Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 18, 2026

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

RE: CCN: 245055
Cycle Start Date: April 30, 2026

Dear Administrator:

On June 12, 2026, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

June 18, 2026

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

Re: Reinspection Results
Event ID: 22FF3B-H2

Dear Administrator:

On June 12, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 30, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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
May 11, 2026

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

RE: CCN:245055
Cycle Start Date: April 30, 2026

Dear Administrator:

On April 30, 2026, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by July 30, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 30, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social

Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 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.

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.

Feel free to contact me if you have questions.

Sincerely,

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 11, 2026

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

Re: State Nursing Home Licensing Orders
Event ID: 22FF3B-H1

Dear Administrator:

The above facility survey was completed on April 30, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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	INITIAL COMMENTS On 4/28/26 to 4/30/26, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H50551273C (2983201) and H50557625C (2792343) with deficiencies cited at F658, F693, and F880. 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		06/02/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure services were provided in accordance with professional standards of nursing practice for 1 of 1 residents (R1) when staff inserted a Foley catheter into a gastrostomy stoma without validated competency for the procedure, without completing appropriate clinical assessment to determine safety prior to insertion, and using improper technique, including inflation of the catheter balloon within the stoma. In addition, the	F0658	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is 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 Corrective action for affected residents: R1’s feeding tube management was reviewed with the attending physician and Medical Director. R4’s tube feeding supplies were labeled appropriately, orders clarified, and providers’ expectations for when a tube is dislodged were updated. Identification of other residents at risk: All residents with enteral feeding tubes were audited to verify current orders including interruption of tube feeding, labeling of supplies, documentation of flushes, and care plans.	06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0658 SS = D	Continued from page 1 facility failed to ensure feeding tube supplies were labeled according to professional standards to avoid the possibility of feeding tube complications and/or related infections for 1 of 3 residents (R4) reviewed for enteral tube feeding Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/31/26, indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had a feeding tube and diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure. R1's nutrition care plan dated 4/24/26, indicated R1 was NPO (nothing by mouth; may not eat or drink) and required tube feeding related to dysphagia following CVA (cerebrovascular accident; blood flow to the brain is interrupted). The goal was to maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and/or symptoms of malnutrition or dehydration through review date of 5/4/26. Another goal was to have minimal complications related to aspiration through review date of 5/4/26. Care plan interventions included a directive to check tube placement and gastric contents per facility protocol; there was no interventions for emergency procedures or facility protocol in the event of tube dislodgment referred to. R1's physician orders from 4/8/26 to 4/11/26 included the following: -dated 5/23/25, medication given though gastrostomy tube (g-tube). -dated 5/27/25, change out syringe and canister for free water every day. -dated 2/11/26 to 4/16/26, Osmolite 1.5 at 85 mL/hr through gastrostomy tube from 6:00 p.m. to 10 a.m. until total volume of 1,360 mL. -dated 2/11/26 to 4/16/26, 180 mL free water flush four times a day to enteral feeding tube to meet hydration needs. -dated 4/8/26 to 4/10/26, monitor enteral feeding site for signs and/or symptoms of infection, patency, and pain. Update provider as needed. R1's physician orders did not include emergency orders or directives for tube dislodgment.	F0658	Continued from page 1 Systemic changes: The facility provided education to licensed nurses related to best practice and the appropriate procedure for a dislodged feeding tube, such as covering sites with clean dressing and sending the resident to the hospital. Monitoring: The Director of Nursing (DON) or designee will audit 3 residents per week for 4 weeks. Findings will be reviewed in QAPI and additional actions taken as needed.	06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0658 SS = D	Continued from page 2 R1's Nursing Note on 4/11/26 at 2:59 a.m., indicated R1 pulled out his gastrostomy tube at approximately 1:30 a.m.. licensed practical nurse (LPN)-F placed a 16 French Foley catheter into R1's stoma to keep patent, as facility protocol. R1 denied pain and vitals obtained with a blood pressure of 73/45 mmHg (millimeters of mercury; standard unit of pressure). R1 was sent to Hospital at approximately 1:45 a.m. A message was left to the on-call provider. Review of the medical record did not identify documentation of a clinical assessment prior to insertion of the Foley catheter, including assessment of tract maturity, duration of dislodgement, or evaluation for potential complications. There was no evidence of a physician order authorizing insertion of a Foley catheter into the gastrostomy stoma. During interview on 4/29/26 at 2:05 p.m., LPN-F stated they found R1's enteral tube out of R1's stoma with the balloon deflated. LPN-F was not sure how long the tube had been out and was directed by registered nurse (RN)-B to insert a Foley catheter into R1's stoma. LPN-F stated they were unaware of the policy to place a Foley catheter into stoma for dislodged enteral feeding tube. LPN-F did not know what size R1's gastrostomy tube was and stated they placed a 16 French Foley catheter into R1's stoma with 5 cc (cubic centimeters; a volume measurement) in the catheter's balloon. During interview on 4/29/26 at 2:40 p.m., RN-B stated they were notified when R1's enteral tube feeding was found dislodged. RN-B watched LPN-B clean R1's stoma and sterilely place the Foley catheter into R1's stoma. RN-B stated the Foley catheter was inserted to avoid stomal closure. RN-B stated staff called the provider and sent R1 to the hospital when they did not hear back from the provider. During interview on 4/29/26 at 4:22 p.m., the director of nursing (DON) did not know what kind or size of gastrostomy tube R1 had at the time it became dislodged on 4/11/26. The DON expected staff to follow their policy to put a Foley catheter in a stoma to keep patent when enteral feeding tube became dislodged. The DON expected staff to be competent related to Foley insertion. The DON expected staff to follow provider orders when an enteral tube feeding became dislodged and stated they did not have a direct provider order to place a Foley catheter in a stoma if a enteral tube feeding became dislodged.	F0658		06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0658 SS = D	Continued from page 3 During interview on 4/30/26 at 11:37 a.m., primary care provider (PCP)-E agreed the facility should have clear directions in place for a dislodged enteral feeding tube with training and competency for placing a Foley catheter into a stomal opening. During interview on 4/30/26 at 10:25 a.m., the medical director stated enteral feed stomal openings close quickly if tube becomes dislodged, and staff have quick access to hospitals. The medical director stated the size of the Foley catheter did not matter as the purpose was to keep the stoma open. The medical director stated they would not want staff to place a Foley catheter into a stomal opening less than six weeks to two months old, because there was a risk for perforation. The medical director stated staff who were competent to put a Foley catheter into a urethra were capable to place in stomal opening in the case of enteral feeding tube dislodgement. LPN-F's Foley Cather Competency Checklist dated 12/19/23, indicated LPN-F met the actions to insert a foley catheter into the meatus of a male resident. The competency did not include the action to place a foley catheter into a stoma used for enteral tube feeds. RN-B's Inserting an Indwelling Urinary Catheter dated 4/20/26, indicated RN-B met the steps required to insert a urinary catheter into a male and female urinary meatus. The competency did not include the action to place a foley catheter into a stoma used for enteral tube feeds. Facility policy Care and Treatment of Feeding Tubes dated 10/2024, directed staff to insert a temporary tube (e.g. Foley catheter) to prevent tract closure if an enteral feeding tube dislodged and send resident to the hospital as soon as possible for possible replacement of the feeding tube. R4 R4's quarterly MDS dated 4/13/26, indicated R4 had moderate cognitive impairment and was independent with activities of daily living. R4 had a feeding tube and diagnoses which included cancer, malnutrition, and depression. R4's physician order dated 3/30/26, directed the staff on the night shift to replace graduate, syringe, and dressing every night. Staff were to replace tubing daily if an open enteral system was used or for up to 48 hours if a closed enteral system was	F0658		06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0658 SS = D	Continued from page 4 used. During observation on 4/28/26 at 4:49 p.m., R4's room had a clear Kangaroo enteral feeding bag with between 50 and 100 milliliters of tannish colored liquid in it hanging from a tube feeding pole. R4 was not in the room, and the bag did not have a label to identify what the liquid was. During interview on 4/28/26 at 4:56 p.m., registered nurse (RN)-A verified the observations and stated staff were expected to label the enteral feeding bag with the formula type and date when feeding started. R4's physician order dated 3/31/26, directed staff to give 150 mL tap water flush three times a day and 30 mL before and after intermittent feedings and medication administration via feeding tube unless directed otherwise. The April 2026 medication and treatment administration record marked the order as completed in the morning, afternoon, and bedtime. The record did not reflect the amount used to flush R4's feeding tube. R4's physician order dated 4/15/26, directed for continuous feed of Osmolite 1.5 at 95 mL/hr (milliliters per hour) for 11 hours from 8 p.m. to 7 a.m. and flush tube with 30 mL of free water flush before and after. The April 2026 medication and treatment administration record marked the order as completed at 7 a.m. and 8 p.m. and did not reflect the amount used to flush R4's feeding tube. During an interview on 4/30/26 at 5:00 p.m. director of nursing (DON) reviewed R4's medication and treatment administration record and expected staff to update the orders with flushes to indicate the amount of flushes R4 received. The DON expected staff to label and date tube feeding bags and supplies for infection control reasons.	F0658		06/02/2026
