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	09/03/2025

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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to follow the Provider Orders for Life Sustaining Treatment (POLST) to provide cardiopulmonary resuscitation (CPR) for 1 of 3 residents (R1), who wished to have CPR in the event of cardiopulmonary arrest (absence of pulse and respirations). This deficient practice resulted in an immediate jeopardy (IJ) when R1 was found absent of pulse and respirations, no CPR was initiated, and R1 passed away. The facility implemented corrective action prior to survey; therefore, the deficient practice was issued at past non-compliance. The IJ began on [DATE], when R1 was found unresponsive with an absence of pulse and respirations, CPR was not initiated, and R1 passed away. The facility administrator and director of nursing (DON) were notified of the IJ on [DATE] at 2:50 p.m. which was identified at the scope and severity of and isolated IJ. The facility implemented immediate corrective action on [DATE] to prevent recurrence, therefore, the IJ was issued at past non-compliance. Findings include: A nursing note written by licensed practical nurse (LPN)-A dated [DATE], indicated when LPN-A checked on R1 Cheyne-Stokes breathing (an abnormal breathing pattern of deep breathing, shallow breathing and no breathing followed by a gasp, commonly seen during the dying process) was observed. LPN-A requested assistance from another facility nurse and R1's hospice nurse who was in the building. When the nurses returned to R1's room, he was not breathing. The nurses checked for a pulse, finding none. Time of death was called at 2:20 p.m. The nurses cleaned R1's body to prepare for the mortuary to pick up. R1's progress note lacked documentation regarding checking R1's code status and initiation of CPR. R1's admission Minimum Data Set (MDS) dated [DATE], indicated intact cognition with diagnoses that included metabolic encephalopathy, type 2 diabetes, and end stage renal disease. R1's POLST dated [DATE], identified R1's wishes were to attempt CPR (full code) with full treatment including intubation, advanced airway interventions, mechanical ventilation and transfer to the hospital if indicated. A Care Conference Summary, locked [DATE], identified R1 was a full code and wished to remain as such. A provider visit note, dated [DATE], identified R1 was seen by nurse practitioner (NP)-A. The note identified R1's advance directive as full code. A provider order dated [DATE], indicated code status as CPR/attempt resuscitation. R1's electronic health record (EHR) indicated R1 elected hospice care on [DATE]. During an interview on [DATE] at 12:52 p.m., LPN-B stated when a resident was found unresponsive and not breathing, a nurse STAT (an emergency page overhead that calls nurses to a specific location) should be called and the resident's chart should be checked for code status. LPN-B stated CPR would be performed if consistent with the resident's wishes. LPN-B confirmed code status would be checked for a resident who had elected hospice care since hospice care did not automatically mean a resident's code status was do not resuscitate (DNR. Allow natural death). During an interview on [DATE] at 1:29 p.m., LPN-C stated a resident's code status needed to be checked for all residents who were found unresponsive and not breathing. LPN-C stated CPR would be performed if consistent with resident's wishes. During an interview on [DATE] at 2:29 p.m., DON confirmed R1's code status was full code, his code status had not checked when he was found unresponsive, and CPR had not been performed. During an interview on [DATE] at 12:18 p.m., Hospice registered nurse (HRN) stated she was at the facility to see R1 on [DATE], because he was having increased pain. When she assessed R1, he was a little confused however, was able to answer basic questions. HRN left the room to call the provider. LPN-A asked HRN to go to R1's room because his breathing was different. When HRN and LPN-A returned to R1's room, he was not responding and was not breathing. HRN checked for a pulse while LPN-A checked for breathing. Finding no pulse and no breaths, time of death was called. HRN did not check the resident's code status, and LPN-A did not leave the room until after time of death was called. HRN confirmed CPR had not been initiated on R1. During an interview on [DATE] at 1:49 p.m., registered nurse (RN)-A stated a nurse STAT page alerted all nurses to respond to a specific location for an emergency. Each nurse would bring equipment based on the location they were working on. Equipment included a crash cart (included supplies needed to perform CPR), vital signs machine, and automated external defibrillator (AED). If a resident was found unresponsive and not breathing, a nurse should check the POLST of the resident and if the resident was full code, CPR should be started immediately. RN-A stated there was no reason CPR would not be started on a resident who elected full code status. During a follow-up interview on [DATE] 2:16 p.m., the DON stated if a resident was found not responding and not breathing, a nurse should check the resident's code status on the POLST. If the resident was full code, the nurse would do chest compressions, give