STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakehouse Healthcare & Rehabilitation Center	3737 Bryant Avenue South Minneapolis, MN 55409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44649 Based on interview and record review the facility failed to provide ensure that 1 of 3 residents (R1) received treatment in accordance with professional standards of practice. R1 was discharged from the hospital with identified sores on his lower legs and the facility did not provide any cares for three days to his legs. Findings include: R1's care plan dated 8/22/24 indicated R1 had a potential for impaired skin integrity related to decreased mobility, incontinence, anticoagulation therapy, diabetes type II and predisposing disease. R1's interventions were: -Encourage good nutrition and hydration to promote healthier skin dated 8/22/24. -Avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short dated 8/22/24. -Keep skin clean and dry revision date of 10/15/24 -Apply Mepilex border dressing to coccyx area to prevent skin breakdown over body prominences dated 10/23/24. -Wear padded boots when in bed to protect heels from breakdown dated 10/23/24. R1's Minimum Data Set (MDS) dated [DATE] indicated R1's Brief Interview for Mental Status (BIMs) score was a nine indicating R1 was moderately cognitively impaired. R1 required moderate assistance with toileting hygiene, lower body dressing, showering, and bathing and transferring. R1's diagnoses were cerebral infarction (stroke), cardiogenic shock (when the heart cannot, pump enough blood and oxygen to the brain and other vital organs), atrial fibrillation (irregular heart rate), cellulitis (bacterial infection of the skin, causing swelling and inflammation) of both lower limbs, and dysphagia (difficulty swallowing). R1's nursing progress note dated 10/7/24 at 3:46 p.m. indicated R1 was sent to the hospital at 2:00 p.m. due to swollen left lower extremity and declined wound care on that leg. The area showed redness and R1 complained of pain. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's nursing progress note dated 10/7/24 at 10:50 p.m. indicated the facility received a call from the emergency department with an updated status that R1 had a urinary tract infection and cellulitis (a bacterial skin infection). R1 was admitted to the hospital. R1's hospital note dated 10/8/24 indicated R1 was admitted with a lower extremity wound, cellulitis and abscess of the foot. R1 was septic related to soft tissue versus urinary infection. The source was soft tissue/cellulitis in his feet versus urine. There was a concern for possible necrotizing fasciitis on both lower extremities given rapid decompensation in the emergency department. R1 was treated with medications Linezolid and cefepime (antibiotics). R1's hospital discharge summary dated 10/15/24 at 2:31 p.m. indicated R1 was hospitalized for septic shock from a leg wound. The discharge summary did not include wound care orders. R1's nursing progress admission note dated 10/15/24 at 9:17 p.m. indicated R1 returned to the facility at 6:11 p.m. R1 was alert and oriented. His skin was clear, except for some dark dry sore scalps [sic] on both legs. Each foot was wrapped in a bandage. The note did not indicate whether the wraps were removed or the conditions of his feet. R1's admission/readmission nursing assessment on 10/15/24 at 9:28 p.m. indicted R1's skin color was normal, tissue turgor (measure of skin elasticity) was normal, temperature was warm, R1 had no wounds. His skin was observed to have been clean. No edema (swelling caused by fluid retention) was identified; however, he had an intervention to elevate his legs for edema. There was no documentation under skin integrity of any concerns. R1's nursing progress note dated 10/18/24 at 2:32 p.m. indicated R1's wound measured 16-centimeter (cm) x 10 cm open blister on top of his left foot with a 5 cm x 1 cm area noted to the inner aspect of his right lower extremity. Both areas cleaned with wound cleaner, oil emulsion dressing applied and covered with an ABD (abdominal gauze pad used to absorb heavily draining wounds) and kerlix and was secured with tape. A skin assessment was not completed. R1's weekly skin evaluation dated 10/21/24 at 1:04 p.m. indicated previously identified skin alterations. No other documentation was noted on the evaluation. R1's electronic medical record (eMAR) dated 10/18 - 10/24/24 indicated the facility started daily wound care to R1's top of left foot, cleanse with wound cleanser, apply Vaseline gauze and cover with ABD and kerlix wrap. In addition, right inner aspect of lower extremity; cleanse with wound spray, apply Vaseline gauze, wrap with kerlix one time a day for wound care. No treatment was completed for R1 from 10/15/24 until 10/18/24. R1's facility wound nurse practitioner visit note dated 10/23/24 indicated R1 was seen for bilateral leg and foot wounds. R1 was recently hospitalized and was noted to have right shin and left dorsal (outer side) foot wounds appearing to be venous ulcers (wounds in the low extremities caused by problems with blood flow). He reported significant pain with wound treatments. He continued to have leg swelling and could not always tolerate compression stockings or wraps. R1's wound was debrided (removing of dead or infected tissue) to the muscle layer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's electronic medical record (eMAR) dated 10/24/24 - 10/29/24 indicated R1 received wound care to his left foot: Cleanse wound, pat dry, apply a thin layer or medihoney, oil emulsion, cover with ABD and rolled gauze, change daily and as needed. In addition, wound care to right leg, cleanse wound, pat dry, cover with oil emulsion gauze, ABD, roll gauze and charge daily and as needed. R1's nursing progress note dated 10/28/24 at 1:20 p.m. indicated at 12:30 p.m. the