STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	07/18/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the physician was notified of a rapid weight gain for resident with diagnosis of Congestive Heart Failure (CHF)(one warning sign of CHF is rapid weight gain which could indicate fluid buildup in the body) and failed to contact physician to receive clarification on orders for 1 of 3 resident (R1) who was admitted to the facility without weight and notification parameters related to CHF diagnosis.Findings Include:R1's admission Minimum Data Set (MDS) assessment dated [DATE] identified an admission of 6/27/25, intact cognition and a medical diagnosis of CHF.R1's physician order dated 6/27/25 identified R1's indicated to weigh R1 for 1 day, then weekly for 4 weeks then monthly.R1's hospital discharge weight was 188 pounds (lbs.) on 6/27/25.R1's recorded daily weights at the facility were as follows:-6/27/25 194 lbs.-6/29/25 192 lbs.-7/2/25 197 lbs. and199 lbs.-7/3/25 197 lbs.-7/4/25 200 lbs. -7/7/25 207 lbs.R1's Nurse Practitioner visit notes dated 6/30/25, indicated daily weights and to follow up with cardiology. No parameters were ordered on this visit. R1's primary physician notes for 7/1/25 visit indicated no changes to orders occurred and plan for CHG was to continue current medications. R1's cardiovascular visit dated 7/7/25 indicated a weight gain of 18 lbs. since hospital discharge. Medication changes included to increase furosemide (Lasix) to 40 milligrams (mg) twice a day, start potassium 40 mg once a day and one tablet of Metolazone before taking Lasix. Daily weight to be taken before food or drink, and after using the bathroom. Call provider if weight gain of 2 lbs. in a day or 5 lbs. in a week. Dry weight is estimated around 190 lbs.Facility progress notes dated 6/27/25 through 7/7/25 lacked evidence of communication with R1's primary physician concerning clarification of weights and parameters to manage R1's CHF diagnosis.When interviewed on 7/17/25 at 10:56 a.m., director of nursing (DON) stated nurses were to clarify orders when needed; R1 discharge order from the hospital was weights only however orders did not give any parameters which was not common for someone with CHF. DON stated nursing did not contact R1 primary physician for clarification and R1 did have a weight gain between admission and his cardiovascular appointment on 7/7/25. DON stated she became aware of R1's weights not being complete routinely and no orders with parameters at that time; education was started with staff and resident audits were started regarding orders the morning of this survey entrance. DON stated not all staff had been educated. DON was not aware of any protocol for staff to follow except knowing best practice to clarify orders when there was weight gain and diagnosed with CHF, primary physicians would be called for this clarity.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	07/18/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	07/18/2025

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a baseline care plan which provided effective and person-centered care direction to meet professional standards of care for 1 of 3 residents (R1) who admitted to the facility with a diagnosis of congested heart failure (CHF). Additionally, the facility failed to implement a baseline care plan within 48 hours of admission for 1 of 3 (R1) reviewed. Findings include:R1's admission Minimum Data Set (MDS) assessment dated [DATE], identified an admission of 6/27/25, intact cognition and a medical diagnosis of congestive heart failure (CHF).R1's physician order dated 6/27/25 identified R1's indicated to weigh R1 for 1 day, then weekly for 4 weeks then monthly.R1's baseline care plan dated 6/30/25, indicated Focus Cardiovascular: the resident has impaired cardia output due to diagnosis of CHF. Interventions listed as:-monitor vital signs and notify MD of significant abnormalities.-Lab work.-Weight monitoring dailyR1's Baseline care plan lacked evidence of specific care parameters for weight monitoring related to R1 diagnosis of CHF (one warning sign of CHF is rapid weight gain which could indicate fluid buildup in the body). Though the care plan did direct to take daily weights, there was lack of direction related to contacting a physician for weight gain within specific time frames necessary to meet R1's person centered care needs to effectively treat his CHF.Base line care plan was not developed and implemented within 48 hours of admission. R1's documented daily weights at facility were as followed:6/27/25 194 lbs.6/29/25 192 lbs.7/2/25 197 lbs. and199 lbs.7/3/25 197 lbs.7/4/25 200 lbs.7/7/25 207 lbs.R1's cardiovascular visit dated 7/7/25, indicated a weight gain of 18 lbs. since hospital discharge and was being seen for CHF. Medication changes included to increase Lasix to 40 milligrams (mg) twice a day, start potassium 40 mg once a day and one tablet of Metolazone before taking furosemide. Daily weight to be taken before food or drink, after using the bathroom. Call provider if weight gain of 2 lbs. in a day or 5 lbs. in a week. Dry weight is estimated around 190 lbs.R1's physician order dated 7/8/25 indicated to take Metolazone 2.5 milligrams (mg) by mouth one time a day until 7/8/25 before taking morning Lasix.Physician orders dated 7/7/25 indicated to take Lasix 20 mg for CHF.R1's physician order dated 7/9/25 indicated to weigh daily C1 before eating or drinking. Call physician for weight gain of over 2 lbs. in 24 hours or increase in 5 lbs. in 1 week.When interviewed on 7/17/25 at 11:26 a.m., R1 stated when admitted to facility, weights were inconsistent, and he was not aware if his physician was contacted when there was a weight gain. R1 did recall gaining weight when first admitted to facility. R1 stated his family had to meet with facility to address weight increase concerns.When interviewed on 7/17/25 at 3:13 p.m., nurse manager (NM) stated protocol for a resident with diagnosis of CHF would include weights and if there was a weight gain the physician would be updated. NM stated the baseline care plan was to be developed within 48 hours and acknowledged R1's baseline care plan was not completed on time and confirmed there was not weight parameters in R1 baseline care plan however, there were not orders for parameters. NM stated a nurse should have clarified the order with the primary physician upon admission.When interviewed on 7/18/25 at 11:11 a.m., director