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	11/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure individualized turning and repositioning programs were based on a completed comprehensive assessment in order to prevent or mitigate the risk of pressure ulcer development and/or deterioration for 1 of 3 resident (R2) reviewed for pressure ulcers.findings include R2's annual Minimum Data Set (MDS) dated [DATE], identified R2 had impaired cognition with diagnoses of Alzheimer's Disease, diabetes and cerebrovascular accident (stroke) and was dependent on staff for all activities of daily living (ADLs) including eating and mobility. R2 was incontinent of bowel and bladder, requiring staff to change incontinent product and perform peri care. R2 had no nutritional risk factors noted. R2 was at risk for PU but did not have a PU. Formal assessment was completed, but no clinical assessment was completed. R2 did not have a turning or reposition program.R2's Braden's assessment dated [DATE] with a score of 14 out of 18, putting R2 at moderate risk for pressure ulcer/injury development. R2's Braden's assessments dated 7/28/25 and 10/28/25 scored 13 out of 18, R2 remained at moderate risk for pressure ulcer development, even though she had a stage 2 on 7/23/25 this wound deteriorated to a stage 3 on 10/2/25. R2's pressure ulcer/injury care area assessment (CAA) worksheet dated 5/5/25, indicated the following triggers incontinent of bowel and bladder, R2 was risk for pressure ulcers and was dependent on staff for turning and repositioning. Under the analysis finding section, there is nothing filed out for the existing pressure ulcer/injury or extrinsic factors. Under intrinsic factors, listed R2 had altered mental status, delirium, with cognitive loss and incontinence. Under diagnoses and condition listed the following, cerebrovascular accident (stroke), chronic or end-stage renal, liver, or heart disease, Alzheimer's disease and other dementia. Under the treatments and other factors section indicated newly admitted or readmitted . There was no family or resident input. Under care plan considerations section, indicated functional status would of pressure ulcer/injury, be addressed in the care plan without any objectives indicated.R2's progress notes between 7/9/25 through 7/22/25 indicated R2 had impaired skin integrity on buttocks/groin. Progress note dated 7/23/25 indicated R2 had an open wound on sacrum. No comprehensive assessment was included. Progress note dated 7/28/25 resident was found with an open area on butt crack, measuring 1.5 cm x 0.5 cm. Progress note dated 7/28/25, indicated the interdisciplinary team met to discuss new pressure injury state 2 to intergluteal theft. The note identified a new interview to turn and reposition every 2-3 hours was added to the care plan, however, the note did not identify how the 2-3 hours was determined and/or appropriate. In review of R2's record, there was no indication a comprehensive assessment was completed to determine tissue tolerance over bony prominences to pressure over time in conjunction with R2's clinical status and other risk factors for pressure ulcer deterioration and/or new development. R2's care plan dated 10/15/25 had a skin integrity focus that identified R2 had an actual skin integrity concern of intergluteal cleft/medial related to impaired mobility, needing assistance with ADLs, incontinence, severe cognitive impairment and severely impaired decision-making needing cues and supervision from staff. R2 had history of moisture associated skin damage (MASD) under both breast and to buttocks. The care plan was revised on 7/28/25 to include the intervention that directed staff to turn and reposition R2 every 2-3 hours and as neededR2's (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

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	11/19/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress noted dated 10/1/25 at 1:24 p.m., R2's coccyx wound was upgraded to a stage 3. In review of R2's record there was no indication of a comprehensive assessment that addressed R2's turning and reposition program and not evident the care plan was revised after the ulcer deteriorated to a stage 3. During an Interview on 11/14/25 at 12:20 p.m., registered nurse (RN)-A indicated that the turning and repositioning schedules were individualized, as with R2, is up for meals and then laid back down in bed and then turned every 2-3 hours. RN-A was not able to articulate how every 2-3 hours for repositioning was determined to be appropriate and/or effective. During an Interview on 11/18/25 at 11:40 a.m. nursing assistant (NA)-Q stated the staff were informed of the turning and repositioning schedules on their daily report sheets, NA-Q stated up for meals otherwise in bed and turned every 2-3 hours. During an interview and observation on 11/18/25 at 1:22 p.m., RN-C described the wound during a dressing change as a stage 3, with moderate serosanguinous drainage. RN-C did not know how the turning and repositioning schedule was determined but the NA taking care of her should know. During an interview on 11/19/25 at 8:30 a.m., director of nursing (DON) indicated R2 was on an alternating air mattress due to her stage 3 ulcer. This device was to assist staff with offloading to the resident. The IDT team meets daily, and they discuss the wounds quickly and then meet once a week at wound rounds and discuss how the wounds are progressing. DON could not articulate how every 2-3 hour turning and repositioning schedule was established or how they were evaluating the effectiveness of the interventions they had in place to relieve the pressure from the pressure ulcer area. During an Interview on 11/19/25 at 10:15 a.m., regional nurse consultant (RNC)-A, stated that the facility did not use a tissue tolerance specific assessment as that had gone by the wayside years ago and indicated there was no formalized process and/or tool to determine a resident's repositioning schedule, and it was more based on the clinical picture however, the determination of which factors were used to determine the schedule were not documented. During an interview on 11/19/25 at 1035 a.m., wound nurse practitioner (NP)-A, stated first made aware of wound for R2 on 7/30/25, when she evaluated the wound and took initial pictures. NP-A described the wound as superficial at that time, and R2 had another area nearby that looked like MASD. R2 had history of MASD in the coccyx area in late June 2025. NP-A put in orders for daily treatments, air mattress and dietary consult for protein supplement. R2's wound was evaluated every week and was improving until 10/1/25, when NP debrided the area and restaged it to a stage 3 out of 4. NP-A put in different dressing orders. They showed improvement and was stable during the evaluations on 10/8/25 and 10/10/25. The wound then deteriorated for the next 5 visits in 3 weeks (10/15/25 through 11/5/25). NP-A kept the same dressing change and encouraged staff to limit R2's time up in wheelchair (up for meals only) on the visits for 10/15/25 and 10/17/25. NP-A further stated the causal factor of the pressure ulcer was pressure from lying on her back and being in the wheelchair prior to the development of the pressure ulcer on 7/25/25.Review of facility policies entitled Pressure Ulcer Monitoring and Interventions did not address turning and repositioning programs based on comprehensive assessments to prevent and/or reduce the risk of pressure ulcers.