

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 01/06/2026
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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review the facility failed to ensure all staff were competent with transferring and walking residents that required transfer assistance for 1 of 3 residents (R1). This deficient practice resulted in R1 falling and fracturing the facial bone. The facility had put corrective measure in place, prior to the start of the survey and therefore, this was issued at past non-compliance. Findings include: R1's face sheet dated 1/6/26, identified diagnoses of respiratory failure, atrial fibrillation (irregular heart rhythm), osteoporosis, and other variants of Turners Syndrome (condition that affects only females, results when one of the X chromosomes (sex chromosomes) is missing or partially missing. [NAME] syndrome can cause a variety of medical and developmental problems, including short height, failure of the ovaries to develop and heart defects.), and disorientation. R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had no issues with hearing or speech, no cognition issues, no behaviors or rejection of care, used a walker, partial assist with toileting hygiene, lower body dressing, supervision with upper body dressing, supervision with sit to stand, chair/bed transfer, and walk 50 feet with two turns. R1 had a fall in the month prior to admission but no falls since admission. R1's care plan dated 12/2/25, identified interventions to follow physical therapy (PT) and occupational therapy (OT) for mobility function. Toileting with stand by assistance and R1 was to ambulate to the bathroom with front wheeled walker (FWW) and toilet self with staff present but providing only encouragement; transfer with stand by assist and use FWW- staff to provide encouragement training in hallway without assistive device. R1 demonstrated mild loss of balance but able to recover independently. R1 demonstrated an inconsistent gait path and had a tendency to wander throughout hallway. Ambulated with FWW in hallway with noted improvement in stability. Educated on current continued use of FWW recommendation. R1 remained appropriate for use of FWW. Nursing Home Incident Report (NHIR) submitted to the State Agency on 12/12/25 at 10:23 a.m., identified R1 requested to walk for walking program. Nursing assistant (NA)-A was walking with resident, when resident fell and hit her head. R1 was transported to the emergency department (ED) for evaluation with physical injuries noted of bruising above right eye, nosebleed, and hematoma (collection of blood outside of a blood vessel) to right side of head. R1's progress note dated 12/13/25 at 7:38 a.m., identified on 12/12/25, R1 was lying on her back on the floor. Right eyelid bruised and swollen shut. Hematoma to right side of forehead and bloody nose. R1 stated she was walking without her walker and fell forward hitting her face. R1 had an ice pack applied to her face and was sent to ED for evaluation as she took blood thinning medication. R1's hospital Discharge summary dated [DATE], identified R1 had a closed facial bone fracture, spent the night at the hospital, and returned to facility on 12/13/25, follow-up visits scheduled with neurosurgery and head computed tomography (CT). R1's progress note dated 12/15/25 at 11:19 a.m., identified R1 had been downgraded to assist of one staff using FWW and gait belt due to recent fall, care plan and Kardex updated. R1's progress note dated 12/19/25 at</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245516	Facility ID: 245516 If continuation sheet Page 1 of 3

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>10:51 a.m., identified R1 had new therapy orders to walk to all meals with FWW and gait belt, assist of one to follow with wheelchair, care plan and Kardex updated. R1's care plan was updated on 12/16/25, and identified education provided to staff to utilize appropriate devices during mobility; on 12/19/25 walk to all meals with FWW and gait belt, wheelchair to follow, with assist of one staff member. During an observation and interview on 1/6/26 at 10:13 a.m., R1 was in a wheelchair with visible bruising under both eyes, had a visitor in the room; the visitor was leaving and R1 stood up from the wheelchair and hugged the visitor and sat back down in the wheelchair. R1 stated on 12/12/25, NA-A came into the room and put a gait belt on her. R1 stated she watched NA-A struggle to put the gait belt on. R1 did not recall taking her walker with when they went on the walk. she should have made sure I had my walker. R1 stated NA-A was not holding the gait belt during the walk and R1 was turning a corner and just went down, it was a very traumatic fall. R1 ended up in the hospital with blood behind her brain, a brain bleed, but was unsure if she had a fracture. R1 stated she did not get dizzy or lose her balance prior to the fall. All the other staff have used the gait belt and walker properly. R1 was updated by facility that all staff would have training on using proper equipment with residents. R1 stated she had just had her follow-up neurology appointment, and the CT scan showed no more bleeding in the brain. During a phone interview on 1/6/26 at 1:17 p.m., NA-A stated she is a per diem (as needed) employee and worked at the facility when shifts were available. The facility had encouraged staff to come in and read care plans, but sometimes care plans were read when there was time. On 12/12/25 she was working on R1's wing and that was the second shift she had worked with her. NA-A indicated R1 was self-directed and she had been told by other staff to let R1 do what she wanted to do and to stand-by and watch. R1 put on her bathroom call light around 10:10 a.m. or 10:15 a.m. NA-A responded to the light and found R1 in the bathroom with no walker and no gait belt on. R1 told NA-A she had walked to the bathroom by herself. NA-A assisted R1 to clean up in the bathroom, and R1 walked out of the bathroom without assistance and her walker then sat in her wheelchair. R1 stated she wanted to take a walk (in the hallway). NA-A asked if R1 