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	04/30/2026

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure services were provided in accordance with professional standards of nursing practice for 1 of 1 residents (R1) when staff inserted a Foley catheter into a gastrostomy stoma without validated competency for the procedure, without completing appropriate clinical assessment to determine safety prior to insertion, and using improper technique, including inflation of the catheter balloon within the stoma. In addition, the facility failed to ensure feeding tube supplies were labeled according to professional standards to avoid the possibility of feeding tube complications and/or related infections for 1 of 3 residents (R4) reviewed for enteral tube feedingFindings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had a feeding tube and diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure.R1's nutrition care plan dated 4/24/26, indicated R1 was NPO (nothing by mouth; may not eat or drink) and required tube feeding related to dysphagia following CVA (cerebrovascular accident; blood flow to the brain is interrupted). The goal was to maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and/or symptoms of malnutrition or dehydration through review date of 5/4/26. Another goal was to have minimal complications related to aspiration through review date of 5/4/26. Care plan interventions included a directive to check tube placement and gastric contents per facility protocol; there was no interventions for emergency procedures or facility protocol in the event of tube dislodgment referred to.R1's physician orders from 4/8/26 to 4/11/26 included the following:-dated 5/23/25, medication given though gastrostomy tube (g-tube).-dated 5/27/25, change out syringe and canister for free water every day.-dated 2/11/26 to 4/16/26, Osmolite 1.5 at 85 mL/hr through gastrostomy tube from 6:00 p.m. to 10 a.m. until total volume of 1,360 mL.-dated 2/11/26 to 4/16/26, 180 mL free water flush four times a day to enteral feeding tube to meet hydration needs.-dated 4/8/26 to 4/10/26, monitor enteral feeding site for signs and/or symptoms of infection, patency, and pain. Update provider as needed.R1's physician orders did not include emergency orders or directives for tube dislodgment.R1's Nursing Note on 4/11/26 at 2:59 a.m., indicated R1 pulled out his gastrostomy tube at approximately 1:30 a.m licensed practical nurse (LPN)-F placed a 16 French Foley catheter into R1's stoma to keep patent, as facility protocol. R1 denied pain and vitals obtained with a blood pressure of 73/45 mmHg (millimeters of mercury; standard unit of pressure). R1 was sent to Hospital at approximately 1:45 a.m. A message was left to the on-call provider.Review of the medical record did not identify documentation of a clinical assessment prior to insertion of the Foley catheter, including assessment of tract maturity, duration of dislodgement, or evaluation for potential complications. There was no evidence of a physician order authorizing insertion of a Foley catheter into the gastrostomy stoma.During interview on 4/29/26 at 2:05 p.m., LPN-F stated they found R1's enteral tube out of R1's stoma with the balloon deflated. LPN-F was not sure how long the tube had been out and was directed by registered nurse (RN)-B to insert a Foley catheter into R1's stoma. LPN-F stated they were unaware of the policy to place a Foley catheter into stoma for dislodged enteral feeding tube. LPN-F did not know what size R1's gastrostomy tube was and stated they (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed a 16 French Foley catheter into R1's stoma with 5 cc (cubic centimeters; a volume measurement) in the catheter's balloon.During interview on 4/29/26 at 2:40 p.m., RN-B stated they were notified when R1's enteral tube feeding was found dislodged. RN-B watched LPN-B clean R1's stoma and sterilely place the Foley catheter into R1's stoma. RN-B stated the Foley catheter was inserted to avoid stomal closure. RN-B stated staff called the provider and sent R1 to the hospital when they did not hear back from the provider.During interview on 4/29/26 at 4:22 p.m., the director of nursing (DON) did not know what kind or size of gastrostomy tube R1 had at the time it became dislodged on 4/11/26. The DON expected staff to follow their policy to put a Foley catheter in a stoma to keep patent when enteral feeding tube became dislodged. The DON expected staff to be competent related to Foley insertion. The DON expected staff to follow provider orders when an enteral tube feeding became dislodged and stated they did not have a direct provider order to place a Foley catheter in a stoma if a enteral tube feeding became dislodged.During interview on 4/30/26 at 11:37 a.m., primary care provider (PCP)-E agreed the facility should have clear directions in place for a dislodged enteral feeding tube with training and competency for placing a Foley catheter into a stomal opening.During interview on 4/30/26 at 10:25 a.m., the medical director stated enteral feed stomal openings close quickly if tube becomes dislodged, and staff have quick access to hospitals. The medical