STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurels Peak Care & Rehabilitation Center	700 James Avenue Mankato, MN 56001

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. 49616 Based on observation, interview, and document review the facility failed to follow physician orders related to weight gain, and monitor and assess edema (a condition characterized by an excess of watery fluid collecting in the cavities or tissues of the body) for 1 of 1 resident (R2) reviewed for fluid overload. Findings include R2's face sheet dated 6/7/24, identified R2 had diagnoses that included congestive heart failure. R2's physician orders included the following -2000 mL (milliliters) fluid restriction, 1080 mL for dietary and 920 mL for nursing (start date 12/16/23). -Compression stockings on in the morning (AM) and off at night (HS) (start date 1/2/24). -Daily weights. Update provider if weight gain of greater than two pounds in one day or five pounds in one week in the am for hypertensive heart disease (start date 3/1/24). R2's care plan dated 9/5/23, identified a goal to follow fluid restriction with the restriction of 2000mL of fluid per day with 1080mL from dietary and 920mL from nursing. R2's occupational therapy (OT) discharge summary dated 8/9/23, identified at discharge R2 would need assistance with socks and shoes as needed due to bilateral leg wraps. R2's physician note dated 6/3/24, identified R2 had been wearing compression socks that he purchased himself from home. Fluid restriction needed due to his heart failure and risk of exacerbation if he drinks too much fluid, ok to discontinue wraps and use compression stockings-on in AM off at HS. R2's weight log from 5/13/24-6/7/24 identified R2 weighed 224.5 pounds (#) on 5/23/24, no weight obtained on 5/24/24, and on 5/25/24 weighed 227#. This identified a weight gain of 2.5#. No indication of the physician being notified of weight gain. On 6/3/24 weight was 227# and on 6/4/24 weight was 231#. This identified a weight gain of 4# in one day. No indication that physician was notified of the weight gain. (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: 245516	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/07/2024
NAME OF PROVIDER OR SUPPLIER Laurels Peak Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 James Avenue Mankato, MN 56001	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Treatment Administration Record (TAR) identified day, evening, and night shifts to fill in how much fluid was consumed for each shift. The TAR identified missing recorded entries for fluid consumption and shifts and was not evident evaluations of 24-hour intake totals were completed. -On 5/3/24, day and evening shifts were not filled out and night shift recorded sleep. -On 5/19/24, day shift filled out 200 mL with nothing marked on the other two shifts. R2's record did not include edema assessments or monitoring. During an observation and interview on 6/7/24 at 9:22 a.m., R2 sat on the edge of his bed without pants on exposing his legs. R2 pressed his fingers into his lower shins, the area stayed indented for approximately one minute (3+ pitting edema). R2 stated he had been using his compression socks and they seemed to help. Staff have not been putting them on, when my legs are really swollen, they say Oh I am busy., so I either put them on myself or I am done with it. I do not ask anymore. I am getting to the point that if my legs do swell up I do not even care. Like today they are a little swollen but not bad. I bought these black compression socks from Walmart and that is what I use. During an interview on 6/7/24 at 3:22 p.m., licensed practical nurse (LPN)-A stated resident weights were completed in the morning. LPN-A did not typically look at the weights, only if it was indicated through shift report. If LPN-A noticed a difference in R2's edema she would pass it on to the next shift but would not document her findings in the medical record. LPN-A explained R2 had a big water bottle that he carried around with him, so most of the documentation for R2's fluid intake was from asking him how much he consumed. Staff would provide R2 with a half a cup of liquid with his bedtime medications and an 8 ounces of a dietary supplement with his evening medications. LPN-A was not aware if any nursing or dietary staff were evaluating R2's daily total fluid consumption. LPN-A removed R2's compression socks and shoes and reported R2's right foot had was trace edema with 1-2+ edema around the ankle area. On R2's left foot there was trace edema, inner ankle +3 and outer ankle +2. LPN-A indicated that they do not have any way to know what R2's edema was at for measurements because it had not been documented. During an interview on 6/7/24 at 10:56 a.m., trained medication aide (TMA)-A stated the nursing assistants (NA) usually get the resident weights and write them down on a paper and would give the paper to the nurse. TMA-A stated sometimes the nurse would put the weights in the computer but most of the time the NA's recorded the weights. TMA-A stated technically any staff could apply ace wraps but usually the nurse would do it. During an interview on 6/7/24 at 11:01 a.m., registered nurse (RN)-A stated she was aware that R2 wore the black compression socks. RN-A would document refused in the TAR if R2 refused to wear them. RN-A was not aware of any instruction/direction to monitor edema, if it was being completed and/or documented. RN-A stated that she would not put his compression socks on but would check to make sure he was wearing them then sign off in the computer. RN-A was not able to find a progress note or physician notification pertaining to R2's weight gain as directed by the physician order. (continued on next page)

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	245516	A. Building B. Wing	06/07/2024

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/7/24 at 11:21 a.m., RN-B indicated nursing did not complete daily charting on edema, but would do standard checking, if appropriate. RN-B reviewed R2's record, RN-B confirmed the physician was not notified of the weight gain. RN-B indicated if there was a noted weight gain that needed to be communicated to the physician the nurse should also assess lung sounds, vital signs, and location and extent of edema if present. During an observation on 6/7/24 at 11:31 a.m., R2 was in the dining room for the noon meal. R2 did not have any beverages. At 11:36 a.m., R2 received his meal but not any beverages. R2 pulled a large 64-ounce beverage container from his electric wheelchair and reported it was filled with juice. During an interview on 6/7/24 at 3:37 p.m., culinary director (CD)-A stated when she received the order for a fluid restriction the allotted amount for dietary was 1080 mL and 920 mL for nursing staff. CD-A explained dietary staff would record intake from dietary however, most of the time the amounts were recorded in percentages versus milliter's consumed. CD-A was not aware if nursing staff monitored the fluid intake from dietary staff or if they were only documenting the amounts that nursing provided. During an interview on 6/7/24 at 3:46 p.m., director of nursing (DON) stated R2 was pretty independent. He had access to water in his room and water fountains in the building. R2 would also have food/beverages delivered to the facility. DON stated dietary only recorded drinks provided by the dietary department, so if R2 were to bring his own beverage they would not add that in with the amount he drank. DON stated typically if there was a fluid restriction the allowance would be divided between shifts. DON explained the facility did not have a 24-hour look back log for further evaluating compliance with the restriction. DON expected nursing staff complete the weights as ordered by the medical doctor and notify the provider of the weight gain if it fell within the parameters of notification. Edema was not typically monitored daily on every resident but should be monitored for certain residents that had edema so the provider could be notified if there were changes. The facility Fluid Restriction Guidelines dated 9/2012, identified guidelines for 1000 mL or less and 1500 mL fluid restrictions. Fluid restrictions would be done with doctors' orders only, and intake would be measured every shift. The facility Notification of Changes Policy dated 3/2024, identified that a change in resident's condition or treatment be reported to the attending physician or delegate. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification to ensure the best outcomes of care for the resident. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition in a timely manner to the parties who will make decisions about care, treatment, and preferences to address the changes.