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	03/10/2026

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** Based on interviews and document review, the facility failed to reassess a resident after a change in condition for 1 of 4 residents (R1) reviewed for quality of care. R1 was assessed after a change in condition about 12:00 a.m., slept through the night, and was not reassessed until a visiting family member requested R1 transfer to the hospital.Findings include: R1's Provider Orders for Life Sustaining Treatment (POLST) dated 8/15/16, Indicated if R1 has no pulse and is not breathing instructions were do not resuscitate (DNR), do not intubate (DNI). When not in cardiopulmonary arrest follow sections in the B Goals for Treatment and C Interventions and Treatment area of the form. Section B indicated provide comfort care - do not intubate but use medication, oxygen, oral suction, and manual clearing of airways, etc. as needed for immediate comfort and in an emergency call the person listed. Section C had both boxes checked for oral and IV/IM antibiotics. R1's revised care plan dated 7/18/25, indicated he could walk independently with a walker. He needed one staff member to help him get out of bed, toilet, bathe, dress, and shower. He was on a toileting schedule for every two to three hours while awake and received incontinent care on the night shift during every two-hour rounds. R1's care conference dated 9/8/25, indicated FM-A was present and his code status was reviewed and confirmed at DNR, focusing on comfort care at the facility. R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated he had normal cognition, no behaviors, and a minimal depression score. He took antipsychotic medication to treat his Schizophrenia diagnosis. R1's oxygen saturation summary document indicated:12/5/25, room air - 95%11/28/25, room air - 96%11/22/25, room air - 93%11/7/25, room air - 91%10/31/25, room air - 95%10/24/25, room air - 94%10/10/25, room air - 94%10/3/25, room air - 95%9/26/25, room air - 96% R1's provider note dated 12/11/25, indicated he was alert and responsive, but had chronic non-comprehensible communication. He had chronic inflammatory arthritis, and lower urinary tract symptoms (LUTS) and altered urination patterns caused by prostate issues. R1's physician order dated 12/13/25 at 11:51 p.m., indicated staff would obtain an Xray today to rule out pneumonia. In addition, staff would test him for influenza. R1's request for an Xray dated 12/13/25 at 11:50 p.m., indicated he needed a chest Xray for a cough. R1's progress note dated 12/14/25 at 00:04 a.m., written by registered nurse (RN)-A indicated dayshift reported a cough. Vital signs at the start of her afternoon shift were normal temperature, heart rate was elevated at 94 (average heart rate for his age was 60-100), respiration rate was 20 (average 12-20 breaths per minute), blood pressure was 100/63 (normal for his age would be 90/60 to 120/80), and his oxygen level was 89-90%. He drank fluids and ate ice cream and yogurt. At the end of the shift his oxygen level dropped to 85 to 90% on room air, and he started on oxygen at 2 liters per minute (LPM). On call nurse practitioner was updated, and they received orders for an Xray. RN-B was updated, and she brought the oxygen to his room. FM-A was updated on his condition. R1 was alert, answering questions while remaining in bed for the rest of the shift. Staff continue to monitor his status. R1's progress note dated 12/14/25 at 7:41 a.m., written by licensed practical nurse (LPN)-A who worked on the night shift indicated she monitored him all night, and he slept. She called the portable Xray company four times to find out when they would come but no one answered. R1's medication administration record (MAR) dated 12/14/25 indicated he took his morning 8:00 a.m. (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	medication. R1's progress note dated 12/14/25 at 11:50 a.m., indicated he was transferred to the hospital related to increased chest congestion and low oxygen saturation less than 81% on 4 LPM. The Xray was not completed because the company did not respond to their calls. The Covid-19 and A/B flu tests were negative. FM-A was at the facility and wanted R1 to go to the hospital. The on-call nurse was updated. R1's late entry progress note dated 12/14/25 at 12:20 p.m. indicated he had a cough and shortness of breath. His oxygen was increased to 4 LPM because his oxygen levels were less than 80%. His blood pressure was 71/45, temperature was 98.1, and heart rate 108. He did take his medication without food. 911 was called because the Xray service was delayed and he was transported to the hospital. During an interview on 3/4/26 at 12:35 p.m., FM-A stated she was R1's cousin and power of attorney. On 12/13/25, around 11:00 p.m. her cousin was notified that he was not feeling well and had a cough. He started on oxygen 2 LPM. She called the provider who ordered a chest Xray and influenza test. When she arrived at the facility around 10:00 a.m. She was told he was able to take his medication in the morning, but they had to crush his pills. When she saw him, he looked like he had a fever, and he was struggling to breathe. He was having delusions, and he did not recognize her. The nursing assistant working at the time told her she had given him a bed bath and made him comfortable. She was very concerned and requested to talk to the head nurse. The head nurse assessed the patient and 911 was called to transport R1 to the hospital. Once at the hospital they were told his oxygen levels were so low that there was nothing they could do for him, and his family should be notified to say goodbye. She was in shock that his condition deteriorated from a cough to death so quickly. She was concerned that the facility did not follow proper criteria when he developed a cough and his condition deteriorated. During an interview on 3/10/26, at 10:39 a.m., the facility medical director (MD)-A stated if a resident indicated comfort care on their POLST, he would not send them to the hospital but treat them at the facility while keeping them comfortable. R1 did not have a fever, and the flu test at the facility was negative. He added this year Influenza A was very deadly because the flu vaccination did not provide sufficient coverage. It was his opinion that R1's condition could rapidly deteriorate from midnight to 10:30 a.m. when he was transferred to the hospital. During an interview on 3/10/26 at 11:29 a.m., RN-A stated on 12/13/25, the only thing she remembered was he needed help to eat. When a resident had a change in condition, they would assess the resident, get a set of vital signs, and update the provider and family. The provider would always ask what their code status was. If he were on comfort care, she would not have expected the provider to send him to the hospital for treatment but treat him at the facility while keeping him comfortable. During an interview on 3/10/26 at 11:37 a.m., RN-B did not remember the details on 12/13/25. As a supervisor she would have been the one to bring oxygen to the room. If the POLST indicated comfort care, she would expect the resident to remain at the facility unless the family wanted him transferred to the hospital. During an interview on 3/10/26 at 12:15 p.m., LPN-B stated comfort care like a hospice resident, if they needed oxygen or develop worsening symptoms, she would have updated the provider and family. During an interview on 3/10/26 at 12:22 p.m., regional director of clinical services (DCS)-A stated she spoke with the triage NP from 12/13/25. The NP indicated based on the POLST and comfort care had I wanted him sent to the hospital I would have. She ordered an Xray and flu test to rule out pneumonia. If positive she would have ordered antibiotics while keeping him comfortable. During an interview on 3/10/26 at 2:00 p.m., the administrator stated the nursing staff document by exception. Protocol on night shift was to check and turn every resident every two hours. Staff were monitoring him, and the nightshift nurse documented that he slept all night. If he had worsened throughout the night, she would have expected her staff to update the provider and family. The staff treated him the same as a hospice resident focusing on managing symptoms and providing comfort. During an interview on 3/10/26 at 2:29 p.m., LPN-A stated she took over R1's care from RN-A on nightshift. She said he was checked on every 2 hours for incontinent care and repositioning. She did check his oxygen levels, and it was above 90% on oxygen. She was surprised to hear his condition worsened and he died. R1 slept all night, and his status did not change enough to warrant calling the (continued on next page)

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