director stated the size of the Foley catheter did not matter as the purpose was to keep the stoma open. The medical director stated they would not want staff to place a Foley catheter into a stomal opening less than six weeks to two months old, because there was a risk for perforation. The medical director stated staff who were competent to put a Foley catheter into a urethra were capable to place in stomal opening in the case of enteral feeding tube dislodgement.LPN-F's Foley Cather Competency Checklist dated 12/19/23, indicated LPN-F met the actions to insert a foley catheter into the meatus of a male resident. The competency did not include the action to place a foley catheter into a stoma used for enteral tube feeds.RN-B's Inserting an Indwelling Urinary Catheter dated 4/20/26, indicated RN-B met the steps required to insert a urinary catheter into a male and female urinary meatus. The competency did not include the action to place a foley catheter into a stoma used for enteral tube feeds.Facility policy Care and Treatment of Feeding Tubes dated 10/2024, directed staff to insert a temporary tube (e.g. Foley catheter) to prevent tract closure if an enteral feeding tube dislodged and send resident to the hospital as soon as possible for possible replacement of the feeding tube.R4R4's quarterly MDS dated [DATE], indicated R4 had moderate cognitive impairment and was independent with activities of daily living. R4 had a feeding tube and diagnoses which included cancer, malnutrition, and depression.R4's physician order dated 3/30/26, directed the staff on the night shift to replace graduate, syringe, and dressing every night. Staff were to replace tubing daily if an open enteral system was used or for up to 48 hours if a closed enteral system was used.During observation on 4/28/26 at 4:49 p.m., R4's room had a clear Kangaroo enteral feeding bag with between 50 and 100 milliliters of tannish colored liquid in it hanging from a tube feeding pole. R4 was not in the room, and the bag did not have a label to identify what the liquid was.During interview on 4/28/26 at 4:56 p.m., registered nurse (RN)-A verified the observations and stated staff were expected to label the enteral feeding bag with the formula type and date when feeding started.R4's physician order dated 3/31/26, directed staff to give 150 mL tap water flush three times a day and 30 mL before and after intermittent feedings and medication administration via feeding tube unless directed otherwise.The April 2026 medication and treatment administration record marked the order as completed in the morning, afternoon, and bedtime. The record did not reflect the amount used to flush R4's feeding tube.R4's physician order dated 4/15/26, directed for continuous feed of Osmolite 1.5 at 95 mL/hr (milliliters per hour) for 11 hours from 8 p.m. to 7 a.m. and flush tube with 30 mL of free water flush before and after.The April 2026 medication and treatment administration record marked the order as completed at 7 a.m. and 8 p.m. and did not reflect the amount used to flush R4's feeding tube.During an interview on 4/30/26 at 5:00 p.m. director of nursing (DON) reviewed R4's medication and treatment administration record and expected staff to update the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	orders with flushes to indicate the amount of flushes R4 received. The DON expected staff to label and date tube feeding bags and supplies for infection control reasons.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure ordered hydration interventions were implemented for 1 of 3 residents (R1) reviewed for enteral tubes.Findings include:R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure. The MDS indicated R1 had a tube feeding which accounted for 51% (percent) or more of total calories R1 received and 501 cc/day (cubic centimeters per day; total volume of liquid per day) or more of average fluid intake per day.R1's nutrition care plan dated 4/24/26, indicated R1 was NPO (nothing by mouth; may not eat or drink) and required tube feeding related to dysphagia following CVA (cerebrovascular accident; blood flow to the brain is interrupted). The goal was to maintain adequate nutritional and hydration status as evidenced by weight stable, no signs and/or symptoms of malnutrition or dehydration through review date of 5/4/26. Another goal was to have minimal complications related to aspiration through review date of 5/4/26. Care plan interventions included the following:-Administer medication one at a time in gastric tube. Follow flushing precautions per order.-Registered dietician to evaluate quarterly and as needed. Monitor caloric intake, estimate needs. Make recommendations for changes to tube feeding as needed.-Tube continuous tube feeding of Isosource 1.5 at 55 mL/hr (milliliters per hour). 30 mL flush before and after feedings (60 mL). Additional free water flush of 120 mL six time per day to meet hydration needs (total 720 mL).R1's physician order indicated the following:-dated 5/23/25, medication given though gastrostomy tube (g-tube).-dated 5/27/25, change out syringe and canister for free water every day.