nurse manager saw physical therapy with R1 in the hallway with R1 in his wheelchair. R1 was yelling in pain at any attempt to move, apply pressure or touch left leg. R1 had bandages over his feet per orders. His skin was warm, red, and taut (tight). His left upper extremity had 3+ pitting swelling (a moderate level of fluid build-up in the body that appears as a deep dent in the skin that takes 30 seconds to go away after pressure is applied). R1's left upper extremity was more swollen but the yelling out in pain was a drastic difference from that morning. R1's nursing progress note on 10/28/24 at 2:53 p.m. indicated at the start of the shift R1 was alert and did not verbalize any pain. R1 was found sitting on the floor next to his bed by a nursing assistant. According to R1 he got up from the bed, walked over to get his cane and he fell on his buttocks while trying to sit back on his bed. R1 denied any injury, and none was observed. R1 was sent to the hospital due to left foot and lower extremity swelling unrelated to the fall. R1's medical intensive care unit progress note (MICU) dated 10/31/24 indicated R1 was admitted on [DATE] for sepsis due to a worsening left foot wound. He was transferred to the MICU on 10/30/24 for clinical instability (hypotension, worsening altered mental status) with acute chronic heart failure causing cardiogenic shock on top of suspected septic shock. R1's sepsis was due to an unspecified organize, unspecified whether active organ dysfunction present. R1's hospital surgical note dated 11/7/24 indicated R1 was admitted on [DATE] with altered mental status and worsened lower extremity cellulitis in association with a known left foot wound. R1's lower extremity wound had progressively worsened in appearance since his 10/8/24 hospitalization with new development of cellulitis to his upper ankle and development of eschar (scab) with regions of necrosis noted on periphery (outer limits). On 10/30/24 R1 appeared to clinically worsen with altered mental status and worsened hypotension and was transferred to MICU for continued cares. Cardiology heavily involved in management of R1's suspected cardiogenic shock resulting from ischemic cardiomyopathy. From a surgical perspective it was felt there was little evidence to support R1 was in septic shock as a result of the wound. However, R1 clinically worsened overnight 11/2/24 - 11/3/24 and was taken to the operating room for a left below the knee amputation on 11/3/24. Upon interview on 12/23/24 at 1:00 p.m. registered nurse (RN)-A stated on 10/6/24 R1 was found to have had a wound on the top of his left foot and increased pain. He was sent to the emergency room and was admitted to the hospital until 10/15/24. Upon chart review with the surveyor RN-A noticed the RN who completed the readmission assessment indicated there were no skin concerns documented on the assessment, but on the progress note it was noted that a was a dark dry scab on both legs and each leg foot was wrapped in a bandage. RN-A stated R1 returned from the hospital without any treatment orders for his legs. RN-A could not find any documentation indicating when and if R1's dressings were removed or if any treatments were completed until 10/18 /24 when the progress note indicated R1 had venous ulcers. RN-A stated the nurse who completed the readmission assessment had been terminated from her position at the facility. RN-A stated the RN who completed the readmission skin assessment should have started house orders and notified the nurse practitioner for orders. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Upon interview on 12/23/24 at 1:49 p.m. R1's facility Nurse Practitioner (NP)-A stated she saw R1 on 12/21/24 and referred him to the facilities wound care team. She stated there were orders in place for cleansing and covering the wound dated 10/18/24. She stated she did not recall writing the orders, but the orders could have been a verbal order as her name was attached to them. She stated with R1's multiple medical concerns the staff should have been looking at his legs daily and charting. The NP stated R1 passed away in the hospital. She believed the cause of death was cardiogenic shock but was not certain. She stated she read in a note that R1's below the knee amputation and his death were not caused from sepsis from his wounds. She stated she does not know if the facility would have started a treatment on 10/15/24 would have made a difference. I don't what happened in those three days. Upon interview on 12/23/24 at 4:40 p.m. the facility wound NP-B stated she only saw R1 once and that was on 10/23/24. She stated R1's wounds were not infected on that day. She stated she completed a successful debridement. She stated the facilities failure to address or begin treatment to his leg wound until 10/18/24 did not add to any harm for R1. Upon interview on 12/23/24 at 3:42 p.m. the director of nursing (DON) stated R1 returned with no orders for wounds and stated that was it also the hospital's fault for not providing orders and this has been an ongoing problem. The DON stated she did notice R1 returned on the 10/15/24 and did not start wound treatment on 10/18/24 she stated the facility attempts to get orders going with 48 hours. The DON expected staff to fully observe skin on all skin assessment or otherwise document reason it could not be completed. Upon interview on 12/24/24 at 9:01 a.m. R1's medical provider stated the facility should be physically observing residents' skin on their assessments. She stated she could not answer if harm was caused with the three days R1's skin was not assessed, however R1's cause of death was from cardiogenic shock. He had so much going on. A facility policy titled Admission policy dated January 2024 indicated the admission procedure included to screen the resident and perform a body check as able.