "to cover care sheets for privacy. HIPAA." During observation and interview on 8/13/25 at 1:04	F0583	Continued from page 5 not near them and not in use to ensure resident health information is kept private. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 5 associates per week for 4 weeks to verify community staff are protecting resident information appropriately. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0583 SS = D	Continued from page 6 p.m., a medication cart was unattended with a resident care sheet titled EVEN SIDE TCU that included nine resident names, including room numbers, diagnoses, personal care preferences, bath and shower days. The Director of Environmental Services (D)-ES and surveyor walked by the unattended care sheet and stopped at the medication cart. D-ES pointed to it and said, “[that] should not be available because it is a HIPAA violation and patient privacy”. Registered nurse (RN)-C walked past the cart and stated, “It should not be left unattended”. RN-D approached and stated she left the unattended care sheet prior to leaving the medication cart and entering a resident room. RN-D stated, “I left it accidentally” and “[it] should not be left out here (pointing to the hallway where another staff member and resident were walking past)”. RN-D stated, “[I] should know better”. During interview with director of nursing (DON) on 8/13/25 at 1:55 p.m., DON stated expectation of staff to secure care sheets with resident information “upside down and not seen”. DON stated rationale was “Patient privacy”. During interview with NA-C on 8/14/25 at 8:23 a.m., NA-C stated, “we [nursing assistants] are told to use the computer instead of paper. Concern for patient information [being] displayed. HIPAA.” During interview with NA-D on 8/14/25 at 8:37 a.m., NA-D stated care sheets should be private and “HIPPA private information not to be visible and not anyone else’s business.” During observation and interview on 8/14/25 starting at 8:58 a.m., an unattended medication cart was observed with a resident care sheet on top titled 5G ODD Nurse Census Sheet that included eight resident names including room numbers, how they take their medications, bath and shower day details, infection control precautions, and behavior monitoring precautions. Two staff members walked past the cart along with one resident in a wheelchair. RN-E approached unattended medication cart and care sheet and stated, “I should not have left it unattended. Important for patient [sic] information is confidential.” Facility policy titled Resident Rights, dated July 2025 identified “The resident has a right to personal privacy and confidentiality of his or her personal and medical records.”			F0583			
F0641 SS = D	Accuracy of Assessments			F0641	– Address how corrective action will be accomplished		10/02/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0641 SS = D	Continued from page 7 CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded with the potential for inaccurate federal reimbursement and resident care planning for 1 of 5 residents (R218) reviewed for MDS accuracy. Findings include: R218's quarterly MDS dated 5/3/25 indicated R218 had memory problems and required assistance with personal cares. The MDS indicated under section "N0350-A: Insulin injections". R218 received 7 insulin injections during the look-back period	F0641	Continued from page 7 for those residents found to have been affected by the deficient practice No resident has had an adverse event from the deficient practice. The MDS for R218 was corrected at the time community was made aware of mistake. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice A review of residents requiring insulin injections, as identified on the most recent MDS, will be conducted to ensure accurate coding and submission. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur All nurses who are coding MDS's for reimbursement will be educated that insulin injections and oral diabetic medication are not the same and should be coded as outlined via RAI standards. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 3 MDS's per week for 4 weeks to verify diabetic medications are being coded correctly. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0641 SS = D	Continued from page 8 (LBP). R218's orders were reviewed and did not indicate orders for insulin, before or after LBP. R218 was diabetic and received two oral agents to treat her diabetes. R218's April and May's medication administration record indicated, R218 did not received insulin during LBP. During interview on 8/13/25 at 2:35 p.m., MDS coordinator verified R218 did not received insulin during LBP. MDS coordinator indicated probably the mistake was done when one of R218's oral diabetic medications was coded as insulin. MDS coordinator indicated she would complete a correction right away, because incorrect coding could affect the federal reimbursement. Facility's administrator indicated, the facility didn't have a MDS policy but followed the RAI manual.	F0641		
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services	F0645	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No resident has had an adverse event from the deficient practice. R40, R9 and R6 have had the finalized PASARRs obtained by the lead agency responsible or documented follow up for determinations that are delegated. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice The community will obtain verification from the Senior Linkage Line that all resident PASARRs are completed. If final determination has been delegated to an exterior agency the lead agency will be contacted and follow up will be documented. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The process in which follow up with the lead agency responsible for PASARRs that are not completed by the Senior Linkage Line has been clarified between the admission department and social services department. Education has been completed with both the social services department and admissions department related to the new procedures.	10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0645 SS = D	Continued from page 9 for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure a level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-Admission Screening and Resident Review (PASARR) was completed to screen for mental health needs for 3 of 4 residents (R40, R9, R6) reviewed for PAS. Findings include:			F0645	Continued from page 9 – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting NHA/designee will audit 5 new admission per week for 4 weeks the PASARR is obtained and if the final determination has been delegated, appropriate documentation is in place. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0645 SS = D	Continued from page 10 R40's quarterly Minimum Data Set (MDS) dated 5/3/25, indicated R40 was admitted to the facility on 1/28/25 and had intact cognition. The MDS indicated R40 was diagnosed with schizophrenia, post-traumatic stress disorder, and a "psychotic disorder". R40's PAS notice dated 1/21/25, indicated a copy of the PAS was included with this notice, but the PAS was not final until the lead agency sent a final determination to the nursing home. R40's entire medical record was reviewed and lacked evidence that a final determination had been received. During an interview with the director of admissions (DOA) on 8/13/25 at 9:26 a.m., the final PAS was requested, and the DOA confirmed she would review R40's medical record and provide the final PAS if able. On 8/14/25 at 10:46 a.m., the DOA stated she oversaw ensuring they had a PAS number for every resident and would sometimes reach out to the entity in charge of completing the final PAS for each resident but was unsure if she had prior to the start of the survey for R40. The DOA confirmed she had not been able to find the final PAS in R40's medical record, so she had contacted the lead agency yesterday. The DOA stated she did not keep documentation of any attempts to obtain the final PAS, so she would be unable to provide any. The DOA stated the director of social services (DOSS) assisted with ensuring the final PAS was received, and he may be able to give further information. During an interview on 8/14/25 at 10:49 a.m., the DOSS stated that admissions oversaw ensuring the final PAS was received, and his department did not assist with this. During an interview on 8/14/25 at 12:19 p.m., the administrator stated the director of admissions oversaw ensuring the final PAS was received before admission. R9's quarterly Minimum Data Set (MDS) dated 7/1/25, indicated R(9) was admitted to the facility on 11/7/24 and was cognitively intact. R9's Clinical Diagnosis Record dated 8/14/25 indicated, R9 was diagnosed major depressive disorder with severe psychotic symptoms, post-traumatic stress disorder and generalized anxiety disorder. R9's PAS notice dated 11/7/24, indicated a copy of the PAS was included with this notice, but the PAS was not			F0645			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0645 SS = D	Continued from page 11 final until the lead agency sent a final determination to the nursing home. R9's entire medical record was reviewed and lacked evidence that a final determination had been received. During interview with the director of admissions (DOA)) on 8/14/25 at 11:54 a.m., DOA stated she was responsible to make sure new residents had a pre-screening done before they were admitted to the facility. DOA stated the social worker was responsible to follow up with Senior Linkage to obtain the final determination. During an interview on 8/14/25 at 12:04 p.m., the social worker director (SWD) verified, R9's medical record did not have the final determination documentation. The SWD stated the admission team followed up to obtain the final determination. R6's admission Minimal Data Set (MDS), dated 6/30/15, identified R6 admitted to the care center on 6/25/25 and had multiple medical conditions including anxiety, major depressive disorder, bipolar, post-traumatic stress disorder, schizophrenia and traumatic brain injury. Review of R6's electronic medical record (EMR) lacked any evidence a level I Pre-Admission Screening (PAS) and, if needed, a Level II Pre-Admission Screening and Resident Review (PASARR) was completed on R6 prior to admission to the care center. During an interview on 8/13/25 at 12:15 p.m., the director of admission (DOA) stated the care facility required that the hospital submit a PAS prior to the resident admitting to the care facility. The DOA stated the admission department would be responsible for uploading the PAS, and if needed the PASARR and social services would be responsible for reviewing the documents for any needed additional services. The DOA confirmed a PAS was not completed for R6, stating there was a new admission coordinator being trained in who "missed it" [the PAS]. The facility's Pre-Admission Screening policy dated 10/22, indicated the facility would ensure a level I screening would be conducted for all applicants before admission.		F0645				
F0656 SS = D	Develop/Implement Comprehensive Care Plan		F0656	– Address how corrective action will be accomplished for those residents found to have been affected by the		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0656 SS = D	Continued from page 12 CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv) In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.	F0656	Continued from page 12 deficient practice R178's care plan was updated to reflect the resident's current plan of care related to the AFO brace. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents with an order or care plan for donning an AFO brace have been reviewed for appropriate care plan instructions and interventions. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Clinical Managers and MDS personnel responsible for updating care plans have been educated on the process of modifying a care plan with personalized interventions. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 3 residents with AFO's per week for 4 weeks to verify care plans are being updated with personalized plans of care. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0656 SS = D	Continued from page 13 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to ensure correct application of a lower extremity brace for 1 of 3 residents (R178) reviewed for the use of a lower extremity brace. Findings include: R178's quarterly Minimum Data Set (MDS) dated 5/22/25, indicated R178 had severely impaired cognition, a functional limitation in the range of motion of both lower extremities, and required staff assistance with all activities of daily living. R178's diagnosis report dated 5/21/25, indicated R178 had a diagnosis of right-sided weakness following a stroke. R178's Medical Record Attestation Statement Delayed Certification Statement dated 7/2/25, indicated the provider instructed staff to "continue" to apply the right AFO brace as R178 tolerated. The statement included no further instructions for brace use. R178's care plan dated 7/3/25, order report dated 8/8/25, and tasks dated 8/13/25, were reviewed and did not include R178's use of a right lower extremity brace. R178's Therapy to Nursing Communication dated 8/13 (with no year included), indicated R178 should wear a right ankle foot orthosis (AFO) brace for greater than four hours a day when up in the wheelchair, and skin should be checked when taking the brace off and putting it back on. During an interview and observation on 8/13/25 at 9:50 a.m., R178 was observed sitting in his wheelchair in his room with an AFO brace on his right lower extremity. Nursing assistant (NA)-I stated R178 required a "total assist" from nursing staff, and he had helped R178 get ready this morning. NA-I stated R178 had a brace for his right foot that he wore every day, only when R178 was out of bed. NA-I confirmed he had received education on how to apply the brace but was unable to find where the instructions were that confirmed when the brace was to be applied. During an interview on 8/13/25 at 10:31 a.m., the director of therapy (DOT), a physical therapy assistant, stated R178 was being seen by physical therapy earlier this year but was discharged at the end			F0656			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0656 SS = D	Continued from page 14 of May. The DOT confirmed R178 was not being seen right now by therapy. The DOT stated therapy had helped to procure the AFO brace for R178 but would need to look into what the discharge instructions were for the use of the AFO. At 12:42 p.m., the DOT stated she had reviewed R178's medical record and was unable to find the initial order for the use of the right AFO brace. The DOT stated she had found the attestation statement dated 7/2/25 saying staff were to continue using the brace but could not find the original order. The DOT stated she was supposed to ensure that when therapy had new orders for brace use, this was added to the resident's care plan, but after reviewing the medical record, this had not occurred. During an interview on 8/13/25 at 11:44 a.m., licensed practical nurse (LPN)-A confirmed that she had received education from therapy staff on when R178 was to use his AFO brace. LPN-A stated R178 was to have his right AFO brace applied when he was out of bed. LPN-A confirmed she had reviewed R178's medical record and could not find that the instructions for the use of the right AFO brace had been added to R178's plan of care. During an interview on 8/14/25 at 1:39 p.m. with the director of nursing (DON) and the DOT, the DOT confirmed the therapy to nursing communication form referenced above was from 8/13/25 and stated staff should be applying the brace when R178 was up in the wheelchair and removing it when he is back in bed. The facility's Comprehensive Care Planning policy dated 10/22, indicated the resident's comprehensive care plan would describe the offered services the resident needed to attain or maintain their highest practicable wellbeing.			F0656			