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (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-	F0693	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is 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 Corrective action for affected residents: R1's	06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0693 SS = D	Continued from page 5 §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure ordered hydration interventions were implemented for 1 of 3 residents (R1) reviewed for enteral tubes. Findings include: R1's quarterly Minimum Data Set (MDS) dated 1/31/26, indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure. The MDS indicated R1 had a tube feeding which accounted for 51% (percent) or more of total calories R1 received and 501 cc/day (cubic centimeters per day; total volume of liquid per day) or more of average fluid intake per day. R1's nutrition care plan dated 4/24/26, indicated R1 was NPO (nothing by mouth; may not eat or drink) and required tube feeding related to dysphagia following CVA (cerebrovascular accident; blood flow to the brain is interrupted). The goal was to maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and/or symptoms of malnutrition or dehydration through review date of 5/4/26. Another goal was to have minimal complications related to aspiration through review date of 5/4/26. Care plan interventions included the following: -Administer medication one at a time in gastric tube. Follow flushing precautions per order.	F0693	Continued from page 5 hydration orders were clarified. Identification of other residents at risk: All residents receiving enteral nutrition were audited to verify hydration orders are implemented appropriately. Systemic changes: MAR/TAR instructions were revised to clearly identify flush volumes, frequency, and required ports. Licensed Nurses completed re-education on enteral hydration and medication administration. Monitoring: The DON or designee will audit 3 residents per week for 4 weeks. Results will be presented to QAPI	06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0693 SS = D	Continued from page 6 -Registered dietician to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. -Tube continuous tube feeding of Isosource 1.5 at 55 mL/hr (milliliters per hour). 30 mL flush before and after feedings (60 mL). Additional free water flush of 120 mL six time per day to meet hydration needs (total 720 mL). R1's physician order indicated the following: -dated 5/23/25, medication given though gastrostomy tube (g-tube). -dated 5/27/25, change out syringe and canister for free water every day. -dated 4/16/26, Isosource 1.5 continuous feeding at 55 cc/hr (cubic centimeters per hour; total volume of liquid per hour). -dated 4/16/26, use gastric port for medications only and flush port with 30 cc water before and after medication administration to prevent the tube from clogging. -dated 4/16/26, flush 120 cc six times per day to meet hydration needs. -dated 4/16/26, use jejunal port for tube feeding only and flush with 30 cc of water every four hours to prevent clogging. R1's discharge summary dated 4/16/26, indicated R1 had acute kidney injury and was admitted to Abbot Northwestern Hospital on 4/11/26 with gastrostomy tube displaced and low blood pressure. Lab work indicated severe hypernatremia (high sodium concentration), hyperkalemia (high potassium levels in blood), and elevated lactate (a substance produced by cells when breaking down carbohydrates for energy). R1 received a new feeding tube and IV fluids to manage electrolyte abnormalities. During observation and interview on 4/29/26 at 8:40 a.m., LPN-A entered R1's room with crushed medications mixed in water. LPN-A paused the feeding which ran through the jejunal port, checked residual for R1's feeding tube, slowly pushed 30 cc of water into R1's gastric port, administered medications through gastric port, and flushed with 30 cc of water through gastric port. LPN-A connected the feeding tube to the jejunal port and	F0693		06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0693 SS = D	Continued from page 7 restarted the feeding. LPN-A stated the medication administration was her first care for R1 this morning, and her shift started at 7 a.m. LPN-A did not flush R1's according to the physician order during this episode of care. During continuous observation on 4/29/26 from 8:40 a.m. to 11:53 a.m., LPN-A nor other staff administered any additional flushes to R1's enteral feeding tube. R1's medication and treatment administration record printed on 4/29/26 at 11:14 a.m., indicated R1 received 60 cc flush with the day shift medication administration, 120 cc flush ordered for 9 a.m., and 30 cc flush to the jejunal port ordered for 10 a.m.. During an interview on 4/29/26 at 11:53 a.m., LPN-A reviewed R1's enteral feeding tube orders. LPN-A verified the order for the 120 cc flush six times a day did not specify which port to flush. The water amount given before and after medication administration and the water mixed with the crushed medications combined to count as the ordered 120 cc flush. LPN-A reviewed the jejunal port flush order. LPN-A stated she followed the part of the order which specified to use the jejunal port for tube feeding only and confirmed she did not flush the jejunal port with 30 cc as ordered. LPN-A stated she did not see the part of the order which directed staff to flush the jejunal port with 30 cc of water every four hours. During observation and interview on 4/29/26 at 5:45 p.m., LPN-D and LPN-E entered R1's room. LPN-D put R1's enteral feeding on hold and disconnected tube. LPN-D placed air into enteral tube using a syringe and auscultated abdominal area. LPN-D flushed the jejunal port with 30 cc of water and the gastric port with 30 cc of water. LPN-D was connecting syringe with crushed medication and water mix to the jejunal port, and LPN-E directed LPN-D to stop and administer medications into the gastric port. LPN-D flushed the gastric port with 30 cc of water after medication administration. LPN-D placed additional water in syringe and was directing syringe to jejunal port, and LPN-E directed LPN-D to gastric port. LPN-D flushed the gastric port with 120 cc of water. LPN-D reviewed R1's orders and verified R1's order to flush 120 cc six times per day did not indicate water or what to flush the port with. LPN-D stated R1 used to have gastric ports only and the jejunal port was new. R1's medication and treatment administration record printed on 4/29/26 at 11:14 a.m., directed staff to	F0693		06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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