of nursing (DON) stated R1 was admitted on [DATE] and the order received upon admission instructed to weigh R1 the day of admission and then weekly for 4 weeks and then monthly. Facility protocol for new admits was to weigh every day for 7 days and, in reviewing his record, there were a few weights missed with R1, so staff had been educated on this protocol. DON stated the order from the hospital was followed however, it would be best practice to have parameters for R1 because of his diagnoses of CHF. Additionally, DON stated R1's baseline care plan did address his diagnosis of CHF and did indicate to complete weights which was the order at the time. Facility policy titled Comprehensive Care Planning, dated 1/2024 indicated Baseline Care Plan: Develop and implement instructions necessary to provide effective and resident-centered care to meet professional standards, develop within 48 hours of admission and include the following: initial goals based on admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations, discharge goals and other applicable items.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	07/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245055	A. Building B. Wing	07/18/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review the facility failed to provide comprehensive nursing care to meet acceptable standards of clinical practice for 1 of 3 resident (R1) who was admitted to the facility with a diagnosis of congestive heart failure (CHF) and no clarification for daily weight and notification parameters were requested to ensure adequate medical care. This resulted in a 13-pound (lbs.) weight gain in ten days. Findings include:The National Institute of Health (NIH) (.gov)Nursing ManagementThe nursing care plan for patients with HF should include:Relieving fluid overload symptomsRelieving symptoms of anxiety and fatiguePromoting physical activityIncreasing medication complianceDecreasing adverse effects of treatmentTeaching patients about dietary restrictionsTeaching patient about self-monitoring of symptomsTeaching patients about daily weight monitoring When To Seek HelpPrompt assessment by the medical team is indicated in the following situations:Worsening symptoms of fluid overloadWorsening hypoxia Uncontrolled tachycardia regardless of the rhythmChange in cardiac rhythmChange in mental statusDecreased urinary output despite diuretic therapyMonitoringPatients with HF require frequent monitoring of vital signs, including oxygen saturation. They may also require constant monitoring of the heart rate and rhythm via telemetry monitoring. Frequent assessment and monitoring for symptoms is also indicated. All patients with HF require daily weight monitoring.Resource: Heart Failure (Congestive Heart Failure) (Nursing) - StatPearls - NCBI BookshelfR1's admission Minimum Data Set (MDS) assessment dated [DATE], identified an admission of 6/27/25, intact cognition and a medical diagnosis of congestive heart failure (CHF).R1's baseline care plan dated 6/30/25, indicated Focus Cardiovascular: the resident has impaired cardia output due to diagnosis of CHF. Interventions listed as:-monitor vital signs and notify MD of significant abnormalities.-Lab work.-Weight monitoring dailyThere were no parameters in this assessment when to notify MD if weight changed.R1's Baseline care plan lacked evidence of specific care parameters for weight monitoring related to R1 diagnosis of CHF (one warning sign of CHF is rapid weight gain which could indicate fluid buildup in the body). Though the care plan did direct to take daily weights, there was lack of direction related to contacting a physician for weight gain within specific time frames necessary to meet R1's person centered care needs to effectively treat his CHF.R1's physician order dated 6/27/25 identified R1's diagnosis of CHF and indicated to weigh for 1 day, then weekly for 4 weeks then monthly.R1's Nurse Practitioner visit notes dated 6/30/25, indicated daily weights and to follow up with cardiology. No parameters were ordered on this visit.R1's primary physician notes for 7/1/25 visit indicated no changes to orders occurred and plan for CHG was to continue current medications.R1's hospital discharge weight was 188 lbs. on 6/27/25. Documented daily weights at facility were as followed:6/27/25 194 lbs.6/29/25 192 lbs.7/2/25 197 lbs. and 199 lbs.7/3/25 197 lbs.7/4/25 200 lbs.7/7/25 207 lbs. R1's cardiovascular visit dated 7/7/25, indicated a weight gain of 18 lbs. since hospital discharge and was being seen for CHF. Medication changes included to increase Lasix to 40 milligrams (mg) twice a day, start potassium 40 mg once a day and one tablet of Metolazone before taking furosemide. Daily weight to be taken before food or drink, after using the bathroom. Call provider if weight gain of 2 lbs. in a day or 5 lbs. in a week. Dry weight is estimated around 190 lbs.R1's physician order dated 7/8/25 indicated to take Metolazone 2.5 milligrams (mg) by mouth one time a day until 7/8/25 before taking morning Lasix.Physician orders dated 7/7/25 indicated to take Lasix 20 mg for CHF.R1's physician order dated 7/9/25 indicated to weigh daily C1 before eating or drinking. Call physician for weight gain of over 2 lbs. in 24 hours or increase in 5 lbs. in 1 week.Interview on 7/16/25 at 1:21 p.m., family member (FM) stated there was concerns with facility not tracking R1's weights and he did have a significant weight increase. FM stated she was concerned the facility was not following physician's orders however he had not returned to the hospital but at a cardio appointment they found the increase in weight of 18 lbs. and had to make medication changes to remove the fluid.When interviewed on 7/17/25 at 11:26 a.m., R1 stated when admitted to facility his weights were inconsistent and was not aware if his physician was contact when there was a weight gain. R1 did recall gaining weight when first admitted to facility and his family had to meet with the facility to address weight increase concerns.When interviewed on 7/17/25 at 12:14 p.m., nursing assistant (NA)-A stated R1 did have daily weights and was to be weighed in the morning and then inform the nurse of the weight. NA-A stated R1 cannot weigh himself and report the weight, staff had to be present for accurate reading.When interviewed on 7/17/25 at 2:54 p.m., health unit coordinator (HUC) stated when a resident is admitted orders are entered into the computer system and the