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the			F0657	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R154 had their care plan updated to reflect the current plan of care related to their AFO brace which has since been discontinued. R222 has had their care plan updated to reflect the current plan of care as it is related to their interventions and history of resident-to-resident altercations. – Address how the facility will identify other		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0657 SS = D	Continued from page 15 resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to update the plan of care 1 of 1 resident (R154) observed for position and mobility. In addition, the facility failed to revise and update a comprehensive care plan for 1 of 1 resident (R222) who had a history of resident-to-resident incidents. Findings include: R154's quarterly MDS dated 7/3/25, identified mild cognitive impairment, used a wheelchair, and had impairments on one side to upper and lower extremities. The MDS lacked identification of an adaptive device such as a brace or ankle-foot orthosis (AFO). R154's orders from admission through 8/15/25 were reviewed and lacked orders for the use of an adaptive device such as a brace or AFO. R154's occupational therapy and physical therapy evaluations and treatment plans dated 5/6/23, lacked documentation pertaining to an AFO. R154's provider visit dated 5/8/23, indicated an initial assessment and plan of care related to a history of stroke, and identified R154's left side was flaccid and an AFO was in place. R154's provider visit dated 6/5/23, identified R154 used a left boot for foot drop and required a Hoyer lift for transfers. The documentation lacked	F0657	Continued from page 15 residents having the potential to be affected by the same deficient practice Residents with an order or care plan for donning an AFO brace have been reviewed for appropriate care plan instructions and interventions. Residents who have had a resident-to-resident altercation in the past year have been reviewed to determine if the care plan interventions are necessary or if the interventions are no longer appropriate. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Clinical Managers and MDS personnel responsible for updating care plans have been educated on the process of modifying a care plan with personalized interventions and discontinuing when they are no longer appropriate. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 3 residents with AFO's per week for 4 weeks to verify care plans are being updated with personalized plans of care. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation. DON/designee will conduct an audit of 3 residents per week, who have had a history of resident-to-resident altercations for 4 weeks to verify care plans are accurate to resident centered interventions. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0657 SS = D	Continued from page 16 recommendations to continue to wear a brace on the LLE. R154's progress notes dated 10/16/23, indicated ibuprofen was administered for pain in the right lower leg and a brace was removed due to pinching. R154's care plan initiated on 7/25/24, identified a self-care deficit related to hemiplegia, impaired balance and limited mobility. A goal was set for R154 to maintain a current level of function and identified interventions to use a left leg brace for positioning. The plan also identified intervention for dressing with an assist of one staff to apply a left leg brace every morning and take off at night for positioning and protection. A provider visit dated 7/21/25, listed R154 had a diagnosis of left foot drop from 11/11/24 through present and lacked information related to AFO. R154's progress notes dated 5/5/23 through 8/13/25, were reviewed and lacked documentation related to a left leg brace/AFO. During an interview on 8/12/25 at 9:41 a.m., registered nurse (RN)-F stated R154 wore the left leg brace for positioning. During an interview on 8/12/25 at 1:49 p.m., R154 stated the brace didn't fit anymore, and they were not wearing it today. During an interview on 8/12/25 at 2:00 p.m., licensed practical nurse (LPN)-E stated R154 was supposed to wear a brace on the left leg, but only when up in the wheelchair. LPN-E stated R154 told staff the brace was bothersome and sometimes they refused to wear it, but R154 had the right to refuse the brace because it was uncomfortable to wear and because it was R154's choice. LPN-E stated therapy assessed the brace a couple of times, and the brace was appropriate for use. During an observation on 8/13/25 at 7:43 a.m., R154 was in bed, and two braces were in the corner of the room on top of a box. R154 stated the brace didn't fit them anymore, it caused pain, and it hadn't been worn all week. During an interview on 8/13/25 at 8:12 a.m., nursing assistant (NA)- G stated R154's Kardex (NA care plan) had not been reviewed but they were aware there was a leg brace on the floor. Sometimes R154 wore it, but most days R154 refused to put it on, and the nurse was notified.			F0657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0657 SS = D	Continued from page 17 During an interview on 8/13/25 at 11:58 a.m., occupational therapist (OT)-J stated R154 had been working with OT since 10/24/25, and was currently working with OT for support and mobility for the motorized wheelchair. OT-J was not aware of a left leg brace. During an interview on 8/13/25 at 12:54 p.m., director of therapy (DOT)-G stated R154's brace was for foot drop and because R154 was no longer ambulating it was no longer appropriate. DOT-G stated it was likely R154 came to the facility with the brace and stated that type of brace could only be worn a short time, or it could cause skin issues, and it should have been assessed. During an interview on 8/13/25 at 3:27 p.m., family member (FM)-T stated the brace was brought from a previous facility. R154's progress note entered by the nurse manager dated 8/13/25, identified R154's admission orders lacked documentation for the diagnosis, purpose, or function of an AFO. Furthermore, the note identified therapy assessed R154 and found the AFO was not clinically or functionally purposeful and therefore, no order was received from a provider. The AFO was determined to be in place per patient preference only and a family member confirmed R154 had the AFO for years and wore the AFO while ambulating prior to admission, however, had been unable to ambulate since admission to the current facility. The provider was updated related to the use and function of the AFO and determined no clinical indication for use, stating no need for AFO. During an interview on 8/14/25 at 12:01 pm., licensed practical nurse (LPN)-E stated R154's hadn't worn a brace/AFO for a while and that the order must have been discontinued. LPN-E confirmed there was no active order for a brace/AFO and when she called for a new order the nurse practitioner (NP) told LPN-E the brace was no longer appropriate because R154 wasn't ambulating and that the brace should be removed from the care plan. R154's family member was contacted and confirmed R154 brought the brace from a previous facility and wore it only when ambulating. LPN-E confirmed putting the brace on the care plan and that the care plan was incorrect. During an interview on 8/14/25 at 2:57 p.m., director of therapy (DOT) stated the brace for R154 was assessed in May of 2023 for about a month to ensure it wasn't causing any skin issues. Because R154 was not standing or ambulating the brace wasn't recommended for use by			F0657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0657 SS = D	Continued from page 18 therapy, it was R154's preference to wear it. The brace was then assessed for fit and skin issues in May of 2024 as R154 indicated it was causing pain. During an interview on 8/14/25 at 3:21 p.m., physical therapist (PT)-K stated a brace or AFO would need a provider order and therapy would assess the fit. Because R154 required a Hoyer lift and not ambulating the brace would not be appropriate. PT-K stated it was most likely that R154 received the AFO from a previous facility when ambulating. PT-K reviewed R154's therapy records and confirmed records reviewed from May 2023 lacked documentation regarding any assessment of a brace or AFO upon admission but could confirm the AFO was assessed a year later in May of 2024. During an interview on 8/14/25 at 4:36 p.m., the director of nursing (DON) stated R154's brace was brought from a previous facility, and it was R154's preference to wear the brace/ AFO. DON verified no provider orders were ever written for the use of the brace/AFO because there were no indications for its use since R154 no longer ambulated. The DON stated R154 chose to be in bed most days and preferred not to wear stockings, so the brace/AFO would be more of a risk than benefit because of the rigidity of the brace and the risk of skin breakdown. The DON stated care plans were created with input from the floor nurse and recommendations made by therapy. The recommendations were discussed with the resident and if the resident agreed the interventions were added to the care plan. The DON confirmed that the expectation was that if a care plan could not be followed or interventions were no longer working the nurse should be notified and the care plan updated. R222's annual Minimum Data Set (MDS) dated 5/23/25, indicated moderate cognitive impairment and did not have behaviors. R222 had impairment to both lower extremities and required setup or clean-up assistance for eating, substantial/maximal assistance for transfers, and independent with wheelchair mobility. R222's diagnoses included aphasia, non-Alzheimer's dementia, and anxiety. R222's care plan focus area behavior/mood dated 7/7/25, included interventions dated 1/23/25 which directed staff to prevent opportunities for physical aggression, which may include considering proximity to others at meals, during activities, in the hall, and when moving throughout the unit and dated 7/7/25 which directed R222 to sit at the same table and spot daily and other residents may sit across from R222 but not next to her.			F0657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0657 SS = D	Continued from page 19 R222's progress notes indicated: -1/16/25, resident had increased behaviors and was combative with another resident and was removed from the common area for her safety. -1/20/25, resident was moved to another floor, and resident and family agreed with the move. -Further progress notes did not mention any other resident-to-resident incidents. R222's Associated Clinic of Psychology (ACP) Progress Note dated 1/17/25, indicated the facility informed ACP R222 struck another resident on the wrist. The progress note indicated R222 did not recall striking another resident, denied interpersonal stressors, fearfulness, and anger, and may benefit from behavioral monitoring. The progress note encouraged staff efforts to prevent opportunities for physical aggression, which may include considering proximity to others at meals, during activities, in the hall, and when moving throughout the unit. R222's ACP Progress Note dated 7/15/25, indicated R222's mood and behaviors appeared "largely stable today". During observation on 8/11/25 at 11:39 a.m., R222 attended an activity, and residents were on both sides of her within arms' reach. During observation on 8/11/25 at 12:36 p.m., R222 sat at a square table with three other residents. Residents were within arms' reach. During interview on 8/13/25 at 1:43 p.m., nursing assistant (NA)-K stated they looked at the electronic care plan to know information about a resident. During observation on 8/14/25 at 8:34 a.m., R222 sat at the end of a table with two other residents within arms' reach for breakfast. During interview on 8/14/25 at 9 a.m., NA-H verified R222 sat within arms' reach of other residents and stated R222 had no special interventions in the dining area. R222 stated there were certain people R222 did not like to sit near, such as those who shouted. NA-H stated they verbally communicated to other staff who R222 liked or did not like to sit next to, or other staff already knew about R222's seating preferences.			F0657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0657 SS = D	Continued from page 20 During interview on 8/14/25 at 10:43 a.m., licensed practical nurse (LPN)-G stated R222 did not have physical altercations with other residents and more often yelled at other residents when behavioral. LPN-G was not aware of the care planned interventions for R222 to not sit next to other residents and only across from other residents. LPN-G confirmed R222 sat next to other residents in the dining area. During interview on 8/14/25 at 5:00 p.m., the director of nursing (DON) stated it was important to honor R222's seating choices, protect R222, and make sure staff implemented care planned interventions. The DON was not aware of R222's resident-to-resident incident history and would look further into R222's history and care planned interventions. The DON stated the interdisciplinary team (IDT) worked together to review and update resident care plans. During a follow-up interview on 8/15/25 at 8:09 a.m., the DON stated R222 no longer engaged in aggressive behaviors, was seen by ACP, and was going to discontinue the intervention(s). The facility's Comprehensive Care Planning policy dated January 2024, directed staff to develop, review, and revise each resident's comprehensive care plan based on the results of the comprehensive assessment. The policy directed staff to update the care plan when a problem, goal, or approach was no longer appropriate or resolved.			F0657			