F0693 SS = D	Continued from page 8 use gastric port for medications only and flush port with 30 cc water before and after medication administration to prevent the tube from clogging during the day, evening, and night shift. The document included the amount of fluids used to flush R1's gastrojejunal tube and varied between 30 and 60 cc's. During interview on 4/29/26 at 3:59 p.m., LPN-B stated staff documented intakes on the medication administration record if the order directed them to. LPN-B stated all residents were at risk for dehydration, and residents with tube feedings were at an increased risk of dehydration. LPN-B reviewed R1's documents, and the order which had varied documentation of 30 and 60 cc flushes administered. LPN-B stated she would want to educate the staff to ensure they documented and gave the correct flushes. During interview on 4/30/26 at 9:12 a.m., registered dietician (RD)-C completed monthly charting on "high-risk" residents such as R1. RD-C stated they reviewed resident medication and treatment administration records to ensure nursing provided appropriate interventions to support residents' nutritional needs. RD-C reviewed R1's order documentation which indicated staff varied giving 30 and 60 cc flushes. RD-C stated they would follow up with nursing to ensure the staff provided R1 with the appropriate flushes. RD-C stated inadequate or incorrect flushing of enteral tube feeding ports could cause clogging or dehydration if there were multiple missed flushing opportunities. RD-C stated administration of medications in the jejunal port instead of the gastric port could affect medication absorption and cause interactions between the feeding formula and medication. During an interview on 4/30/26 at 5 p.m., the director of nursing (DON) expected staff to give residents flushes as ordered, with free water flushes considered a separate amount than flushes with medications, to ensure proper hydration and tube patency. The DON expected staff to give medications and flushes in the correct ports to support proper medication absorption and tube patency.	F0693		06/02/2026
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	F0880	Preparation and/or execution of this plan does not constitute admission or agreement by the provider that a deficiency exists. This response is 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	06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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 9 a 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 involved in direct resident contact.	F0880	Continued from page 9 Corrective action for affected residents: R1 and R4's enteral supplies were immediately corrected. Syringes and containers were dated, emptied after use, separated for air drying, and barriers placed under supplies. Identification of other residents at risk: All residents with feeding tubes were audited for compliance to ensure EBP in place. Systemic changes: nurses were re-educated regarding enteral equipment handling and Enhanced Barrier Precautions. Monitoring: The Infection Preventionist or designee will conduct audits of 3 nurses per week with results reported to QAPI.	06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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 10 §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 enhanced barrier precautions (EBPs) were followed for 1 of 1 resident (R1) when medication was administered via enteral tube. In addition, the facility failed to ensure proper infection control practices related to syringes and containers used for flushing enteral tubes for 2 of 3 residents (R1, R4) reviewed for enteral tubes. Findings include R1’s quarterly Minimum Data Set (MDS) dated 1/31/26, indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had a feeding tube and diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure. R1’s infection care plan revised 4/24/26, indicated R1 was at risk for infection due to gastric tube. The care plan directed staff to follow enhanced barrier precautions with all contact cares due to R1’s gastric tube. During an observation on 4/29/26 at 8:40 a.m., licensed practical nurse (LPN)-A donned gloves and no gown to administer R1’s medications through his gastrojejunostomy tube. During an interview on 4/29/26 at 11:53 a.m., LPN-A stated staff wore gloves and gowns to complete cares, such as dressing and toileting, and foley catheter cares for residents who were on enhanced barrier precautions. LPN-A stated they did not need	F0880		06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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 11 a gown to administer R1's medications through his gastrojejunostomy tube. R1's physician order dated 5/27/25, directed staff to change out syringe and canister for free water every day during the night shift. During observation on 4/28/26 at 4:13 p.m., R1's nightstand had an irrigation syringe with a plunger in it, and the syringe was in an irrigation container filled with water. The syringe and bottle did not have a date. There was no barrier under the container. During interview on 4/28/26 at 4:27 p.m., LPN-C stated the night shift changed the irrigation syringe and bottle every night. LPN-C verified the irrigation syringe and container were not dated and stated the container should be emptied and the plunger separated from the syringe barrel to allow the equipment to dry. R4 R4's quarterly MDS dated 4/13/26, indicated R4 had moderate cognitive impairment and was independent with activities of daily living. R4 had a feeding tube and diagnoses which included cancer, malnutrition, and depression. R4's physician order dated 3/30/26, directed the staff on the night shift to replace graduate, syringe, and dressing every night. Staff were to replace tubing daily if an open enteral system was used or for up to 48 hours if a closed enteral system was used. During observation on 4/28/26 at 4:49 p.m., R4's nightstand had an irrigation syringe, with a plunger in it, in a gray mug with a handle filled with water and not dated. A clear container with water was labeled with the date 4/28/26 and had a syringe with a plunger in it. There were no barriers under the water mug or clear container. During interview on 4/28/26 at 4:56 p.m., registered nurse (RN)-A verified the observations and stated staff were to empty the water from the containers and separate the plunger from the syringe barrel and rinse out before using again. During an interview on 4/29/26 at 3:59 p.m., LPN-B, the facility infection control nurse, expected staff to wear gloves and gowns to administer medications through a resident's gastrojejunostomy tube. LPN-B stated enhanced barrier precautions protected staff and residents and prevented the spread of germs.	F0880		06/02/2026