-dated 4/16/26, Isosource 1.5 continuous feeding at 55 cc/hr (cubic centimeters per hour; total volume of liquid per hour).-dated 4/16/26, use gastric port for medications only and flush port with 30 cc water before and after medication administration to prevent the tube from clogging.-dated 4/16/26, flush 120 cc six times per day to meet hydration needs.-dated 4/16/26, use jejunal port for tube feeding only and flush with 30 cc of water every four hours to prevent clogging.R1's Discharge summary dated [DATE], indicated R1 had acute kidney injury and was admitted to [NAME] Northwestern hospital on 4/11/26 with gastrostomy tube displaced and low blood pressure. Lab work indicated severe hypernatremia (high sodium concentration), hyperkalemia (high potassium levels in blood), and elevated lactate (a substance produced by cells when breaking down carbohydrates for energy). R1 received a new feeding tube and IV fluids to manage electrolyte abnormalities.During observation and interview on 4/29/26 at 8:40 a.m., LPN-A entered R1's room with crushed medications mixed in water. LPN-A paused the feeding which ran through the jejunal port, checked residual for R1's feeding tube, slowly pushed 30 cc of water into R1's gastric port, administered medications through gastric port, and flushed with 30 cc of water through gastric port. LPN-A connected the feeding tube to the jejunal port and restarted the feeding. LPN-A stated the medication administration was her first care for R1 this morning, and her shift started at 7 a.m. LPN-A did not flush R1's according to the physician order during this episode of care.During continuous observation on 4/29/26 from 8:40 a.m. to 11:53 a.m., LPN-A nor other staff administered any additional flushes to R1's enteral feeding tube.R1's medication and treatment administration record printed on 4/29/26 at 11:14 a.m., indicated R1 received 60 cc flush with the day shift medication administration, 120 cc flush ordered for 9 a.m., and 30 cc flush to the jejunal port ordered for 10 a.m During an interview on 4/29/26 at 11:53 a.m., LPN-A reviewed R1's enteral feeding tube orders. LPN-A verified the order for the 120 cc flush six times a day did not specify which port to flush. The water amount given before and after medication administration and the water mixed with the crushed medications combined to count as the ordered 120 cc flush. LPN-A reviewed the jejunal port flush order. LPN-A stated she (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	followed the part of the order which specified to use the jejunal port for tube feeding only and confirmed she did not flush the jejunal port with 30 cc as ordered. LPN-A stated she did not see the part of the order which directed staff to flush the jejunal port with 30 cc of water every four hours.During observation and interview on 4/29/26 at 5:45 p.m., LPN-D and LPN-E entered R1's room. LPN-D put R1's enteral feeding on hold and disconnected tube. LPN-D placed air into enteral tube using a syringe and auscultated abdominal area. LPN-D flushed the jejunal port with 30 cc of water and the gastric port with 30 cc of water. LPN-D was connecting syringe with crushed medication and water mix to the jejunal port, and LPN-E directed LPN-D to stop and administer medications into the gastric port. LPN-D flushed the gastric port with 30 cc of water after medication administration. LPN-D placed additional water in syringe and was directing syringe to jejunal port, and LPN-E directed LPN-D to gastric port. LPN-D flushed the gastric port with 120 cc of water. LPN-D reviewed R1's orders and verified R1's order to flush 120 cc six times per day did not indicate water or what to flush the port with. LPN-D stated R1 used to have gastric ports only and the jejunal port was new.R1's medication and treatment administration record printed on 4/29/26 at 11:14 a.m., directed staff to use gastric port for medications only and flush port with 30 cc water before and after medication administration to prevent the tube from clogging during the day, evening, and night shift. The document included the amount of fluids used to flush R1's gastrojejunal tube and varied between 30 and 60 cc's.During interview on 4/29/26 at 3:59 p.m., LPN-B stated staff documented intakes on the medication administration record if the order directed them to. LPN-B stated all residents were at risk for dehydration, and residents with tube feedings were at an increased risk of dehydration. LPN-B reviewed R1's documents, and the order which had varied documentation of 30 and 60 cc flushes administered. LPN-B stated she would want to educate the staff to ensure they documented and gave the correct flushes.During interview on 4/30/26 at 9:12 a.m., registered dietician (RD)-C completed monthly charting on high-risk residents such as R1. RD-C stated they reviewed resident medication and treatment administration records to ensure nursing provided appropriate interventions to support residents' nutritional needs. RD-C reviewed R1's order documentation which indicated staff varied giving 30 and 60 cc flushes. RD-C stated they would follow up with nursing to ensure the staff provided R1 with the appropriate flushes. RD-C stated inadequate or incorrect flushing of