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure routine personal hygiene (i.e., nail care) was completed and provided to reduce the risk of complication (i.e., infection, skin scratches) for 1 of 1 residents (R87) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. Findings include: R87's annual Minimum Data Set (MDS) assessment, dated			F0677	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R87 had their nails trimmed and cleaned. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents who are dependent for nail care will be reviewed for cleanliness and length. Appropriate documentation is in place for those who have refused or have care planned preferences. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0677 SS = D	Continued from page 21 6/14/25, identified R87 had moderately impaired cognition with physical behavioral symptoms (hitting, kicking, pushing, scratching, grabbing, abusing others sexually) occurring 1-3 days that do not put resident at significant risk for physical illness or injury and do not significantly interfere with resident's care or participation in activities or social interactions. MDS identified rejection of care was noted 1-3 days during look-back period and there were no changes in behavioral symptoms since last MDS assessment. MDS identified R87 was dependent on staff assistance for shower/bathing needs and required setup/cleanup assistance from staff for personal hygiene needs. R87's care plan, printed 8/14/25, identified R87 required assist of staff for bathing/showering, trim and clean nails on bath days and as needed, and report any changes to the nurse, and for personal hygiene was independent and offer assist of 1 staff as needed. Furthermore, the care plan indicated the resident was resistive to accepting showers from specific staff members with the following interventions: allow resident to make decisions about treatment regime; if resident resists with ADLs, reassure resident, leave and return 5-10 minutes later and try again; provide consistency in care to promote comfort with ADLs. R87's progress notes reviewed for 7/10/25 to 8/13/25 and indicated the following: -8/5/25: weekly skin evaluation completed and residents' skin intact. No other comments. -7/24/25: "the resident refused skin evaluation. Education/encouragement provided to resident regarding skin evaluation," with a comment of "resident refused shower." -7/17/25: weekly skin evaluation completed and residents' skin intact. No other comments. -7/10/24: weekly skin evaluation completed and residents' skin intact. No other comments. The progress notes lacked any evidence of offering R87 nail care or refusals of nail care. During interview and observation on 8/11/25 at 1:52 p.m., R87 was observed to have long fingernails that were about a quarter inch long with dark colored debris underneath them. R87 stated, "no one has done anything with them for a while...they should do that." R87 stated staff trim his fingernails for him.	F0677	Continued from page 21 Nars and nurses will be informed that nail care is scheduled with the resident's shower day. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 5 residents per week for 4 weeks to verify community staff are providing appropriate nail care or documenting refusals appropriately. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0677 SS = D	Continued from page 22 During an observation on 8/13/25 at 10:14 a.m., R87 was observed ambulating with a walker in the hallway. R87's fingernails were observed to long with dark colored debris underneath them. During an interview on 8/13/25 at 10:29 a.m., licensed practical nurse (LPN)-I stated they were familiar with R87. LPN-I stated nail care was to be done on shower days, and the nursing assistants provided the nail care unless a resident was diabetic, then a nurse trimmed the resident nails. LPN-I stated there was no place in the electronic medical record where it was documented that nail care was completed including on the skin assessment. LPN-I reviewed documentation for nursing assistants and verified that nail care was not documented. LPN-I stated again, "I don't document anywhere when I do nail care." During an interview on 8/13/25 at 11:57 a.m., nursing assistant (NA)-M stated they were familiar with R87. NA-M stated R87 needed assist of 1 staff with cares and showers. NA-M stated nail care was done during showers typically but could be done anytime. NA-M stated R87 would refuse assistance at times. NA-M went and met with R87 to observe fingernails. NA-M stated R87 are "kind of long," "need to be cut," and "have dark stuff under his nails." NA-M stated she would have thought they would have been trimmed during his shower last Thursday. R87 told NA-M that NA-M could cut his nails after lunch as lunch was just about to arrive. During an interview on 8/14/25 at 1:22 p.m., quality assurance registered nurse (QA) stated the expectation would be that a resident would be offered to have their nails trimmed during their weekly shower/bath at a minimum. QA stated if they noticed their nails needed to be trimmed in between that time they would reapproach them. QA stated, "we don't document this as it is a standard of practice and it's routine." During an interview on 8/14/25 at 3:00 p.m., director of nursing (DON) stated the expectation regarding a resident's nails would be to follow the residents' preferences such as if they preferred to have longer fingernails, that would be ok but staff would support the resident to help keep the nails clean. DON stated she was unaware of a place where nail care was being documented in the electronic medical record but stated if a resident was continually refusing nail care, that would be documented in the EMR. A facility policy titled Activities of Daily Living (ADLs), dated August 2024, indicated "a resident who is unable to carry out activities of dial living will			F0677			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0677 SS = D	Continued from page 23 receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.”	F0677		
F0679 SS = D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure a therapeutic recreation assessment was addressed in the electronic medical record (EMR) and care planned to ensure a resident was offered appropriate activities for engagement while at the care facility for 1 of 2 residents (R76) reviewed for activities. Findings include: R76 's admission Minimal Data Set (MDS), dated 7/24/25, indicated R76 was admitted to the care center on 7/22/25 and was cognitively intact. R76's Activity Interview for Daily and Activity Preferences, dated 7/24/25, included a question "How important is it to you to listen to music you like?" which indicated R76 answered "Very Important" R76's Therapeutic Rec/Life enrichment Assessment, dated 7/24/25, which had boxes to fill in resident information such as past work experience/professions, religious preferences and current or past interest and hobbies, was left blank with "will enter info 7/26/25" typed in to the first blank box of the assessment. A completed paper form of the same assessment was received during survey on 8/14/25 with a date of 7/24/25. R76's care plan, dated 8/13/24, lacked an activity section used to inform staff of R76's activity preferences and goals.	F0679	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R76 had his therapeutic recreation assessment and care plan updated on 8/14/2025. Along with a radio provided per resident's request. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice An audit of admissions in the last 30 days was completed to ensure residents have a therapeutic recreation assessment and care plan completed within the assessment schedule. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Therapeutic Recreation staff have been educated on expectations of the assessment schedule. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting Therapeutic Recreation Direction will conduct an audit of 5 residents per week for 4 weeks to verify assessments, care plans, and interventions are added per appropriate timelines. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation	10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0679 SS = D	Continued from page 24 R76's electronic medical record lacked evidence of life enrichment activities being offered or provided to R76. During an interview on 8/11/25 at 4:18 p.m., R76 stated he would like a radio in his room to keep him entertained as he does not like group activities. R76 stated he informed a "few different" facility staff members he would like a radio however never heard back. R76 stated, "you ask and things never happen." During observation on 8/12/25 at 3:01 p.m., R76 was sitting in his wheelchair in his room, no music or television on in his room, asleep in his wheelchair. During observation on 8/13/25 at 11:16 a.m., and again on 8/14/25 at 8:18 a.m., R76 was sitting in a quiet room, asleep in in his wheelchair without any television, music or other type of activity or stimulation. During an interview on 8/14/25 at 8:28 a.m., the Director of Therapeutic Recreation (D-TR) stated the initial therapeutic recreation assessment was divided between the three therapeutic recreation staff, stating the department was a bit short staff but they tried to ensure everyone was assessed and care planned for appropriate activities. The D-TR stated the department had plenty of leisure activities for residents, including radios, which should be discussed with the resident during the initial assessment. During a follow up interview on 8/14/25 at 9:28 a.m., the D-TR confirmed R76's initial therapeutic recreation assessment in the EMR was blank and the care plan lacked an activities section. The D-TR stated she spoke with R76 that morning, brought him a radio and apologized for the delay. The D-TR also stated she completed his therapeutic recreation assessment. A facility policy titled Activities, dated 10-2024, indicated the admission assessment for therapeutic recreation should be completed within 14 days of admittance to the care facility. The policy further identified the activities department was an "integral part of interdisciplinary care planning."		F0679				
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.		F0684	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. R20 has been discharged from the facility with hearing aids in his possession. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice.		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0684 SS = D	Continued from page 25 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to ensure hearing aids were routinely applied or offered daily for 1 of 1 resident (R20) reviewed who had severe hearing loss. Findings include: R20's quarterly Minimum Data Set (MDS) dated 5/13/25, identified R20 with intact cognition, did not reject cares, required hearing aids, and diagnoses of paralysis due to a stroke affecting his non dominant side, hepatitis, seizures, anxiety, and depression. R20's care plan (CP) dated 5/1/25, identified HEARING LOSS: Resident has bilateral hearing loss with Goal of "Staff to assist res with placement of hearing aids in bilateral ear". During observation and interview with R20 on 8/11/25 at 1:38 p.m., R20 was lying in bed without hearing aids. R20 asked State Surveyor several times to speak louder. R20 stated he did not know where his hearing aids were. R20 stated, "I need to have my hearing aids to hear. No one told me where they are." During interview with nursing assistant (NA)-B on 8/12/25 at 2:06 p.m., NA-B stated expectation of nursing assistants to look at resident care sheet to inform them of what assistance was needed, bath or shower days, oral status, bowel and bladder status, rehabilitation needs and miscellaneous information for each resident in addition to receiving verbal report from outgoing shift. NA-B stated "I put hearing aids in if the care plan tells me to. [R20] used to have them." NA-B walked to R20's room and looked around, "It is not here. I did not put them in this morning" and stated she did not inform the nurse of missing hearing aids. NA-B stated she could not remember when the last time she saw R20's hearing aids. "Could have been a few weeks or last month. I don't know." During interview with registered nurse (RN)-I on 8/12/25 at 2:18 p.m., RN-I looked in R20's electronic medical record (EMR) and said, "I see it in the care plan. It does say he has hearing aids." RN-I walked to R20's room and looked around and said, "not in there." RN-I said she did not check with R20 at start of shift to see if he had his hearing aids. "I should have. He went whole day without them. I don't have them in the medication cart either. I do not know where they are. I did not receive report or information that they were	F0684	Continued from page 25 All residents with hearing aides have been reviewed. Their care plans are up to date with the preferences for storage. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. Clinical Managers who are responsible for updating care plans when residents refuse hearing aids have been educated about updating the care plan related to storage should a resident request them in the future. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting. DON/designee will conduct an audit of 5 residents per week for 4 weeks to verify care plans related to hearing aids are accurate. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0684 SS = D	Continued from page 26 missing or put somewhere.” During interview with licensed practical nurse (LPN)-C on 8/12/25 at 2:33 p.m., LPN-C stated as her role of nurse manager she had possession of R20's hearing aids. LPN-C stated, "I have them in my office. I have had them a couple weeks.” LPN-C looked in R20's EMR and verified there was no communication with R20 or staff to inform them of location of R20's hearing aids. LPN-C stated, “I forgot to put in note. It should be in the care plan where the hearing aids are. I should update the care plan, so staff know.” During interview with Director of Nursing (DON) on 8/13/25 at 2:24 p.m., DON verified R20's EMR failed to identify LPN-C having secured his hearing aids and providing report to staff or to R20 verbally or in a progress note of this action. Facility policy on quality of care was requested but not received.	F0684		