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 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	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 12 During interview on 4/30/26 at 4:25 p.m., LPN-B expected staff to dump out the water from irrigation containers after use. Standing water and used syringes sitting in water caused germs. During an interview on 4/30/26 at 5 p.m., the director of nursing (DON) stated R1 was on enhanced barrier precautions related to his gastrojejunostomy tube and expected staff to wear a gown and gloves to prevent contamination when the tube was accessed. The DON did not want irrigation syringes left in water for infection control reasons, such as prevention of waterborne pathogens. Facility policy Flushing a Feeding Tube dated 10/2024, directed staff to remove plunger from barrel and air dry after administration of water. Facility policy Enhanced Barrier Precautions dated 10/2025, indicated EBP was the use of gowns and gloves during high contact resident care activities to reduce transmission of multidrug-resistant organisms. High contact resident care activities included feeding tube device care and use.	F0880		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/28/26 to 4/30/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H50551273C (2983201) and H50557625C (2792343) with a licensing order issued at 0830 and 1390	20000		

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20000	Continued from page 1 Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	20000		
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or	20830	Corrected	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 2 the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure ordered hydration interventions were implemented for 1 of 3 residents (R1) reviewed for enteral tubes. Based on interview and record review, the facility failed to ensure services were provided in accordance with professional standards of nursing practice for 1 of 1 residents (R1) when staff inserted a Foley catheter into a gastrostomy stoma without validated competency for the procedure, without completing appropriate clinical assessment to determine safety prior to insertion, and using improper technique, including inflation of the catheter balloon within the stoma. In addition, the facility failed to ensure feeding tube supplies were labeled according to professional standards to avoid the possibility of feeding tube complications and/or related infections for 1 of 3 residents (R4) reviewed for enteral tube feeding. Findings include: R1’s quarterly Minimum Data Set (MDS) dated 1/31/26, indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure. The MDS indicated R1 had a tube feeding which accounted for 51% (percent) or more of total calories R1 received and 501 cc/day (cubic centimeters per day; total volume of liquid per day) or more of average fluid intake per day. R1’s nutrition care plan dated 4/24/26, indicated R1 was NPO (nothing by mouth; may not eat or drink) and required tube feeding related to dysphagia following CVA (cerebrovascular accident; blood flow to the brain is interrupted). The goal was to maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and/or symptoms of malnutrition or dehydration through review date of 5/4/26. Another goal was to have minimal complications related to aspiration through review date of 5/4/26. Care plan interventions included the following: -Administer medication one at a time in gastric tube. Follow flushing precautions per order.	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 3 -Registered dietician to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed. -Tube continuous tube feeding of Isosource 1.5 at 55 mL/hr (milliliters per hour). 30 mL flush before and after feedings (60 mL). Additional free water flush of 120 mL six time per day to meet hydration needs (total 720 mL). R1's physician order indicated the following: -dated 5/23/25, medication given though gastrostomy tube (g-tube). -dated 5/27/25, change out syringe and canister for free water every day. -dated 4/16/26, Isosource 1.5 continuous feeding at 55 cc/hr (cubic centimeters per hour; total volume of liquid per hour). -dated 4/16/26, use gastric port for medications only and flush port with 30 cc water before and after medication administration to prevent the tube from clogging. -dated 4/16/26, flush 120 cc six times per day to meet hydration needs. -dated 4/16/26, use jejunal port for tube feeding only and flush with 30 cc of water every four hours to prevent clogging. R1's discharge summary dated 4/16/26, indicated R1 had acute kidney injury and was admitted to Abbot Northwestern Hospital on 4/11/26 with gastrostomy tube displaced and low blood pressure. Lab work indicated severe hypernatremia (high sodium concentration), hyperkalemia (high potassium levels in blood), and elevated lactate (a substance produced by cells when breaking down carbohydrates for energy). R1 received a new feeding tube and IV fluids to manage electrolyte abnormalities. During observation and interview on 4/29/26 at 8:40 a.m., LPN-A entered R1's room with crushed medications mixed in water. LPN-A paused the feeding which ran through the jejunal port, checked residual for R1's feeding tube, slowly pushed 30 cc of water into R1's gastric port, administered medications through gastric port, and flushed with 30 cc of water through gastric port. LPN-A connected the feeding tube to the jejunal port and	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 4 restarted the feeding. LPN-A stated the medication administration was her first care for R1 this morning, and her shift started at 7 a.m. LPN-A did not flush R1's according to the physician order during this episode of care. During continuous observation on 4/29/26 from 8:40 a.m. to 11:53 a.m., LPN-A nor other staff administered any additional flushes to R1's enteral feeding tube. R1's medication and treatment administration record printed on 4/29/26 at 11:14 a.m., indicated R1 received 60 cc flush with the day shift medication administration, 120 cc flush ordered for 9 a.m., and 30 cc flush to the jejunal port ordered for 10 a.m.. During