

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 08/21/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>Based on observation, interview and document review, the facility failed to consistently monitor and assess a resident for potential complications related to dialysis treatment post treatment, failed to monitor fluid restrictions, failed to notify the provider of refusal of dialysis, and failure to complete dialysis treatment and monitor daily weights per order for 1 of 1 resident (R99) reviewed for dialysis.</p> <p>Findings include:</p> <p>R99's facesheet printed on 8/21/24, included diagnoses of diabetes type 2, peripheral vascular disease (slow progressive disorder of blood vessels outside the heart), end stage renal disease (kidneys no longer work to meet the needs of the body), edema (swelling) and cellulitis (bacterial skin infection) of lower limb.</p> <p>R22's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R99 had intact cognition, end stage renal disease (ESRD), had 2 venous/arterial ulcers present and was receiving hemodialysis (a machine filters wastes, salts and fluid from the blood).</p> <p>During observation and interview on 8/19/24 at 2:23 p.m., R99 returned from dialysis and was taken to her room by the transportation driver. R99 was sitting in room in her wheelchair. R99 was crying and stated it didn't go well today at dialysis and they had to stop dialysis early. R99 stated she got short of breath and her legs bothered her so she told them to stop. R99 had an oxygen concentrator in her room but she stated she no longer uses that. R99 stated she feels better now and is no longer short of breath. R99 had a dialysis port in her right upper chest, which was intact with no signs of bleeding present and dressing was intact. R99 stated sometimes the facility staff let her drink all she wants and other times they tell her she can't have any fluids. R99 had a full cup of water sitting on her bedside table. During interview with R99 from 2:23 p.m. until 3:15 p.m., no staff entered R99's room to complete post dialysis assessment.</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 08/21/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R99's plan of care dated 4/1/24, last updated 7/22/24, included R99 was at risk for complications related to dialysis secondary to diagnosis of chronic kidney disease stage 5. Attends dialysis three times weekly and has right chest port placed. Goal included resident will attend dialysis and have no uncontrolled bleeding from central line. Interventions included if resident is unable to make dialysis appointment secondary to weather, transportation issues etc update the provider, dialysis unit and responsible party for further instruction. Monitor central dialysis catheter port site for signs of bleeding every shift; dialysis per schedule Monday, Wednesday and Friday. Fluid restriction per order, 1400 ml/24 hour (720 ml days, 780 ml nights) last updated 7/3/23.</p> <p>A progress note dated 7/17/24 at 11:46 a.m., by RN-C indicated R99 refused dialysis treatment today and was seen by provider with new order for daily weights.</p> <p>A progress note dated 7/19/24 at 4:19 p.m., by LPN-B indicated R99 was seen for dialysis but terminated treatment early related to left leg falling asleep and feeling uncomfortable. Patient was educated on risks of terminating treatment early.</p> <p>A progress note 7/23/24 at 8:46 a.m., by LPN-C indicated R99 was transferred to the ED for chief concern of resident showing signs of toxin build up due to not finishing dialysis treatments.</p> <p>A progress note dated 7/23/24 at 9:29 a.m., by LPN-B indicated R99 was refusing to go to appointment and had emesis. Provider was notified and order received to send resident to emergency department (ED) for evaluation of toxin overload. R99 initially refused transfer, daughter was notified and agreed R99 should go to the ED and R99 agreed. R99 left via ambulance.</p> <p>A progress note dated 7/23/24 at 12:48 p.m., by LPN-B indicated order received to start 1500 ml fluid restriction.</p> <p>A doctor's order dated 7/23/24, included start 1500 ml fluid restriction and continue other diet orders.</p> <p>An After Visit Summary, dated 8/8/24, indicated R99 was hospitalized [DATE] - 8/8/24, for peripheral vascular disease with BLE wounds and chronic limb-threatening ischemia (lack of blood flow).</p> <p>A progress note dated 8/9/24 at 4:17 p.m., by RN-A included a communication note was sent to physician and certified nurse practitioner (CNP) regarding resident's readmission to the facility on [DATE].</p> <p>Provider orders dated 8/19/24, included daily weights and call provider with weight gain of 3 lb in one day or 5 lb in 7 days one time a day, dated 8/16/24, and regular diet, regular texture, regular thin consistency dated 8/8/24.</p> <p>Review of progress notes for July and August did not include any further notes regarding stopping dialysis early or refusing to go to dialysis.</p> <p>Review of EMR indicated a weight was completed on 8/18/24 with previous weight documented 7/23/24.</p> <p>Review of fluid intakes for 8/6/24 through 8/21/24 included:</p> <p>(continued on next page)</p>