F0692 SS = D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review,	F0692	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R214 has been reviewed by the RD, and interventions are appropriate. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents who have had a weight loss greater than 5% in the last 30 days have been reviewed by the RD's on staff to ensure appropriate interventions. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Nursing assistants will be re-educated on the process related to delivering room trays and verification that no residents are missed for meals, unless out of the building. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting	10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0692 SS = D	Continued from page 27 the facility failed to ensure residents had received ordered meals to increase calorie intake and weight per provider orders for 1 of 5 resident (R214) reviewed for nutrition and weight loss. Findings include: R214's comprehensive Minimum Data Set (MDS) assessment dated 5/23/25, identified R214 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R214 was dependent on staff for activities of daily living (ADL's) and needed assistance from staff for set up/clean-up for eating. Pertinent medical diagnoses included traumatic brain dysfunction, quadriplegia (a medical condition described as paralysis of all four limbs), diabetes melilites (DM), osteoporosis, cerebrovascular accident (CVA--a sudden interruption of blood supply to the brain that caused brain cells to be deprived of oxygen and nutrients which led to brain damage, loss of function or death), seizure disorder, and malnutrition. R214 had one, stage three and one stage four pressure ulcer as well as one moisture associated skin damage (MASD) wound. R214's assessment documented their height as 66 inches and 128 pounds. R214's provider orders dated 10/14/24, identified a consistent carbohydrate diet, regular texture with thin consistency. R214's weight summary report identified on 7/1/25, R214's weight was 131.1 pounds and on 8/1/25, they weighed 123.1 pounds, a difference of 6.10% weight loss which indicated severe weight loss according to the Centers for Medicaid/Medicare Services (CMS). R214's care plan last reviewed on 5/17/25, identified a self-care deficit and they required total assist of one staff with eating. Additionally, nutrition was identified as a focus with interventions including explain and reinforce the importance of maintaining the diet ordered, encourage compliance, explain the consequences of refusals as it related to obesity/malnutrition risk factors. Food and beverage preferences were small warm milk for breakfast with cornflakes, no lactose in milk/cheese/sour cream/yogurt/pudding. Staff were directed to monitor and record/report to provider any signs of malnutrition, muscle wasting or emaciation. The guidelines for staff were significant weight loss: three pounds in one week, greater than five percent in one month, greater than seven and on half percent in three months, greater than ten percent in six months. Staff to provide supplements as ordered: Argiment (a			F0692	Continued from page 27 NHA/designee will audit 5 residents for 4 weeks to ensure that residents who have had weight loss have been offered all meals. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0692 SS = D	Continued from page 28 nutritional supplement) twice daily, ProSource 30 cubic centimeters (cc) three times per day, a sandwich at bedtime and drink of choice, and ensure this was given twice daily. Staff were to provide snacks as needed and as requested, provide and serve diet as ordered, monitor intake, and record every meal. Registered dietician to evaluate and make diet changes recommendations as needed. R214's Nutrition Screen and Assessment dated 5/18/25, identified high risk nutritional status related to multiple pressure ulcers, bilateral wounds, and sacral wounds. R214's diet order was consistent carbohydrate diet, regular textures, thin liquids, lactose intolerant. R214 was mostly independent with set up and assist as needed. R214 liked warm milk with his cornflakes in the morning. R214 spoke Spanish and the kitchen was contacted about menus in Spanish. Nutritional supplements were identified as Argiment twice a day, Prosource 30 cc three times a day, peanut butter and jelly every day. A box labeled unintentional weight loss in past three months was marked YES and documented weight on 5/1/25 was 127.9 pounds and on 4/1/25 weight was 129.8 pounds. R214's goal weight was 145 pounds and had a body mass index (BMI) of 20.6. R214's Nutrition Screen and Assessment dated 8/12/25, identified high risk nutritional status for skin healing. R214's diet order was consistent carbohydrate diet, regular textures, thick liquids. R214 liked warm milk with their cornflakes in the morning. Resident was independent with eating. A box labeled unintentional weight loss was marked NO and indicated weight on 8/1/25, R214 was 123.1 pounds and had a BMI of 19.9. Goal weight was set at "maintain weight". A note in the comment section read "Gradual weight loss". During an observation and interview on 8/13/25 at 10:13 a.m., R214 had no breakfast tray in the room and dining aid (DA)- B stated breakfast was finished today at 9:15 a.m., all meals were served and pointed to the dining cart pushed back against the wall. R214's Nutrition Amount Eaten/Drank dated 7/31/25 through 8/14/25, indicated the resident refused breakfast on 8/12/25 and refused all three meals on 8/13/25. During an observation and interview on 8/13/25 at 1:30 p.m., R214 was in the dining room seated in a wheelchair. Nursing assistant (NA)-G brought over a tortilla and beans. R214 stated breakfast was never delivered. He stated the aid came in for repositioning at 8:00 a.m., and the meal was requested but never		F0692				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0692 SS = D	Continued from page 29 received. R214 identified NA-G as their assigned aid. During an interview on 8/13/25 at 1:31 p.m., NA-G stated R214 didn't generally eat breakfast and was unsure who was supposed to pass the tray, but then stated it was busy, and two rooms did not get trays. NA-G stated the other aid was supposed to pass the trays and they would pick them up. During an interview on 8/13/25 at 1:33 p.m., registered nurse (RN)-A was standing at the medication cart and stated they were not sure who was supposed to pass room trays today. During an interview on 8/14/25 9:45 a.m., the administrator stated if the facility heard a resident wanted a meal staff would get them food. Anyone could call down to the kitchen and get a meal at any time. The staff work closely with the kitchen, a dining ticket could be reprinted, and a new meal could be delivered. The administrator was unsure what would happen if a resident was unable to call the kitchen or advocate for themselves and stated the expectation was that all residents received their ordered meals and that the dining ticket matched what was served. During an interview on 8/14/25 at 10:53 a.m., registered dietician (RD)-L stated R214 was trialing many interventions for weight gain and wound healing. R214 received warm milk and cornflakes for breakfast every day and had agreed to try scrambled eggs. R214 accepted a new supplement this morning to replace the Ensure and has agreed to the new supplement three to four times a day. RD-L stated it was very important R214 received meals and supplements for weight gain and wound healing and was surprised R214 hadn't gained weight with all the interventions and supplements in place. During an interview on 8/14/25 at 11:18 a.m., licensed practical nurse (LPN)-F stated all aids had assigned groups and if they were new the other aids would explain their duties at the start of the shift. LPN-F was not aware of any residents that hadn't received a meal, but ultimately the aid assigned to the group of residents would be responsible for passing the tray. During an interview on 8/14/25 at 12:20 p.m., licensed practical nurse (LPN)-E stated two aids split their assigned group and one passed the trays and the other picked up the trays. There was no document that assigned this task, the nursing assistants communicated the duties. It was very important that residents received their meal trays because everyone needed to	F0692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0692 SS = D	Continued from page 30 eat for weight gain and wounds. The expectation was that staff deliver all meals and document all refusals. LPN-E stated the aid that documented R214 refused breakfast on 8/12/25 and all three meals on 8/13/25 needed education on documentation and confirmed the documentation for this meal was incorrect. A policy, Meals Service dated 1/25, identified the purpose was to ensure all meals are served timely and proper food temperatures and maintained. To ensure that residents have the assistance needed to consume their meals. Procedure: Identify each resident. Check the diet card against the items on the tray for accuracy and food preference. Replace missing food items if necessary.	F0692		
F0699 SS = D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to follow care planned interventions to prevent re-traumatization for 1 of 1 resident (R6) reviewed for trauma informed care who was diagnosed with post-traumatic stress disorder and had identified triggers. Findings include: R6's admission Minimal Data Set (MDS), dated 6/30/15, identified R6 admitted to the care center on 6/25/25 and had multiple medical conditions including anxiety, major depressive disorder, bipolar, post-traumatic stress disorder (PTSD), schizophrenia and traumatic brain injury. R6's brief interview for mental status (BIMS) assessment, dated 7/1/25, indicated R6 was cognitively intact. R6's trauma history assessment, dated 7/1/25, identified R6 had a history of sexual abuse by males at a young age and could not be in the same room as another male with the door closed. R6's care plan, dated 7/1/25, indicated R6 reported childhood sexual abuse at the hands of two older males, making him distrust the majority of males he has worked with since this event. An intervention, dated 7/1/25, indicated R6 preferred	F0699	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R6 has appropriate, person centered, interventions. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents are assessed for trauma upon admission, quarterly, annually and with change of condition. Personalized interventions are care planned and relayed to staff as appropriate. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Nursing Staff will be re-educated on the importance of implementing trauma-informed interventions for residents. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 5 residents per week for 4 weeks to verify interventions are begin followed appropriately. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation	10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0699 SS = D	Continued from page 31 to avoid male caregivers due to past abuse. During an interview on 8/11/25 at 1:37 p.m., R6 stated he had been having some anger issues due to feeling like he was not getting the physical care he needed and not feeling like facility care staff were taking his PTSD seriously. R6 stated there were still males entering his room alone. R6's Associated Clinic of Psychology (ACP) note, dated 8/6/25, indicated R6 was "very angry" with "anger issues". The ACP provider stated R6 could not tolerate male staff in his room and preferred female caregivers and physical and occupational staff. The note indicated honoring female staff was "important for staff safety." During observation on 8/11/25 at 1:10 p.m., an unnamed male entered R6's room with his lunch tray and closed the door after he entered to discuss R6's lunch choices with him. During an interview on 8/13/25 at 7:54 a.m., nursing aide (NA)-O (a male aide) stated he often helped R6 "when he need[ed] it." NA-O stated R6 was fairly independent with his activities of daily living but at times would need assistance in the bathroom and would call for help. During an interview on 8/13/25 at 9:17 a.m., NA-P stated she had been working at the care facility for about one year and was only aware of one resident on the unit (not R6) who had a preference for female caregivers. During an interview on 8/13/25 at 7:58 a.m., NA-Q stated she worked in a different unit but would come over to assist another resident (not R6) who preferred female only caregivers. NA-Q stated there were no other residents on the unit who only wanted female caregivers. During an interview on 8/13/25 at 10:42 a.m., registered nurse (RN)-J, referencing the care sheets (used by staff which contained resident specific information such as diagnoses, bath days and any special treatment such as wound care, oxygen use or preference for specific caregivers), and stated there was only one resident on second floor (not R6) that had a preference for female only caregivers. The sheets lacked any information regarding R6 preferring female only caregivers. During an interview on 8/13/25 at 11:00 a.m., R6 stated "I don't feel safe at times" further elaborating that male staff continued to come into his room despite him voicing his past trauma and distrust of men. During an interview on 8/14/25 at 10:51 a.m., nurse manager and RN-K confirmed the careplan and kardex (aide care plan) identified R6 as preferring female only staff, stating it would be expected that staff were aware and following R6's preferences. During an interview on 8/14/25 at 11:25 a.m., R6's ACP provider stated R6 often made threatening statements, and his preference for not wanting med in his room was			F0699			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0699 SS = D	Continued from page 32 associated with his history of abuse. The ACP provider stated, "for his [R6] well-being and staff safety, males should stay out [of his room]." A facility policy on behavioral management and trauma informed care was requested but not received.		F0699				
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication errors were prevented for 2 of 2 residents (R138, R30) observed during medication administration. This resulted in a medication error rate of 7.14% (percent) with two errors out of 28 opportunities. Findings include: R138 R138's admission Minimum Data Set (MDS) dated 5/20/25, indicated intact cognition and diagnoses of anemia, atrial fibrillation, heart failure, hypertension, hyponatremia, hyperlipidemia, non-Alzheimer's dementia, and malnutrition. The MDS indicated R138 had a feeding tube. R138's provider order dated 5/6/25, indicated R138 required potassium chloride (used to treat and prevent low potassium levels in the body) ER (extended-release) 10 mEq (milliequivalents) via PEG-tube (percutaneous endoscopic gastrostomy tube; a tube passed into the stomach through the abdominal wall) one time a day with instructions to dissolve in water. During observation and interview on 8/13/25 at 8:14 a.m., licensed practical nurse (LPN)-H prepared R138's medications. All tablets were crushed, including potassium extended release, and each medication was placed in separate medication cups. LPN-H added water to each medication cup and flushed R138's PEG-tube before medication administration, between each		F0759	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R138 had no adverse impact due to this deficient practice. A med error report will be completed. R30 had no adverse impact due to this deficient practice. A med error report will be completed. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents who take medications have the opportunity to be impacted. Yet, the process to educate all licensed nurses will remediate the situation for like residents. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Licensed Nurses and Trained Medication Aids will be educated on the 6 rights of medication administration. Licensed Nurses will be educated on updating providers if resident's preferences for medication administration change. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 5 residents per week for 4 weeks to verify to verify the 6 rights of med administration are followed. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0759 SS = D	Continued from page 33 medication, and after medication administration. LPN-H verified they crushed all tablets given to R138 and knew what medications could or could not be crushed based on nursing school and a nursing drug book. During interview on 8/14/25 at 10:39 a.m., (LPN)-G stated extended-release potassium should be dissolved in water if by the “book”. R30 R30’s significant change in status MDS dated 7/16/25, indicated R30 had intact cognition and diagnoses of benign prostatic hyperplasia and kidney disease. R30’s provider order dated 4/10/25, indicated R30 required two capsules of tamsulosin hydrochloride (helps to improve urination and reduce discomfort for men with enlarged prostate.) 0.4 mg (milligrams) by mouth one time a day and specified to give after a meal. During medication administration on 8/13/25 between 9:13 a.m. and 9:28 a.m., registered nurse (RN)-B prepared R30’s medication which included tamsulosin. RN-B entered R30’s room and R30 was still eating breakfast. R30 took all medications and continued his meal. During interview on 8/13/25 at 11:59 a.m., RN-B stated provider orders indicated what medications were given before, during, or after meals. RN-B reviewed R30’s orders and stated R30 stated he wanted all his medications at the same time during previous interaction. RN-B stated they would update the provider, and staff would update the care plan. During interview immediately after above interview, LPN-C expected staff to honor resident choices for medications and update the provider. During interview on 8/14/25 at 5:00 p.m., the director of nursing (DON) expected staff to dissolve instead of crush potassium chloride extended release. The DON expected staff to follow the doctor’s orders and update a provider if a resident preferred to take medication in a way different than ordered. During interview on 8/15/25 at 7:16 a.m., the consultant pharmacist (CP) stated crushing potassium extended release was advised against or discouraged due to compromising the extended-release function of the medication. CP stated abrupt release of potassium could cause irritation of the GI (gastrointestinal) tract.		F0759				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0759 SS = D	Continued from page 34 The CP stated tamsulosin given during a meal instead of 30 minutes after a meal decreased the medication effectiveness by potentially decreasing the absorption rate and peak level of the medication. Tamsulosin given after a meal decreased side effects, such as low blood pressure and dizziness. The facility's Medication Administration policy dated May 2025, directed staff to verify resident name, medication name, form, route, and time. The policy directed staff to administer medications per provider orders and administer medication as ordered in accordance with manufacturer specifications.		F0759				