an interview on 4/29/26 at 11:53 a.m., LPN-A reviewed R1's enteral feeding tube orders. LPN-A verified the order for the 120 cc flush six times a day did not specify which port to flush. The water amount given before and after medication administration and the water mixed with the crushed medications combined to count as the ordered 120 cc flush. LPN-A reviewed the jejunal port flush order. LPN-A stated she followed the part of the order which specified to use the jejunal port for tube feeding only and confirmed she did not flush the jejunal port with 30 cc as ordered. LPN-A stated she did not see the part of the order which directed staff to flush the jejunal port with 30 cc of water every four hours. During observation and interview on 4/29/26 at 5:45 p.m., LPN-D and LPN-E entered R1's room. LPN-D put R1's enteral feeding on hold and disconnected tube. LPN-D placed air into enteral tube using a syringe and auscultated abdominal area. LPN-D flushed the jejunal port with 30 cc of water and the gastric port with 30 cc of water. LPN-D was connecting syringe with crushed medication and water mix to the jejunal port, and LPN-E directed LPN-D to stop and administer medications into the gastric port. LPN-D flushed the gastric port with 30 cc of water after medication administration. LPN-D placed additional water in syringe and was directing syringe to jejunal port, and LPN-E directed LPN-D to gastric port. LPN-D flushed the gastric port with 120 cc of water. LPN-D reviewed R1's orders and verified R1's order to flush 120 cc six times per day did not indicate water or what to flush the port with. LPN-D stated R1 used to have gastric ports only and the jejunal port was new. R1's medication and treatment administration record printed on 4/29/26 at 11:14 a.m., directed staff to	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 5 use gastric port for medications only and flush port with 30 cc water before and after medication administration to prevent the tube from clogging during the day, evening, and night shift. The document included the amount of fluids used to flush R1's gastrojejunal tube and varied between 30 and 60 cc's. During interview on 4/29/26 at 3:59 p.m., LPN-B stated staff documented intakes on the medication administration record if the order directed them to. LPN-B stated all residents were at risk for dehydration, and residents with tube feedings were at an increased risk of dehydration. LPN-B reviewed R1's documents, and the order which had varied documentation of 30 and 60 cc flushes administered. LPN-B stated she would want to educate the staff to ensure they documented and gave the correct flushes. During interview on 4/30/26 at 9:12 a.m., registered dietician (RD)-C completed monthly charting on "high-risk" residents such as R1. RD-C stated they reviewed resident medication and treatment administration records to ensure nursing provided appropriate interventions to support residents' nutritional needs. RD-C reviewed R1's order documentation which indicated staff varied giving 30 and 60 cc flushes. RD-C stated they would follow up with nursing to ensure the staff provided R1 with the appropriate flushes. RD-C stated inadequate or incorrect flushing of enteral tube feeding ports could cause clogging or dehydration if there were multiple missed flushing opportunities. RD-C stated administration of medications in the jejunal port instead of the gastric port could affect medication absorption and cause interactions between the feeding formula and medication. During an interview on 4/30/26 at 5 p.m., the director of nursing (DON) expected staff to give residents flushes as ordered, with free water flushes considered a separate amount than flushes with medications, to ensure proper hydration and tube patency. The DON expected staff to give medications and flushes in the correct ports to support proper medication absorption and tube patency. R1's quarterly Minimum Data Set (MDS) dated 1/31/26, indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had a feeding tube and diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure.	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 6 R1's nutrition care plan dated 4/24/26, indicated R1 was NPO (nothing by mouth; may not eat or drink) and required tube feeding related to dysphagia following CVA (cerebrovascular accident; blood flow to the brain is interrupted). The goal was to maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and/or symptoms of malnutrition or dehydration through review date of 5/4/26. Another goal was to have minimal complications related to aspiration through review date of 5/4/26. Care plan interventions included a directive to check tube placement and gastric contents per facility protocol; there was no interventions for emergency procedures or facility protocol in the event of tube dislodgment referred to. R1's physician orders from 4/8/26 to 4/11/26 included the following: -dated 5/23/25, medication given though gastrostomy tube (g-tube). -dated 5/27/25, change out syringe and canister for free water every day. -dated 2/11/26 to 4/16/26, Osmolite 1.5 at 85 mL/hr through gastrostomy tube from 6:00 p.m. to 10 a.m. until total volume of 1,360 mL. -dated 2/11/26 to 4/16/26, 180 mL free water flush four times a day to enteral feeding tube to meet hydration needs. -dated 4/8/26 to 4/10/26, monitor enteral feeding site for signs and/or symptoms of infection, patency, and pain. Update provider as needed. R1's physician orders did not include emergency orders or directives for tube dislodgment. R1's Nursing Note on 4/11/26 at 2:59 a.m., indicated R1 pulled out his gastrostomy tube at approximately 1:30 a.m.. licensed practical nurse (LPN)-F placed a 16 French Foley catheter into R1's stoma to keep patent, as facility protocol. R1 denied pain and vitals obtained with a blood pressure of 73/45 mmHg (millimeters of mercury; standard unit of pressure). R1 was sent to Hospital at approximately 1:45 a.m. A message was left to the on-call provider. Review of the medical record did not identify documentation of a clinical assessment prior to insertion of the Foley catheter, including assessment of tract