

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 03/17/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245055	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2025
NAME OF PROVIDER OR SUPPLIER Lakehouse Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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 0686 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 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 needed. R2's 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		