F0791 SS = D	Routine/Emergency Dental Srvcs in NFs CFR(s): 483.55(b)(1)-(5) §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink		F0791	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R87 was by the dentist S. Johnson DDS on 8/14/2025. Who documented, “a prosthodontist is not recommended at this time because pt. Would not be able to tolerate having denture in his mouth.” – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents who see the dentist have the potential to be impacted. Residents who have seen the dentist in the last 180 days will be audited to ensure clarity whether a referral to a specialist is warranted or not. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur HIM and HUCs will be educated on the importance of scheduling dental follow up appointments timely. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting DON/designee will conduct an audit of 5 residents per week for 4 weeks to verify dental notes/referrals are followed up. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0791 SS = D	Continued from page 35 adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure identified dental concerns (i.e., need for dentures) were acted upon and, if needed, referred to the appropriate resource in a timely manner for 1 of 2 residents (R87) reviewed who voiced dental concerns. R87's annual Minimum Data Set (MDS) assessment, dated 6/14/25, identified R87 had moderately impaired cognition. Further, the MDS identified a section labeled, "L0200," along with spaces to record no natural teeth or tooth fragments(s) (edentulous). This was answered, "None of the above were present." Further, R87's Clinical Census report, printed 8/14/25, identified R87's current payor source listed as, "Medicaid MN." During an interview on 8/11/25 at 1:52 p.m., R87 stated, "I don't have any dentures, and I want to wear dentures." R87 explained the facility was supposed to make arrangements for getting her dentures "but that was a long time ago." Furthermore, R87 stated he was limited on what he can eat due to not having teeth/dentures. R87's care plan, printed 8/14/25, identified R87 was independent with oral care, had no natural teeth and "only two root-tips present #20, 21." Furthermore, it indicated R87 had expressed interest in getting dentures with the following interventions: coordinate arrangements for dental care, transportation as needed; follow up with dental for denture creation, placement, and fitting as needed (date initiated on 7/30/25) and diet as ordered. Further, identified R87 "Likes: Jello with his dinner, has a stash of it and buys food at the vending/gift shop per CNA (certified nursing			F0791			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0791 SS = D	Continued from page 36 assistant). Likes Mountain Dew, Sweet Tea, Jello, mashed potatoes, little protein” and “Food/beverage preferences: Likes: pancakes, frosted flakes, frozen meals, potatoes, tilapia, ranch dressing, chocolate pudding, jello” with a regular diet with regular texture and thin liquids. R87’s progress notes, dated 2/10/25 to 8/13/25, reviewed and identified the following: -3/13/25: Therapy note: R87 “was seen extensively for swallowing skills. He is able to safely consume level 5/0, minced and moist and thin liquids. This is due to his lack of teeth and his preference for softer foods. He has many food preferences and likes to discuss these at length. He is sometimes nonsensical with his preferences and contradicts himself. He reports that he is only able to consume mashed potatoes. Recommend a dental consult for dentures.” The progress notes lacked any additional information of R87 dental appointments for dentures. Furthermore, lacked any evidence of R87 not wanting to proceed with dentures. R87’s Chart Progress Note, dated 3/14/25, indicated R87 was seen for dental exam and completed a step in the denture making process which R87 tolerated well. R87’s Chart Progress Notes, dated 3/27/25, indicated R87 was seen for denture fabricating process. R87 had some difficulty tolerating this step in the process and it was recommended if R87 wanted to proceed with dentures a referral would be made, at any time, to a specialist. R87’s Oral/Dental Assessment Form, dated 5/2/25, indicated R87 had no natural teeth or tooth fragments(s). Furthermore, assessment notes indicated “Pt (patient) would like dentures.” The notes to nursing staff for follow up/care conferences indicated, “Pt would like denture, so please help me schedule.” R87’s Care Conference Summary, dated 6/18/25, identified R87’s most recent dental appointment was 5/2/25. Furthermore, indicated “resident stated that he would like dentures but has been unable to tolerate plate used for denture fabrication d/t (due to) discomfort on two separate occasions. Dentist noted that if he cannot tolerate this process, he would likely be unable to tolerate dentures. Appointment will be made if resident wants to attempt denture process again.”			F0791			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0791 SS = D	Continued from page 37 R87's physician's provider note, dated 7/28/25, indicated "requests dentures-order for dentistry referral." During an interview on 8/13/25 at 2:25 p.m., licensed practical nurse (LPN)-I stated they were familiar with R87. LPN-I verified R87 did not have any teeth or dentures. LPN-I stated R87 was currently being seen by in-house dental services and in the process of having dentures being made as he had expressed numerous times the desire to have dentures. LPN-I stated R87 has expressed the desire to eat “regular” food and has not been able to due to not having dentures. LPN-I stated the dentist came every Friday and hopefully R87’s dentures would be ready soon but was unsure of where they were in the process. LPN-I stated R87 talked about dentures frequently and the desire to have them. On 8/14/25 at 10:36 a.m., nursing assistant (NA)-N stated R87 did not have dentures, however NA-N stated they didn't typically work with R87. On 8/14/25 at 10:40 a.m., family member (FM)-A stated R87 had been talking about wanting dentures for some time. FM-A stated they visit R87 frequently and have heard R87 tell staff he would like dentures. FM-A stated he was aware that the dentist was in the process of making dentures for R87 but had not been updated in the last 3 months or so about the process. FM-A stated they were to be notified with any changes with R87 or concerns. During an interview on 8/14/25 at 11:32 a.m., director of health information management (HIM) stated she was responsible for following up with in-house dental services. HIM reviewed R87’s electronic medical record (EMR) and stated when R87 was last seen by in-house dental services on 3/27/25, he did not tolerate part of the process of making dentures, he may need to be seen by a specialist and to follow up as needed. HIM verified, after reviewing of EMR, R87 had expressed desire to get dentures after that appointment. During an interview on 8/14/25 at 1:25 p.m., quality assurance registered nurse (QA) stated residents were assessed upon admission and on an on-going basis for dental needs and referrals were made as needed. QA stated if a resident expressed the desire or needed dentures, then a referral would be made and followed up on. QA stated she was going to follow up regarding on R87. No further documentation was provided. During a follow-up interview on 8/14/25 at 2:31 p.m., HIM stated R87 was added to the dental schedule today		F0791				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0791 SS = D	Continued from page 38 and seen for denture fabricating process. HIM verified R87 was added to today's (8/14/25) schedule after visiting with surveyor earlier today and had not been scheduled to be seen. HIM verified there was no additional documentation as R87 had not been seen for follow up after expressing desire for dentures. During an interview on 8/14/25 at 3:03 p.m., director of nursing (DON) stated the expectation would be if a resident expressed a desire to get dentures or needed dentures, and it would be followed up on in a timely manner. A facility policy titled Dental Services, dated February 2024, indicated routine dental services are available to meet the resident's oral health services in accordance with the resident's assessment and plan of care. Furthermore, "all dental services provided are recorded in the resident's medical record."			F0791			
F0808 SS = D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is NOT MET as evidenced by: Based on interview, and document review the facility failed to ensure 2 of 2 resident (R9, R105) received ordered therapeutic diet to maintain or improve their nutritional status. Findings include: R9 R9's quarterly Minimum Data Set (MDS) assessment dated 7/16/25, indicated R9 had intact cognition with no hallucinations, delusions, behaviors or rejection of care present. R9 was dependent on staff for activities of daily living (ADL's) to include set up assistance for eating. R9's MDS assessment documented height as 76 inches and 171 pounds and was triggered for weight loss. Pertinent medical diagnoses include traumatic			F0808	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R9 has been reviewed by the community's RD for appropriate interventions. R87 has been reviewed by the community's RD on staff for appropriate interventions. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice All residents who have had a weight loss greater than 5% in the last 30 days and 10% in 6 months have been reviewed by the RD's on staff to ensure appropriate interventions. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Dietary aides have been re-educated on the procedure for reading meal tickets and validating appropriate portions.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0808 SS = D	Continued from page 39 brain injury, coronary artery disease (CAD), malnutrition, anxiety, post-traumatic stress disorder (PTSD), and hyponatremia. R9 had one stage four pressure ulcer present upon admission. R9's provider orders indicated on 11/12/24, a therapeutic diet of regular texture, thin consistency, for double portions all meals, cut into bite sized pieces was ordered. R9's Medical Diagnosis list included moderate protein-calorie malnutrition dated 1/27/25. R9's care plan last revised on 7/9/25, identified an actual impairment for skin integrity of the coccyx and applied interventions for good nutrition and hydration to promote healthier skin. The plan also included a focus for ADL and mobility and identified interventions for eating as staff would assist with set up to maximize independence with eating. A report titled Nutrition-Amount Eaten/Drank dated 7/16/25 through 8/14/25, identified amounts eaten. The column identified as 0-25% was marked one time, a column identified as 26-50% was marked three times, a column identified as 51-75% was marked twenty-one times, a column identified as 76-100% was marked sixty-two times. R9 was marked not available one time and no refusals were documented out of the eighty-eight possible meals served. R9's Weight Summary report dated 8/1/25, indicated 172.8 pounds. Six months prior on 1/22/25, R9's weight was recorded as 198.1 pounds which was a 12.77% weight loss over six months which was identified as severe weight loss according to the Centers for Medicaid/Medicare Services (CMS). R9's current dining ticket dated 8/13/25, indicated pudding cup-1 each, double entrée meal-1, beef vegetable soup-8 ounces (oz), Greek yogurt-1, mashed potatoes/gravy-1, beef pot roast with roasted vegetables-1 cups, mini baker potatoes-4 oz, country trio vegetables-4oz, bread, margarine-1 each, ice cream or sherbert-#8 scoop, milk- 8 fluid oz. R9's March through August 2025, Treatment Assessment Record (TAR) identified double portions at all meals, order mashed potatoes and gravy with lunch and dinner. Order vegetable beef soup with lunch, tomato soup with dinner every shift with a start date of 11/12/24. Staff documented R9 received double portions for all meals except two during this timeframe. The TAR also identified ice cream as needed for nutrition with a			F0808	Continued from page 39 Nursing staff have been re-educated on providing supplements and snacks and documenting as appropriate. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting CSD/designee will conduct an audit of 5 meals per week for 4 weeks to verify that portions are plated per the ticket. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation. DON/designee will conduct an audit of 5 residents per week for 4 weeks to validate charting of supplements. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0808 SS = D	Continued from page 40 start date of 11/12/24, the TAR lacked any documentation that R9 received the ice cream as needed. R9's progress notes dated 1/27/25, identified an order for double portions at all meals. Order mashed potatoes and gravy with lunch and dinner. Order vegetable beef soup with lunch, tomato soup with dinner every shift. R9's progress note dated 6/20/25, identified a nutritional risk note related to wounds. Diet order: regular with regular thin liquids and double portions. No meals refused for the past 14 days. During an interview on 8/11/25, R9 expressed concerns that the therapeutic diet was not followed. During observation and interview on 8/13/25 at 1:38 p.m., R9 stated breakfast was good, but it wasn't a double portion, and lunch has been sitting for twenty minutes. R9 stated the dining ticket was usually highlighted so the servers did not forget the double portions. The plate was observed to have one piece of bread, four golden potatoes, approximately two tablespoons of vegetables, and approximately ¼ cup of roast beef. One Greek yogurt and one ice cream cup was on the side of the tray along with one margarine, but no soup was present. Registered nurse (RN)-A verified the dining ticket stated double portions and confirmed R9 did not receive double portions. No servers were available to verify portion size. During an interview on 8/14/25 at 9:48 a.m., District Regional Manager (DRM)-F stated residents received therapeutic diets and it was possible that a resident did not receive soup based on the consistency, but if it was ordered and no thickened restrictions were present then soup should have been given on the meal tray. R9's lunch tray delivered on 8/13/25 was reviewed with the DRM-F and DRM-F stated it didn't sound like R9 received double portions if there was only one piece of bread and four round potatoes. During an interview on 8/14/25 9:45 a.m., the administrator stated if the facility heard a resident wanted a meal staff would get them food. Anyone could call down to the kitchen and get a meal at any time. The staff work closely with the kitchen, a dining ticket could be reprinted, and a new meal could be delivered. The administrator was unsure what would happen if a resident was unable to call the kitchen or advocate for themselves and stated the expectation was that all residents received their ordered meals and that the dining ticket matched what was served.		F0808				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0808 SS = D	Continued from page 41 During an interview on 8/14/25 at 10:53 a.m., regional dietician (RD)-L stated it was very important residents received their ordered meals for wound healing, weight gain, and encouragement. During an interview on 8/14/25 at 12:20 p.m., LPN-E stated it was very important that all residents receive their meals for nutrition, wound healing, and appropriate weight. A document with facility mealtimes indicated lunch for this unit was served between12:00 p.m. and 1:00 p.m. During observation and interview on 8/14/25 at 1:15 p.m., R9 stated the Greek yogurt wasn't served at lunch, but was on the dining ticket. R105 R105's comprehensive Minimum Data Set (MDS) assessment dated 5/15/25, indicated R105 had intact cognition with no hallucinations, delusions behaviors or rejections of care present. R105 used a wheelchair and was dependent on staff for activities of daily living (ADL's) to include set up assistance for eating. Pertinent medical diagnoses include orthopedic conditions, congestive heart failure (CHF), urinary tract infections (UTI), diabetes mellitus (DM), malnutrition, anxiety, and depression. R105's MDS assessment documented height as 66 inches and 341 pounds and was not triggered for weight. R105 had one area of moisture associated skin damage (MASD). R105's weight summary identified on 5/3/25, R105's weight was 341 pounds and on 8/6/25 R105's weight was 307.4 a 9.85% weight loss over three months which was identified as severe weight loss according to the Centers for Medicaid/Medicare Services (CMS). R105's provider orders dated 8/12/25, identified a regular diet with double protein for diet and Gelatein (a high-protein gelatin) one time a day for skin integrity, MASD healing. Additional protein needs were to provide a sandwich once a day at bedtime. R105's Nutritional Screen and Assessment dated 5/6/25, identified a pressure ulcer noted on the coccyx. R105 was on a regular diet with double protein, independent with meals, and staff were to provide cottage cheese at lunchtime and a sandwich at bedtime. The assessment indicated R105's height was 66 inches, and their weight was 341 pounds with a comment that resident was morbidly obese related to body mass index (BMI) greater			F0808			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0808 SS = D	Continued from page 42 than 35 with comorbidities. Some gradual weight loss can be beneficial if able and increased protein for wounds. A box marked risk assessment and summary indicated R105 was at a high risk for nutrition. R105 had nutritional problem or potential nutritional problem related to diagnoses of UTI, DM, depression, anxiety disorder, long term use of anticoagulant, localized edema, CHF and morbid obesity. Per assessment on 5/2/25, pressure ulcer noted on coccyx and lower extremity edema. No chewing or swallowing issues noted. Updated food preferences, educated on increased protein intake and suggested double protein at meals. R105's Nutritional Screen and Assessment dated 8/8/25, identified MASD to posterior right thigh with daily treatment, a regular diet with double protein, Gelatein 80 kcal, 20g protein with a variety of other supplements. A supplement of sandwich once a day at bedtime, Gelatein once a day and double protein portions were recommended. The assessment indicated R105's height was 66 inches, and their weight was 307.4 with a comment of resident was morbidly obese and BMI was 49 with comorbidities. Some gradual weight loss can be beneficial if able. The summary notes and goals were unchanged from the 5/6/25 assessment. R105's progress note dated 6/5/25, identified a nutritional risk related to wounds. Diet order was regular texture and thin liquids, received double protein portions at meals and bedtime snack. Resident had significant weight loss since admission 30 days ago likely multifactorial related to variable intake, multiple meal refusals, and improved edema. Resident was susceptible to weigh fluctuations related to edema and diuretic use. The note indicated some wight loss was desired given obesity with comorbidities, however significant weight loss could leave resident at risk for malnutrition and impaired wound healing. The goal was for gradual weight loss or weight maintenance to support wound healing. Given variable intake, significant weight loss, and increased needs for wound healing the registered dietician recommended additional Boost glucose control every day. R105's progress note dated 7/18/25, identified a dietician note and update to nutrition, cottage cheese was decreased to one time a day at lunch, the boost was discontinued and Gelatein plus was started every day for higher protein and less calories. Double meat portions at meals discontinued with dinner but continued for breakfast and lunch due to decreased meal consumption. A progress note dated 7/28/25, identified a dietitian			F0808			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0808 SS = D	Continued from page 43 note and update to nutrition, the diet order was regular, R105 received cottage cheese once a day, double protein portions twice a day, sandwich at bedtime and Gelatein everyday with good acceptance. Resident was meeting nutritional needs to support sound healing with current intake, double meal portions, and additional snacks/supplements. R105's May and June 2025, Treatment Assessment Record (TAR) were reviewed and lacked any documentation for double meal portions, sandwiches, or cottage cheese as indicated in R105's nutritional screen and assessment from 5/6/25. R105's July and August 2025, TAR was reviewed and Gelatein one time a day for skin integrity, MASD healing with a start date of 7/22/25 through 8/12/25 was identified and staff documented the resident received the Gelatein every day. The document lacked any indications of double portions or sandwich as indicated in the nutritional screen and assessment from 8/8/25. During observation on 8/11/25 at 1:42 p.m., the dining ticket was observed on the meal tray and had the following: double meat portion-1, Gelatein plus 1each, baked chicken fried steak-1each, macaroni and cheese #8 scoop, wax beans 4 (ounces) oz, bread/margarine 1 each, pears 4 oz, milk 8 fluid oz. A Gelatein plus container was on the bedside table, unopened with a label that read R105's information and dated 8/4/25. The tray consisted of toss salad, with French dressing, Shasta soda, ice water, and one round personalized pizza. During an interview on 8/11/25 at 1:51 p.m., R105 complained about the type of meals received, then stated the aids did not bring what was ordered, stating they were supposed to get Gelatein and had not had it since 8/4/25. Double portions were ordered, but the aid told R105 they were getting pizza today. R105 stated sometimes the Gelatein was delivered and sometimes it wasn't. During an interview on 8/11/25 at 2:11 p.m., registered nurse (RN)-I reviewed the dining ticket and stated there was no residue of baked chicken fried steak, only the pizza and verified the Gelatein was not delivered with the noon meal. During an interview on 8/11/25 at 2:13 p.m., nursing assistant (NA)-B stated the resident used their personal cell phone and called down to the kitchen to order the pizza. R105 stated that was not correct and just woke up from a nap, then pointed to the cell phone			F0808			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0808 SS = D	Continued from page 44 in the basket of the wheelchair on the opposite side of the room. R105 stated it happened all the time and he never got what was supposed to be on the tray. During an interview on 8/12/25 at 9:29 a.m., licensed practical nurse (LPN)-E stated R105 didn't get out of bed most days, there was an ongoing issue with the food, and residents were asked to contact the kitchen with any issues. During an interview on 8/11/25 at 5:25 p.m., the director of culinary services (DOC)-E stated 'always available' meals were to be requested by 10:00 a.m. each day. The forms were located on every unit and the aids could help complete the form and send it down to the kitchen. Otherwise, residents completed the form and placed it in the basket. If a resident called down to the kitchen the staff would honor their request. There was no phone log to document request, but a dedicated person was assigned to answer the phone each day. No phone calls were received today for 'always available' meals, no forms were received, and R105 had not called down to request pizza. DOC-E stated the dining ticket should reflect the meal that was served, the two should match even if the resident requested an always available meal. During an interview with the district regional manager (DRM)-F and the administrator on 8/14/25 at 9:45 a.m., DRM-F stated residents were vocal enough to call the kitchen if they have not received a meal or if the meal served was incorrect. The expectation was that staff look at the dining ticket and ensure the meal and the items served match. All Gelatein goes up to the floor with the meals and was dated and labeled with the resident's name. During this same interview the administrator stated the expectation was that residents received the prescribed meals, and the dining ticket reflects what was served on the tray, the two should match. A policy, Meals Service dated 1/25, identified the procedure for meal service was to identify each resident, check the diet card against the items on the tray for accuracy and food preferences.			F0808			
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a			F0880	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice No resident has had an adverse event due to the deficient practice.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0880 SS = D	Continued from page 45 safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff			F0880	Continued from page 45 – Address how the facility will identify other residents having the potential to be affected by the same deficient practice Residents are put on the appropriate level of precautions in coordination with community infection prevention policies and as dictated by the CDC. Community provides appropriate PPE and signage outside resident's doors for staff, visitors, and vendors safety. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Nursing staff will be re-educated on infection prevention, and how to identify appropriate levels of precautions Indicate how the facility plans to monitor its performance to make sure that solutions are lasting NHA/designee will audit 5 staff per week to ensure they are wearing appropriate PPE for residents that require enhanced barrier precautions. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0880 SS = D	Continued from page 46 involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was used for 2 of 7 residents (R3, R12) when providing care for residents in enhanced barrier precautions (EBP). Findings include: The CDC article titled Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 4/2/24, indicated that MDRO transmission in skilled nursing facilities was common and contributed to substantial resident morbidity. EBP is an infection control intervention to reduce transmission of MDROs by using gowns and gloves during "high contact resident care activities". The article indicated high-contact activities include providing hygiene, changing briefs, dressing, urinary catheter care, transferring, etc. The article indicated that EBP should be implemented (when contact precautions did not apply) for residents with indwelling medical devices (urinary catheter) or chronic wounds, regardless of MDRO colonization status. R3's significant change Minimum Data Set (MDS) dated 6/10/25, indicated R3 was diagnosed with diabetes. The MDS indicated R3 had two unstageable pressure ulcers and required assistance with all activities of daily living. During an interview on 8/13/25 at 2:27 p.m., the nurse			F0880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0880 SS = D	Continued from page 47 manager, registered nurse (RN)-G, confirmed that R3 had multiple pressure ulcers that were unstageable but open and required dressing changes. During an interview and observation on 8/14/25 at 10:20 a.m., an EBP sign was observed on R40's door. Nursing assistant (NA)-C and NA-J were observed to wheel R40 into her room and then close her door. Neither aide was observed to don a gown. RN-G was observed to walk by the room, knock, and then open R40's door. NA-C and NA-J were observed with gloves and no gowns on, assisting R40 to transfer to bed. RN-G then left the room and closed R40's door. NA-C and NA-J were observed to exit R40's room, and R40 was observed in bed. NA-C stated they had just assisted R40 to bed and had checked R40's brief for incontinence. NA-C and NA-J confirmed they had not worn a gown as they only needed to be worn during morning cares. During interview on 8/14/25 at 11:08 a.m., the facility's infection preventionist/registered nurse (RN)-H stated the staff needed to wear a gown and gloves whenever they touch a resident on transmission-based precautions (TBP) or EBP. The RN-H added "you absolutely need to use a gown with any contact care that requires to touch the residents like changing a brief, transferring, repositioning, or taking vital signs." R12's quarterly