maturity, duration of dislodgement, or	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 7 evaluation for potential complications. There was no evidence of a physician order authorizing insertion of a Foley catheter into the gastrostomy stoma. During interview on 4/29/26 at 2:05 p.m., LPN-F stated they found R1's enteral tube out of R1's stoma with the balloon deflated. LPN-F was not sure how long the tube had been out and was directed by registered nurse (RN)-B to insert a Foley catheter into R1's stoma. LPN-F stated they were unaware of the policy to place a Foley catheter into stoma for dislodged enteral feeding tube. LPN-F did not know what size R1's gastrostomy tube was and stated they placed a 16 French Foley catheter into R1's stoma with 5 cc (cubic centimeters; a volume measurement) in the catheter's balloon. During interview on 4/29/26 at 2:40 p.m., RN-B stated they were notified when R1's enteral tube feeding was found dislodged. RN-B watched LPN-B clean R1's stoma and sterilely place the Foley catheter into R1's stoma. RN-B stated the Foley catheter was inserted to avoid stomal closure. RN-B stated staff called the provider and sent R1 to the hospital when they did not hear back from the provider. During interview on 4/29/26 at 4:22 p.m., the director of nursing (DON) did not know what kind or size of gastrostomy tube R1 had at the time it became dislodged on 4/11/26. The DON expected staff to follow their policy to put a Foley catheter in a stoma to keep patent when enteral feeding tube became dislodged. The DON expected staff to be competent related to Foley insertion. The DON expected staff to follow provider orders when an enteral tube feeding became dislodged and stated they did not have a direct provider order to place a Foley catheter in a stoma if a enteral tube feeding became dislodged. During interview on 4/30/26 at 11:37 a.m., primary care provider (PCP)-E agreed the facility should have clear directions in place for a dislodged enteral feeding tube with training and competency for placing a Foley catheter into a stomal opening. During interview on 4/30/26 at 10:25 a.m., the medical director stated enteral feed stomal openings close quickly if tube becomes dislodged, and staff have quick access to hospitals. The medical director stated the size of the Foley catheter did not matter as the purpose was to keep the stoma open. The medical director stated they would not want staff to place a Foley catheter into a stomal opening less than six weeks to two months old, because there	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 8 was a risk for perforation. The medical director stated staff who were competent to put a Foley catheter into a urethra were capable to place in stomal opening in the case of enteral feeding tube dislodgement. LPN-F's Foley Cather Competency Checklist dated 12/19/23, indicated LPN-F met the actions to insert a foley catheter into the meatus of a male resident. The competency did not include the action to place a foley catheter into a stoma used for enteral tube feeds. RN-B's Inserting an Indwelling Urinary Catheter dated 4/20/26, indicated RN-B met the steps required to insert a urinary catheter into a male and female urinary meatus. The competency did not include the action to place a foley catheter into a stoma used for enteral tube feeds. Facility policy Care and Treatment of Feeding Tubes dated 10/2024, directed staff to insert a temporary tube (e.g. Foley catheter) to prevent tract closure if an enteral feeding tube dislodged and send resident to the hospital as soon as possible for possible replacement of the feeding tube. R4 R4's quarterly MDS dated 4/13/26, indicated R4 had moderate cognitive impairment and was independent with activities of daily living. R4 had a feeding tube and diagnoses which included cancer, malnutrition, and depression. R4's physician order dated 3/30/26, directed the staff on the night shift to replace graduate, syringe, and dressing every night. Staff were to replace tubing daily if an open enteral system was used or for up to 48 hours if a closed enteral system was used. During observation on 4/28/26 at 4:49 p.m., R4's room had a clear Kangaroo enteral feeding bag with between 50 and 100 milliliters of tannish colored liquid in it hanging from a tube feeding pole. R4 was not in the room, and the bag did not have a label to identify what the liquid was. During interview on 4/28/26 at 4:56 p.m., registered nurse (RN)-A verified the observations and stated staff were expected to label the enteral feeding bag with the formula type and date when feeding started. R4's physician order dated 3/31/26, directed staff to give 150 mL tap water flush three times a day and	20830		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
20830	Continued from page 9 30 mL before and after intermittent feedings and medication administration via feeding tube unless directed otherwise. The April 2026 medication and treatment administration record marked the order as completed in the morning, afternoon, and bedtime. The record did not reflect the amount used to flush R4's feeding tube. R4's physician order dated 4/15/26, directed for continuous feed of Osmolite 1.5 at 95 mL/hr (milliliters per hour) for 11 hours from 8 p.m. to 7 a.m. and flush tube with 30 mL of free water flush before and after. The April 2026 medication and treatment administration record marked the order as completed at 7 a.m. and 8 p.m. and did not reflect the amount used to flush R4's feeding tube. During an interview on 4/30/26 at 5:00 p.m. director of nursing (DON) reviewed R4's medication and treatment administration record and expected staff to update the orders with flushes to indicate the amount of flushes R4 received. The DON expected staff to label and date tube feeding bags and supplies for infection control reasons. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and/or revise policies and procedures related to enteral tube management and emergency response to ensure care and services are provided according to professional standards of practice and physician orders. The director of nursing or designee should educate staff and implement competency validation related to enteral tube care and interventions. The facility should develop a monitoring system such as measurable audits to ensure staff follow physician orders, facility policy, and competency expectations. The results of those audits should be reviewed through the QAPI process to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20830		06/02/2026
