

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 03/06/2025
NAME OF PROVIDER OR SUPPLIER Laurels Peak Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42355</p> <p>Based on observations, interview and documents review the facility failed to ensure enhanced barrier precautions (EBP-where gown and gloves used for high contact resident care activities) was used for 2 of 2 resident (R3 and R5).</p> <p>Findings include:</p> <p>R3's Admission Minimum Data Set (MDS) dated [DATE], identified diagnoses of malignant neoplasm (cancer) of the brain with intact cognition. R3 had an unstageable area covered with slough and/or eschar (dead tissue/cells, usually black in color).</p> <p>During an observation and interview on 3/5/25 at 1:10 p.m., R3 was in bed and nursing assistants (NA)-R and NA-N were performing peri care for urine incontinence. Neither NA had put on a gown, but did have gloves on. NA-R and NA-H both assisted R3 by lowering her pants and then unsecured the brief. NA-R performed peri care and removed soiled brief and placed in trash can and removed her gloves. NA-R did not perform hand hygiene before putting on clean gloves and placed new brief and applied barrier cream to the buttocks. NA-R and NA-N repositioned R3 on to her left side. Both NA uniforms touched the bed and R3. NAs removed their gloves and used hand sanitizer once outside of R3's room. NA-R stated R3 was on EBP's for her wound on left upper buttock and since there were not doing a dressing change to this area, staff did not need to wear a gown.</p> <p>R5's Quarterly MDS dated [DATE], identified diagnoses of diabetes, osteomyelitis (infection and inflammation of the bone). R5 had a stage 4 pressure ulcer and an unstageable pressure ulcer. R5 had moderate impaired cognition.</p> <p>During an observation and interview on 3/6/25 at 9:34 a.m., NA-C entered R5's room without gloves or gown. At 9:37 a.m., NA-C exited R5's room removing his gloves. NA-C stated when he repositioned R5 he should have worn a gown.</p> <p>During an interview on 3/5/24 at 1:55 p.m., director of nursing (DON) stated it was her expectation EBP's were used when there were areas of high contact with the resident. This would include checking/changing briefs and repositioning.</p> <p>The facility policy on enhanced barrier precautions dated 4/1/2024, identified that EBP is required for the following:</p> <p>(continued on next page)</p>

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 03/06/2025
NAME OF PROVIDER OR SUPPLIER Laurels Peak Care & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. High-contact resident care activities include:</p> <ul style="list-style-type: none"> a. Dressing b. Bathing c. Transferring d. Providing hygiene e. Changing linens f. Changing briefs or assisting with toileting g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. h. Wound care: any skin opening requiring a dressing.