Minimum Data Set (MDS) dated 7/16/25, identified severe cognitive impairment and diagnoses of coronary artery disease, heart failure, hypertension, obstructive uropathy, urinary tract infections in the last 30 days, and non-Alzheimer's dementia. R12 required substantial/maximal assistance with toileting hygiene, upper and lower body dressing, and supervision or touching assistance for chair/bed-to-chair transfers and toilet transfers. R12 had an indwelling catheter. R12's care plan focus area dated 7/23/25, identified R12 had a foley catheter and an intervention dated 7/23/25 which indicated enhanced barrier precautions were in place, signage on door, and PPE cart outside room. During observation on 8/13/25 at 1:07 p.m., a sign indicating Enhanced Barrier Precautions was on the outside of R12's door and identified providers and staff must wear gloves and gown for High-Contact Resident Care Activities including dressing, transferring, providing hygiene, and device care with urinary catheters. A cart of PPE was outside R12's room. Nursing assistant (NA)-H entered R12's room,		F0880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0880 SS = D	Continued from page 48 completed hand hygiene and applied gloves. NA-H emptied R12's urinary leg bag, provided perineal hygiene, and changed R12's pants which were soiled. NA-H doffed gloves and completed hand hygiene. During interview on 8/13/25 at 1:32 p.m., NA-H stated they used a gown for residents on isolation and could decide if they wore a gown or not to empty a urinary catheter. During interview on 8/14/25 at 10:39 a.m., licensed practical nurse (LPN)-G agreed R12 was on enhanced barrier precautions and had a catheter. LPN-G expected staff to follow the sign on R12's door to keep infection from spreading. During interview on 8/14/25 at 5 p.m., the director of nursing (DON) expected staff to wear gloves and gown to empty a urinary catheter for resident protection. The facility's Enhanced Barrier Precautions policy dated March 2024, indicated enhanced barrier precautions referred to the use of gown and gloves during high-contact resident care activities for residents with increased risk of MDRO (multi-drug-resistant bacteria) acquisition, such as residents with an indwelling medical device (urinary catheter). The policy identified high-contact resident care activities as dressing, transferring, providing hygiene, changing briefs, and device care such as urinary catheters.		F0880				
F0921 SS = F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is NOT MET as evidenced by: During observation, interview and record review the facility failed to ensure facility was kept sanitary and maintained in good repair on all six resident units which had the potential to affect all 225 residents, staff, and visitors of the facility. Findings include: Walls:		F0921	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice R20 discharged from the facility but the room was repaired prior to discharge on 8/13/2025 R76 Door jam was repaired on 8/12/2025 upon identification. R146 discharged on 8/14/2025. Ceiling tiles have been replaced and door is being evaluated for repair. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/15/2025
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0921 SS = F	Continued from page 49 During observation on 8/12/25 at 8:56 a.m., on the sixth floor, wall outside R184's room had gouges and underlying wallboard exposed. Partial repair was done but not painted to match the wall. The wall across from aviary was tan in color with nine sections or areas of wall covering four feet by two feet with repairs but no matching paint. During observation on 8/12/25 at 9:26 a.m., in second floor dining room, two residents were seated at a dining room table. The wall of the dining room had gouges and scrapes observed with repairs done but no paint to match the wall cover. During observation and interview with the administrator and director of environmental services (D)-ES on 8/13/25 at 8:31 a.m., on the seventh floor, the D-ES and surveyor observed knee wall in dining room with gouges and visible wallboard repaired but did not have any matching paint. D-ES and administrator state "we are identifying areas that need repair and replacements." D-ES stated he had not received any maintenance requests from staff to repair and match paint for the dining room. During observation on 8/13/25 at 9:20 a.m., in third floor dining room, all of the walls had wallboard that had been repaired but no paint to match the walls. Several residents were eating breakfast in the area. During observation and interview with licensed practical nurse (LPN)-B on 8/13/25 at 9:36 a.m., LPN-B stated "gouges should be looked at. I would like it to be repaired or replaced in my home" and "It does not look good if there are so many holes and dings in the wall." LPN-B stated process for repairing equipment was for staff to utilize a walkie talkie to the maintenance department or submit request through the computer system. LPN-B stated they had not submitted anything to maintenance for repairs to any resident walls, doors, or carpets. Floors: During observation on 8/12/25 at 9:05 a.m., on fifth floor a long black vinyl piece was resting against the baseboard of the alcove right off the elevator and across from the dining room. The vinyl piece was not attached to anything. A section of carpeting in the dining room was missing the transition piece from laminate flooring of the dining room to the carpeted areas outside the dining room. One resident sitting in wheelchair next to the gap in flooring stated he was	F0921	Continued from page 49 The community maintains a homelike environment by initiating work orders, routine rounding, completion of room readiness and by resident request. All residents have the potential to be impacted. The community will complete room rounds to identify a punch list of items such drywall repair, paint touch ups, etc. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur Staff will be educated to report and complete a work order for all maintenance related concerns. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting NHA/designee will audit 10 rooms per week for 4 weeks to verify good working order and homelike environment. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation. NHA/designee will audit 5 work orders per week for 4 weeks to ensure timeliness of completion.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0921 SS = F	Continued from page 50 concerned for ambulatory residents and staff for risk of tripping. During observation on 8/13/25 at 8:53 a.m., three dark stains were seen on R97's carpet inside door. The black stains on the tan carpet ranged from two to three inches in circumference and was visible from the hallway. During interview with D-ES on 8/13/25 at 12:10 p.m., D-ES stated the missing transition piece on fifth floor dining room was replaced, "It is a safety issue. Do not want anyone to trip." During observation and interview on 8/13/25 at1:08 p.m., R191's carpet in their room had large dark stain visible to the hallway. D-ES stated, "it should definitely be cleaned. It is stained" and had not received a maintenance request to clean the carpet. Ceiling: During observation and interview with nursing assistant (NA)-B on 8/12/25 at 2:06 p.m., in R20's unoccupied bedroom, NA-B looked at the dark stains on his 4 white ceiling tiles and stated, "I would not like it in my home. It is not good to see those stains on the ceiling and the unpainted section there (pointing to the unfinished wall repair two feet by three feet in size next to R20's head of bed). NA-B stated process for repairing equipment is for staff to utilize walkie talkie to the maintenance department or submit request through the computer system. NA-B stated they had not submitted anything to maintenance for repairs to R20's wall or ceiling tiles. During observation and interview with licensed practical nurse (LPN)-C on 8/12/25 at 2:42 p.m., LPN-C looked at R20's wall and ceiling tiles and stated, "Oh stains" and "the wall needs to be redone. If it was my house, I would not like to see that." LPN-C stated process for repairing equipment is for staff to utilize walkie talkie to the maintenance department or submit request through the computer system. LPN-C stated they had not submitted anything to maintenance for repairs to R20's wall or ceiling tiles. During observation and interview with R20 on 8/12/25 at 3:06 p.m., R20 stated, "I don't like the wall. Its right next to my head when I lay in bed. The paint does not match and it looks unfinished. It is not attractive. No one has mentioned it to me. It was here when I [admitted to facility]". R20 then pointed to ceiling of his room and four white ceiling tiles that			F0921			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0921 SS = F	Continued from page 51 were darkly stained. “I think it looks crappy.” Doors: During observation and interview with nursing assistant (NA)-A on 8/13/25 at 9:01 a.m., NA-A and surveyor observed a missing piece of laminate wood about eight inches long by three inches from R196’s bathroom door about 4 feet up from the floor near the hinges. The edges were ragged and sharp. NA-A stated “Not in good repair to me. I don’t like that. It looks bad” and “It is dangerous and could hook on someone’s clothes and could snag.” NA-A stated process for repairing equipment is for staff to utilize walkie talkie to the maintenance department or submit request through the computer system. NA-A stated they had not submitted anything to maintenance for repairs to R196’s bathroom door. During observation and interview with R76 on 8/13/25 at 9:24 a.m., R76 pointed to bottom of door jamb which had area pulling away leaving ragged edges. “I don’t like the look of that. It is unattractive and [sic] piece could hook on something and cut me.” During observation on 8/12/25 at 9:01 a.m., R146’s door to hall had gouge marks running horizontal about four feet up from floor running entire width of it. During interview with R146 on 8/13/25 at 8:49 a.m., R146 stated, “I don’t like the line on the door. It is not old, they should cover it.” R146 stated the condition of the door had been like that “a long time”. R146 pointed to ceiling tiles in her bathroom which were darkly stained and said, “It is dirty and stained. It does not look good” and no one offered to repair or replace it. During interview with administrator and D-ES on 8/13/25 at 12:29 p.m., the administrator stated she agreed that "the walls, doors, carpets, ceiling tiles and dining rooms and halls should be repaired or replaced with matching paint. [I] agree it is important for residents to live in [a]space that is in good condition.” During resident council meeting interview on 8/13/25 at 10:07 a.m., R233 stated the environmental concerns included stained walls, carpets, ceilings, and unfinished repairs. R233 stated, “I would make sure everything is clean and wiped up and finished painted. That is something that someone who visits us should not see. I don’t like it.” R199 stated facility had “started patching them [walls]. Never got around to completing it” and “I don’t think anyone gives a d**n what I think”.			F0921			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0921 SS = F	Continued from page 52 During interview with D-ES on 8/13/25 at 1:11 p.m., D-ES reviewed facility's maintenance request logbook for 2/2025 to 8/2025 and verified there were no requests for resident dining room wall, door, or carpet repairs. D-ES stated, "It isn't fair for them [residents] to see that unfinished work". Facility policy titled Residential Environment dated October 2022 identified "All facility personnel are responsible for reporting broken, defective or malfunctioning equipment or furnishings upon identification of the issue."		F0921				
F0925 SS = F	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: During observation, interview and record review, the facility failed to ensure an effective pest control program was in place to eliminate fruit flies and black flies for 5 residents (R6, R69, R76, R88, and R223) who verbalized concern about flies. This had the potential to affect all 225 residents of the facility. Findings include: R6's admissions Minimum Data Set (MDS) dated 7/11/25, identified R6 with no physical or verbal behaviors and did not reject cares, no impairment of upper extremity range of motion, impairment of lower extremity range of motion, utilized a wheelchair for mobility, and required assistance with toileting, and dressing. R69's quarterly MDS dated 8/5/25, identified R69 with intact cognition, no physical or verbal behaviors and did not reject cares, no impairment of upper or lower extremity range of motion, utilized a walker for mobility, and required set up or clean-up assistance with eating, oral hygiene, toileting hygiene, dressing, and personal hygiene. R76's admissions MDS dated 8/5/25, identified R76 with intact cognition, no physical or verbal behaviors and did not reject cares, no impairment of upper and lower extremity range of motion, utilized a walker for mobility, and required assistance with dressing, and toileting.		F0925	– Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice Adams Pest Control came to the community on 8/25 specifically to treat kitchenettes, resident rooms identified, and other spaces within the community that have seen an increase in insects during the summer months. – Address how the facility will identify other residents having the potential to be affected by the same deficient practice The community has a preventative maintenance contract with Adams Pest Control for routine insects. – Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur The community has increased its preventative maintenance contract with Adams Pest Control for routine inspection and coordination of pest control. The community will provide education to nursing staff on appropriate means of communication should areas of the community begin to have an increase in routine pests/insects. – Indicate how the facility plans to monitor its performance to make sure that solutions are lasting		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0925 SS = F	Continued from page 53 R88's quarterly MDS, dated 7/1/8/25, identified R88's short-term and long-term memory to be intact, no impairment of upper extremity range of motion, impairment of lower extremity range of motion, utilized wheelchair for mobility, and required assistance with toileting, and dressing. R223's significant change in status assessment MDS dated 7/25/25, identified R223 with intact cognition, no physical or verbal behaviors and did not reject cares, impairment of one side of upper and lower extremity for range of motion, utilized a wheelchair for mobility, and required assistance with toileting and dressing. Review of facility's monthly pest control visit notes, the facility was treated for "Cluster Flies, Drain Flies, Flies, Fruit Flies, House Flies" on the following dates: 2/11/25, 3/14/25 which identified fruit flies throughout the kitchen and garbage collection areas, 4/4/25, 5/14/25, 6/12/25, and 7/11/25 (which identified fruit flies). During observation and interview with R6 on 8/11/25 at 1:06 p.m., R6 pointed to several fruit flies and regular black flies buzzing around her room and said her room is "visibly dirty". R6 stated she was upset about it and "I am at the point of begging" to rid her room of them. During observation and interview with R88 on 8/11/25 at 3:44 p.m., R88 was lying in bed with a fly swatter in her right hand. A fly was buzzing around her, and she was swatting at it. "This is bothering me. My friend had to bring in the fly trap (pointing to window with sticky fly strip hanging down from window blind). They need to do something about pests in here." R88 stated she stayed in bed, rarely got out of the bed, and was "stuck with the flies". During observation and interview with R76 on 8/11/25 at 4:24 p.m., R76 had multiple flies in room flying around his food tray and legs. R76 was swatting flies away. R76 stated, "They come and they go." During observation and interview with director of environmental services (D)-ES on 8/13/25 at 1:16 p.m., D-ES and surveyor walked into R88's room, with permission, and observed two large black flies buzzing around and the fly strip that was attached to the blinds. "I know we did not get a work request for the			F0925	Continued from page 53 NHA/designee will audit 10 rooms per week for 4 weeks to verify good working order. Results of audit will be reported to the facility QAPI committee for determination of frequency of continuation.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