21390	Infection Control CFR(s): MN Rule 4658.0800 Subp. 4 A-I Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following:	21390	Corrected	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
21390	Continued from page 10 A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBPs) were followed for 1 of 1 resident (R1) when medication was administered via enteral tube. In addition, the facility failed to ensure proper infection control practices related to syringes and containers used for flushing enteral tubes for 2 of 3 residents (R1, R4) reviewed for enteral tubes. Findings include R1’s quarterly Minimum Data Set (MDS) dated 1/31/26, indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had a feeding tube and diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure. R1’s infection care plan revised 4/24/26, indicated	21390		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
21390	Continued from page 11 R1 was at risk for infection due to gastric tube. The care plan directed staff to follow enhanced barrier precautions with all contact cares due to R1's gastric tube. During an observation on 4/29/26 at 8:40 a.m., licensed practical nurse (LPN)-A donned gloves and no gown to administer R1's medications through his gastrojejunostomy tube. During an interview on 4/29/26 at 11:53 a.m., LPN-A stated staff wore gloves and gowns to complete cares, such as dressing and toileting, and foley catheter cares for residents who were on enhanced barrier precautions. LPN-A stated they did not need a gown to administer R1's medications through his gastrojejunostomy tube. R1's physician order dated 5/27/25, directed staff to change out syringe and canister for free water every day during the night shift. During observation on 4/28/26 at 4:13 p.m., R1's nightstand had an irrigation syringe with a plunger in it, and the syringe was in an irrigation container filled with water. The syringe and bottle did not have a date. There was no barrier under the container. During interview on 4/28/26 at 4:27 p.m., LPN-C stated the night shift changed the irrigation syringe and bottle every night. LPN-C verified the irrigation syringe and container were not dated and stated the container should be emptied and the plunger separated from the syringe barrel to allow the equipment to dry. R4 R4's quarterly MDS dated 4/13/26, indicated R4 had moderate cognitive impairment and was independent with activities of daily living. R4 had a feeding tube and diagnoses which included cancer, malnutrition, and depression. R4's physician order dated 3/30/26, directed the staff on the night shift to replace graduate, syringe, and dressing every night. Staff were to replace tubing daily if an open enteral system was used or for up to 48 hours if a closed enteral system was used. During observation on 4/28/26 at 4:49 p.m., R4's nightstand had an irrigation syringe, with a plunger in it, in a gray mug with a handle filled with water and not dated. A clear container with water was labeled with the date 4/28/26 and had a syringe with	21390		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
21390	Continued from page 12 a plunger in it. There were no barriers under the water mug or clear container. During interview on 4/28/26 at 4:56 p.m., registered nurse (RN)-A verified the observations and stated staff were to empty the water from the containers and separate the plunger from the syringe barrel and rinse out before using again. During an interview on 4/29/26 at 3:59 p.m., LPN-B, the facility infection control nurse, expected staff to wear gloves and gowns to administer medications through a resident's gastrojejunostomy tube. LPN-B stated enhanced barrier precautions protected staff and residents and prevented the spread of germs. During interview on 4/30/26 at 4:25 p.m., LPN-B expected staff to dump out the water from irrigation containers after use. Standing water and used syringes sitting in water caused germs. During an interview on 4/30/26 at 5 p.m., the director of nursing (DON) stated R1 was on enhanced barrier precautions related to his gastrojejunostomy tube and expected staff to wear a gown and gloves to prevent contamination when the tube was accessed. The DON did not want irrigation syringes left in water for infection control reasons, such as prevention of waterborne pathogens. Facility policy Flushing a Feeding Tube dated 10/2024, directed staff to remove plunger from barrel and air dry after administration of water. Facility policy Enhanced Barrier Precautions dated 10/2025, indicated EBP was the use of gowns and gloves during high contact resident care activities to reduce transmission of multidrug-resistant organisms. High contact resident care activities included feeding tube device care and use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and/or revise policies and procedures related to enhanced barrier precautions and infection control practices for enteral feeding equipment and supplies. The director of nursing or designee should educate staff regarding appropriate use of personal protective equipment, handling and storage of enteral feeding supplies, and infection prevention practices related to enteral tube care. The facility should develop a monitoring system such as measurable audits to ensure staff follow infection control policies, enhanced barrier precaution requirements, and proper cleaning, labeling, and storage of enteral feeding equipment. The results of	21390		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/30/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEHOUSE HEALTHCARE & REHABILITATION CENTER	**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
21390	Continued from page 13 those audits should be reviewed through the QAPI process to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		06/02/2026