enteral tube feeding ports could cause clogging or dehydration if there were multiple missed flushing opportunities. RD-C stated administration of medications in the jejunal port instead of the gastric port could affect medication absorption and cause interactions between the feeding formula and medication.During an interview on 4/30/26 at 5 p.m., the director of nursing (DON) expected staff to give residents flushes as ordered, with free water flushes considered a separate amount than flushes with medications, to ensure proper hydration and tube patency. The DON expected staff to give medications and flushes in the correct ports to support proper medication absorption and tube patency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure enhanced barrier precautions (EBPs) were followed for 1 of 1 resident (R1) when medication was administered via enteral tube. In addition, the facility failed to ensure proper infection control practices related to syringes and containers used for flushing enteral tubes for 2 of 3 residents (R1, R4) reviewed for enteral tubes. Findings include R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 had moderate cognitive impairment and required staff assistance with activities of daily living. R1 had a feeding tube and diagnoses which included stroke, hemiplegia or hemiparesis, heart failure, kidney disease, diabetes mellitus, aphasia, malnutrition, and respiratory failure.R1's infection care plan revised 4/24/26, indicated R1 was at risk for infection due to gastric tube. The care plan directed staff to follow enhanced barrier precautions with all contact cares due to R1's gastric tube.During an observation on 4/29/26 at 8:40 a.m., licensed practical nurse (LPN)-A donned gloves and no gown to administer R1's medications through his gastrojejunostomy tube.During an interview on 4/29/26 at 11:53 a.m., LPN-A stated staff wore gloves and gowns to complete cares, such as dressing and toileting, and foley catheter cares for residents who were on enhanced barrier precautions. LPN-A stated they did not need a gown to administer R1's medications through his gastrojejunostomy tube.R1's physician order dated 5/27/25, directed staff to change out syringe and canister for free water every day during the night shift.During observation on 4/28/26 at 4:13 p.m., R1's nightstand had an irrigation syringe with a plunger in it, and the syringe was in an irrigation container filled with water. The syringe and bottle did not have a date. There was no barrier under the container.During interview on 4/28/26 at 4:27 p.m., LPN-C stated the night shift changed the irrigation syringe and bottle every night. LPN-C verified the irrigation syringe and container were not dated and stated the container should be emptied and the plunger separated from the syringe barrel to allow the equipment to dry.R4R4's quarterly MDS dated [DATE], indicated R4 had moderate cognitive impairment and was independent with activities of daily living. R4 had a feeding tube and diagnoses which included cancer, malnutrition, and depression.R4's physician order dated 3/30/26, directed the staff on the night shift to replace graduate, syringe, and dressing every night. Staff were to replace tubing daily if an open enteral system was used or for up to 48 hours if a closed enteral system was used.During observation on 4/28/26 at 4:49 p.m., R4's nightstand had an irrigation syringe, with a plunger in it, in a gray mug with a handle filled with water and not dated. A clear container with water was labeled with the date 4/28/26 and had a syringe with a plunger in it. There were no barriers under the water mug or clear container.During interview on 4/28/26 at 4:56 p.m., registered nurse (RN)-A verified the observations and stated staff were to empty the water from the containers and separate the plunger from the syringe barrel and rinse out before using again.During an interview on 4/29/26 at 3:59 p.m., LPN-B, the facility infection control nurse, expected staff to wear gloves and gowns to administer medications through a resident's gastrojejunostomy tube. LPN-B stated enhanced barrier precautions protected staff and residents and prevented the spread of germs.During interview on 4/30/26 at 4:25 p.m., LPN-B expected staff to dump out the water from irrigation containers after use. Standing water and used syringes sitting in water caused germs.During an interview on 4/30/26 at 5 p.m., the director of nursing (DON) stated R1 was on enhanced barrier precautions related to his gastrojejunostomy tube and expected staff to wear a gown and gloves to prevent contamination when the tube was accessed. The DON did not want irrigation syringes left in water for infection control reasons, such as prevention of waterborne pathogens.Facility policy Flushing a Feeding Tube dated 10/2024, directed staff to remove plunger from barrel and air dry after administration of water.Facility policy Enhanced Barrier Precautions dated 10/2025, indicated EBP was the use of gowns and gloves during high contact resident care activities to reduce transmission of multidrug-resistant organisms. High contact resident care activities included feeding tube device care and use.