STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245516	A. Building B. Wing	06/11/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and document review the facility failed to accurately document a resident's verbal and physical abuse towards staff, and rejection of cares for 1 of 3 residents (R2) reviewed when the Minimum Data Set (MDS) indicated the resident did not have any behaviors or rejection of cares during an evaluation period over seven days. The nursing progress notes for the same period documented daily rejections of care and yelling at staff when they tried to provide hygiene and incontinent care. Findings include: R2's nursing progress notes during the evaluation period dated from 2/27/25 through 3/6/25, indicated she refused the following: medication, walk, brush her hair, change soiled clothing, and bed linen, shower, and housekeeping services. R2's annual MDS dated [DATE], indicated she had moderate impaired cognition and dementia. She was unable to move the right side of her body or communicate her thoughts and feelings after a stroke leading to worsening anxiety and depression. She required staff assistance to dress, shower, brush her hair, and provide incontinent care. There were no incidents of verbal or physical abuse towards staff or refusing care during the seven-day evaluation period. Her evaluation identified care areas of concern for cognitive impairment, communication, activities of daily living, psychosocial wellbeing, falls, nutrition, and psychotropic medication use. During an interview on 6/10/25 at 2:13 p.m., social worker (SW)-A stated anytime a patient shows behaviors such as rejecting care, verbally and physically abusive towards staff should be documented in the MDS to receive full reimbursement for the services provided. Requested policy how to complete an MDS, it was not provided.

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. The facility failed to develop and revise a person centered behavior care plan, document the risk verse benefit associated with refusing care, identify root cause analysis, and determine what triggered her anxiety and agitation, and provide ordered psychiatric follow up care for 1 of 3 residents (R2) reviewed, when she was found to have maggots on her body because she refused to accept help to change soiled clothing and bed linen, and let housekeeping clean her room. Findings include: R2's initial admission care plan dated 2/10/23, indicated cognition deficit, unable to communicate her thoughts and needs, history of refusing care and becoming agitated when approached. She required the assistance from one person to dress, bath, incontinent care and brush her hair. Mood and behavior interventions included being alert to any changes in her mood, monitor and document her behaviors, and give medication as ordered by the doctor. The interventions were renewed during quarterly and annual assessments and no other interventions were developed. R2's care plan dated 9/8/23, indicated her inability to express her needs and her impaired cognition affected her behaviors. Interventions remained unchanged and no other interventions were developed. R2's psychiatric appointment dated 2/19/25, indicated her daughter reported in the fall of 2024 she was started on a low anti-anxiety medication to help with her frustration. She was started on sertraline for her irritability and anxiety. Staff instructed to monitor her response to the new medication over the next month. Schedule a follow up appointment in one month to assess the effectiveness of the medication and make any necessary adjustments. R2's care plan dated 2/26/25, developed after her appointment with the psychologist on 2/19/25, indicated interventions included monitoring for adverse drug reactions and update the medical provider as needed. The ordered one month follow up appointment to assess medication changes was not listed. R2's medical doctor (MD) dated 3/27/25, indicated her continued refusals to change urine soaked linen and clothing, refusing daily hygiene and showers is becoming a health hazard. Continue to work with psychologist to develop strategies and ideas to improve behavior and communication. R2's nurse practitioner (NP)-A dated 4/24/25, indicated her last virtual visit with the psychiatrist was 4/24/25 when Sertraline was started. Requested the psychiatrist's note but facility was unable to provide. NP-A documented there was a strong odor of urine during her visit. NP's plan of care included staff to provide incontinent care and keep her room clean. R2's NP note dated 5/29/25, indicated she was seen by a psychiatrist in February and started on sertraline because the resident refused bathing and incontinent care. She was supposed to have a follow up appointment in one month, but staff held off scheduling it hoping to find a different placement for the resident. Alternative placement had been difficult and instructed staff to make an appointment to see the psychologist. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's MD note dated 5/29/25, indicated she had an appointment on 2/19/25, and sertraline was started. She was supposed to have a follow up appointment in one month, but staff held off scheduling the appointment hoping to find alternative placement. Nurse manager will make a follow up appointment. R2's MD note dated 6/2/25, indicated she refused bathing and during wound care they found maggots in her folds. Staff questioned if they could premedicate her with anxiety medication to decrease anxiety levels. MD gave a new order for Ativan to be given 30 to 60 minutes before showering. R2's interdisciplinary team (IDT) note dated 6/9/25, indicated she continued to be incontinent of urine and refused staff assistance. Staff offered incontinent care and supplies every two hours without improvement in behaviors. During a medical record review on 6/10/25 at 2:35 p.m., requested risk verse benefit assessments but no records were provided. During an interview on 6/10/25 at 12:44 p.m., the receptionist at the Department of Psychiatric and Psychology confirmed R2 had appointment scheduled for next week. The appointment was initiated on 6/3/25. During an interview on 6/10/25 at 1:40 p.m., family member (FM)-A stated the facility was unable to provide the neurological care her mother needed after her stroke. She stated a few months ago the facility started to look for a new placement to deal with her neurological conditions and behaviors. The facility would call her and her brother when R2 refused care. She said the facility had tried alternative approaches to resolve her behaviors including alternative communication devices. Their efforts have only escalated the behaviors and the reason they wanted her transfer to a different facility better suited for stroke patients. She denied telling the facility not to schedule the one month follow up psychologist and wanted her mother's medication reviewed. Her mother never wants the lights on in the room. During an interview on 6/11/25 at 1:04 p.m., director of nursing (DON) stated R2 had resided at the facility for a while and had a history of refusing cares, brushing her hair, and bathing. Some staff has better luck getting her to agree to cares. They try to have consistent staffing for her. In the last few weeks if she refused to let the NA help her, the nurse would reapproach. She felt that they are moving in the right direction and the floor manager checks on her often. She stated they did not set up the initial follow up appointment with the psychologist because the family indicated they wanted to hold off until they found alternative placement. Care Planning Policy dated 11/24, indicated each resident had a person-centered care plan developed by all team members to identify medical, physical, psychosocial, and functional needs. Nursing staff we will review patient rights, identify problem areas, and develop interventions specific and meaningful to the patient. Dementia Training not dated involved care for dementia patients, abuse and neglect topics associated with dementia. Interventions include identifying environmental factors and analyze the behaviors. Challenging behaviors involve identifying common triggers, develop strategies to minimize the behaviors associated with dementia including communication techniques, and recognize caregiver stress.