F0925 SS = F	Continued from page 54 flies in her room. I will have to look at it.” During interview with D-ES on 8/13/25 at 1:11 p.m., D-ES reviewed facility’s maintenance request logbook for 2/2025 to 8/2025, and stated there were no requests for additional pest control visits to address flies. D-ES also reviewed and verified the pest control visit notes stated facility did not reach out to ask for additional services to address the flies. D-ES stated the services were “clearly not effective”. During interview with director of nursing on 8/13/25 at 2:10 p.m., DON stated “It is really hard to manage [flies].” During interview with licensed practical nurse (LPN)-D on 8/14/25 at 8:15 a.m., LPN-D stated she had “seen some flies yesterday in a resident’s room” but was unable to say which room. LPN-D stated expectation of staff to notify nurse manager or maintenance through walkie talkie or submit a request through the computer for issues relating to flies or pests. LPN-D stated she failed to notify anyone of the flies. During interview with nursing assistant (NA)-C on 8/14/25 at 8:23 a.m., NA-C stated, “there have been complaints from residents about flies” and expectation of staff to notify nurse manager or maintenance through walkie talkie or submit a request through the computer for issues relating to flies or pests. NA-C stated she failed to notify anyone of the flies. During interview with NA-D on 8/14/25 at 8:37 a.m., NA-D stated the appearance of flies, “Usually [sic] happens a lot during summertime and they [flies] move around the place.” NA-D stated expectation of staff to notify maintenance through walkie talkie or submit a request through the computer for issues relating to flies or pests. NA-D stated she failed to notify anyone of the flies. During interview with NA-F on 8/14/25 at 9:07 a.m., NA-F stated flies appeared in the dining room and “sometimes the residents will say they bother them. In the hallway there will be some.” NA-F stated he had seen them recently but did not notify maintenance of his observations. During observation on 8/14/25 at 9:31 a.m., R223 was sitting in wheelchair on the fifth floor waiting for the elevator. R223 was swatting a fly buzzing around her. R233 stated, “These things are crazy”. During interview with R69 on 8/14/25 at 8:51 a.m., R69		F0925				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/15/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
F0925 SS = F	Continued from page 55 stated, “there is a few black flies that are around here. No one is doing anything about it. Sometimes the flies come into my room and I hate that. Bothers me. Wish this place would get rid of them. Who wants flies buzzing around them? Especially when I am lying in bed.” Facility policy titled Residential Environment dated October 2022, state, “Pest control should be scheduled at routine intervals and available should a concern arise.”			F0925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/12/2025, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakehouse Healthcare & Rehabilitation Center 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. 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us			K0000			10/02/2025

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 reverse for further 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 CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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	
K0000	Continued from page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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. Building Info: Lakehouse Healthcare & Rehabilitation Center is an 8-story building with a full basement. The building was constructed at 2 different times. The original 5 story building was constructed in 1964 and was determined to be of Type II(222) construction. In 1983, an 8 story addition was constructed to the North that was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction, the facility was surveyed as one building. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 260 beds and had a census of 225 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:		K0000				
K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure		K0321	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists.		10/02/2025	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0321	Continued from page 2 Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.5.9. These deficient findings could have an widespread impact on the residents within the facility. On 08/12/2025, at 1:10 PM, it was revealed by observation that the door to the fire door to the laundry room failed to properly close and latch. An interview with the Special Projects Manager and the			K0321	Continued from page 2 This response is also not to be construed as an admission of fault by the facility, its employees, agents or other individuals who draft or may be discussed in this response and plan of correction. This plan of correction is submitted as the facility's credible allegation of compliance. Facility door to the fire door in laundry failed to close and latch. Door was adjusted to self-close and latch. Laundry Room doors have been added to the monthly preventative maintenance schedule. Facility will monitor by monthly review of documentation of PMs. Conducted by the facility Maintenace Director/designee until discontinued by QAPI.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0321	Continued from page 3 Maintenance Engineer verified these deficient findings at the time of discovery.			K0321			
K0353 SS = F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 33.2.3.5.3, and 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.1.2. These deficient findings could have a widespread impact on residents within the facility. 1. On 08/12/2025 at 11:02 AM, it was revealed by observation that there were wires zip tied to the sprinkler pipe above the ceiling near resident rooms 714 and 733 2. On 08/12/2025 at 11:40AM, it was revealed by observation that there were wires resting on the sprinkler pipe above the ceiling near resident rooms 614, 633,535, 435, 414, 335, 314, 214, 231. 3. On 08/12/2025 at 12:05 PM , it as revealed by observation that there were wires and conduit resting			K0353	The community removed wires touching sprinkler pipes. The facility maintenance team was educated on the requirement of having pipes free from touching wires. Community low voltage vendors have been educated on the requirement of having sprinkler pipes free from touching wires. Facility Maintenace Director/designee will complete an audit of 5 places throughout the community weekly for 4 weeks to ensure pipes are free from touching wires until discontinued via QAPI.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0353 SS = F	Continued from page 4 on the sprinkler pipe above the ceiling near resident room 514 and 273 An interview with the Special Projects Manager and the Maintenance Engineer verified these deficient findings at the time of discovery.			K0353			
K0362 SS = F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. These deficient finding could have an widespread impact on the residents within the facility. On 08/12/2025 at 12:29 PM, it was revealed by observation that there were multiple penetrations in the smoke barriers above the ceiling near resident rooms 714, 733, 614, 633, 514, 314, 231, 256,273. An interview with the Special Projects Manager and the Maintenance Engineer verified these deficient findings at the time of discovery.			K0362	Penetrations have been sealed with fire rated materials. The facility maintenance team was educated on the requirement of having effective smoke barriers and sealing any holes with fire rated materials. Community vendors have been educated on the requirement of sealing any holes created with fire rated materials. Facility Maintenance Director/designee will complete an audit of 5 places throughout the community weekly for 4 weeks to ensure there are no holes in smoke barriers that are not sealed with fire rated materials until discontinued via QAPI.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0362 K0362 SS = F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3.5 and 19.3.6.3.10. These deficient findings could have an widespread impact on the residents within the facility. 1. On 08/12/2025, at 12:09 PM, it was revealed by observation that the door to the fire door near room 272 failed to properly close and latch.			K0362 K0362	Facility fire and smoke doors will close on their own. Doors were adjusted to self-close and latch. Doors will be maintained by regularly preventative maintenance checks. Facility Maintenance Director/designee will monitor by review of documentation of PMs until discontinued via QAPI.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0363 SS = F	Continued from page 6 2. On 08/12/2025, at 12:50 PM, it was revealed by observation that the door to the fire door near the education failed to properly close and latch. 3. On 08/12/2025, at 12:58 PM, it was revealed by observation that the door to the fire door near room L59 failed to properly close and latch. 4. On 08/12/2025, at 1:10 PM, it was revealed by observation that the door to the fire door to the laundry room failed to properly close and latch. An interview with the Special Projects Manager and the Maintenance Engineer verified these deficient findings at the time of discovery.			K0363			
K0712 SS = F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per 42 CFR 483.470(i). This deficient finding could have a widespread impact on the residents within the facility. On 08/12/2025 at 9:15 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that a fire drill was conducted during the first shift during the fourth quarter of 2024. An interview with the Special Projects Manager and the Maintenance Engineer verified these deficient findings at the time of discovery.			K0712	There will be a fire drill conducted on each shift at least quarterly. The community has scheduled out fire drills for the next year to assure compliance. Documentation of fire drill and verification of times, conditions, and shifts will be reviewed. Facility Administrator/designee		10/02/2025
K0920 SS = D	Electrical Equipment - Power Cords and Extens			K0920	Extension cords will not replace fixed wiring.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0920 SS = D	Continued from page 7 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 70, (2011 edition), National Electrical Code, sections 400-8, and UL 1363. This deficient finding could have an isolated impact on the residents within the facility. On 08/12/2025 at 12:15 PM, it was revealed by observation that there was an extension cord being used to plug a large portable AC unit near the resident library 2R. The extension cord was removed at the time of survey. An interview with the Special Projects Manager and the Maintenance Engineer verified these deficient findings at the time of discovery.			K0920	Continued from page 7 The extension cord was removed on 8/12. Facility maintenance and administration team was educated that extension cords cannot be used for non -PCREE (patient-care-related-electrical-equipment) Facility Maintenance Director/Designee will monitor through weekly environmental rounds until discontinued via QAPI.		
K0923 SS = D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet			K0923	Oxygen tanks belonging to hospice companies or discharged residents will be appropriately stored. Oxygen tanks were picked up and removed from central supply.		10/02/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0923 SS = D	Continued from page 8 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 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain oxygen storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.2.6 and 11.6.2.3 (11). This deficient finding could have an isolated impact on the residents within the facility. On 8/12/2025 at 12:45 PM, it was revealed by observation that there were multiple green oxygen cylinders were being stored in the central supply room that are not secured in a rack or cart. An interview with the Special Projects Manager and the			K0923	Continued from page 8 Community vendors will be educated on timely removal of oxygen tanks. Facility Central Supply/designee will audit storage rooms weekly and have tanks picked up as appropriate.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 01 B. WING		(X3) DATE SURVEY COMPLETED 08/12/2025	
NAME OF PROVIDER OR SUPPLIER LAKEHOUSE HEALTHCARE & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 3737 BRYANT AVENUE SOUTH , MINNEAPOLIS, Minnesota, 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
K0923 SS = D	Continued from page 9 Maintenance Engineer verified these deficient findings at the time of discovery.			K0923			
K0930 SS = D Bldg. 01	Gas Equipment - Liquid Oxygen Equipment CFR(s): NFPA 101 Gas Equipment - Liquid Oxygen Equipment The storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections 11.7.2 through 11.7.4 (NFPA 99). 11.7 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store liquid oxygen per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.7.4. This deficient finding could have an isolated impact on the residents within the facility On 08/12/2025 at 11:49 AM, it was revealed by observation that there was one oxygen tank stored near resident room 311. An interview with the Special Projects Manager and the Maintenance Engineer verified these deficient findings at the time of discovery.			K0930	The community does not store oxygen tanks in hallways. The oxygen tank was removed immediately and relocated to the designated area. Community nursing staff will be educated not to store oxygen tanks within the hallway. Facility Maintenance Director/designee will monitor through weekly environmental rounds.		10/02/2025