wanted to use her front wheeled walker and NA-A would push the wheelchair behind her, R1 declined. NA-A stated she applied the gait belt around R1's waist. When R1 stood up and NA-A attempted to hold the gait belt, R1 told NA-A NO I can do it!. NA-A followed R1 as she walked from her room to the entrance of therapy, that is where they turned. NA-A stated there was a dip in the floor, R1 mis-stepped which caused R1 to fall forward very fast. NA-A reiterated that she had taken her time and even read R1's care plan but given R1's refusal of all the crutches she offered, she respected R1's wishes. R1 wanted to do everything herself. During an interview on 1/6/26 at 1:47 p.m., nurse manager (NM)-A stated on 12/12/25, she came from a meeting to assist R1 off the floor. The nurse practitioner was onsite and examined R1 and gave an order to send her to the ED. R1 was able to move all extremities and verbalized what happened. NM-A applied ice to R1's face while they waited for the ambulance to arrive. NM-A is part of the IDT and is involved with fall prevention and interventions after a fall occurs. The root cause of R1's fall was R1 refused to use her FWW and NA-A let R1 inappropriately walk without assistive devices. During an interview on 1/6/26 at 10:21 a.m., director of rehabilitation services (DOR)-A stated R1's level of function prior to admitting at the facility was not using assistive devices and therapy was working to get R1 independent with the FWW. By 12/12/25, therapy had been working with R1 to walk without her walker, going short distances to build up endurance. R1 was not safe to walk 100 feet without her walker, she would fatigue and lose her balance. The week of 12/12/25, therapy had talked with R1 about being independent in her room and not needing to use her walker, but not that she could walk in the hallways unassisted. DOR-A stated on 12/12/25, she was called out of a meeting around 10:30</p> <p>(continued on next page)</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a.m., due to R1 falling on the ground. DOR-A assisted the NM-A and a NA to use a mechanical lift to move R1 from the floor to the wheelchair. When R1 returned on 12/13/25, she was assist of one with all activities and had a fear using less assistance from staff. By 12/30/25, R1 was a stand-by assist in her room with FWW, and on 1/5/26, she was able to be independent in her room with FWW. After falls, the Interdisciplinary Team (IDT) works together to come up with appropriate interventions. During a phone interview on 1/6/26 at 1:59 p.m., medical doctor (MD)-A stated one of the biggest risk factors of a fall would be a fracture and brain bleed but there could be lots of minor injuries also that would set back therapy as well. Anyone that has a brain bleed the doctor needs to be cognizant about anticoagulation and repeated falls, where the brain bleed is at, how much of the brain is bleeding, and what it will affect. Orbital fractures, such as what R1 was diagnosed with, staff should watch for more pain and headaches, and that could reduce therapy time and take longer to reach her goals. MD-A reviewed R1's hospital chart and stated R1 had a telephone visit with neurology on 1/6/26, to discuss the CT that was completed 1/5/26 and It did not look like they thought much of the injuries. Falls are discussed at the facility Quality Assurance Performance Improvement (QAPI) meetings. MD-A is notified of any falls with injuries, or that require hospital or ED visits. During an interview on 1/6/26 at 2:51 p.m., Administrator stated for audits the nurse management staff would observe staff and residents completing the tasks of walking and transfers to make sure it was done correctly; after the observation they would review with staff what to do if a resident would refuse to use an assistive device, and where they would locate the information on each resident to know what devices they utilized. The facility investigation revealed it was a one-time occurrence, and that staff member is no longer employed at the facility. An audit on all resident Kardex's was also completed to make sure all residents information was current and up to date. Staff should always follow the care plans and Kardex. Reviewed with Administrator the corrective actions taken by the facility to correct the deficient practice and the dates they were completed. The deficient practice was issued at past non-compliance after the following corrective actions were implemented, and verified the facility took the following actions, prior to the start of the survey: -NA-A was suspended on 12/12/25, and resigned from her position on 12/12/25. -updated R1's care plan on 12/16/25, and ongoing as needed. -reviewed and updated as needed all residents care plans on 12/16/25. -education on ambulation began on 12/16/25 and will be ongoing-education on following care plans/Kardex began on 12/16/25 and will be ongoing. -audits to ensure staff are aware of following care plans and what to do if a resident refuses to utilize appropriate devices began 12/16/25 and will be ongoing. -PHQ-9 and trauma assessments completed 12/16/25. -R1 continues to work with therapy on ambulation and independence to return to community setting. The facility Fall Prevention and Management policy updated 11/2025, identified nursing staff will begin to try to identify possible or likely causes of the incident and evaluate the chain of events or circumstances preceding a recent fall. The IDT will review falls daily at morning meeting and care plans will be updated to reflect fall interventions. The facility Safe Resident Handling Program policy updated 11/2025, identified the policy was to protect the health and comfort of residents and staff when residents require assistance in moving through the consistent use of mechanical aides/devices. Gait belts must be used for ambulatory residents when indicated in the care plan to allow employees to hold onto the belt to provide support and stabilize the resident when walking. Training of nurses and other direct care employees will be provided to demonstrate proper application and use of available safe patient handling equipment.		