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 08/21/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>8/6/24 No fluid intake documented</p> <p>8/7/24: No fluid intake documented</p> <p>8/8/24: 220 ml fluid intake</p> <p>8/9/24: No fluid intake documented</p> <p>8/10/24: 240 ml fluid intake</p> <p>8/11/24: 240.0 ml fluid intake</p> <p>8/12/24, 8/13/24, 8/14/24 - No fluid intake documented</p> <p>8/15/24: 350 ml fluid intake</p> <p>8/16/24: 250 ml fluid intake</p> <p>8/17/24: 225 ml fluid intake</p> <p>8/18/24: 225 ml fluid intake</p> <p>8/19/24, 8/20/24 no fluid intake documented.</p> <p>During observation and interview 8/20/24 at 8:22 a.m., R99 continued to state some staff enforce a fluid restriction and others say she can have all she wants to drink. R99 got teary eyed and stated the communication here (at facility) isn't good.</p> <p>During interview on 8/20/24 at 11:05 a.m., license practical nurse (LPN)-A indicated R99 used to be on a fluid restriction but doesn't think she is anymore and was unsure about daily weights. LPN-A indicated R99 has been refusing to go to dialysis at times and when she goes she stops treatment about half the way through. LPN-A indicated she would let the care coordinator for R99 know or the physician.</p> <p>During interview on 8/21/24 at 7:41 a.m., nursing assistant (NA)-B stated she does not believe R99 is on a fluid restriction and was unsure about daily weights. NA-B indicated if she refuses anything including dialysis she would let the nurse know.</p> <p>During interview on 8/21/24 at 8:27 a.m., registered nurse (RN)-B indicated R99 is not currently on a fluid restriction but is on daily weights. RN-B stated she would notify the care coordinator if R99 refuses dialysis. RN-B indicated when R99 returns from dialysis, the port should be checked and complete a set of vital signs at a minimum.</p> <p>(continued on next page)</p>		

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 08/21/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 8/21/24 at 1:15 p.m., trained medication aide (TMA)-A indicated R99 is on daily weights and are done right away in the mornings. TMA-A confirmed there was no weight documented for this morning and other dates were missing also. TMA-A stated R99 isn't on a fluid restriction anymore and when asked if there was an order to stop, TMA-A stated she can't see the orders but it isn't on her list of things to document on. TMA-A indicated the nurse would be responsible for any post-dialysis care when R99 returns.</p> <p>During interview 8/21/24 at 10:20 a.m., nurse practitioner (NP)-B stated if weights are ordered they should be completed and expects fluid restrictions to be followed. NP-B stated staff should let her know when R99 refuses dialysis. NP-B indicated she was notified recently (unable to state the date) that she refused to go to dialysis and upon asking questions found out she had refused three times in a row but had not been notified with the other two refusals. NP-B expected staff would follow the facility protocols for assessments upon return from dialysis.</p> <p>During interview 8/21/24 at 1:51 p.m., licensed practical nurse (LPN)-B, also identified as care coordinator, indicated R99 is on a daily weights but sometimes refuses. LPN-B indicated R99 has also been refusing to go to dialysis. LPN-B indicated she would expect vital signs and dialysis port to be assessed at a minimum upon return from dialysis especially if R99 had shortness of breath or any other complication during dialysis. LPN-B indicated staff do let her know when R99 refuses to go to dialysis and she notifies the provider. LPN-B reviewed the EMR and confirmed there was no progress note indicating provider notification for dialysis refusal or stopping dialysis early and was unable to find when dialysis was refused or terminated early in the EMR. LPN-B indicated staff should be documenting weights and if refusing they should document that also. LPN-B confirmed a nurse should have checked on and completed an assessment on R99 upon return from dialysis on 8/19/24 if she had complaints of shortness of breath and leg pain during dialysis. LPN-B stated the initial order for fluid restriction was received the date R99 went to the hospital from the nephrologist (kidney specialty doctor). LPN-B confirmed the care plan did include the fluid restriction but that when hospitalized the order was discontinued and should have been followed up on with the nephrologist.</p> <p>During interview on 8/21/24 at 2:18 p.m., the director of nursing (DON) indicated she would expect vital signs to be completed if R99 complained of shortness of breath during her dialysis upon return. The DON stated she would expect staff to contact the provider if R99 refuses dialysis or stops dialysis during treatment especially because of her full code status. The DON stated when R99 was hospitalized , the fluid restriction was not reordered from the hospital upon discharge but would expect if on care plan, staff to follow-up with a provider who initially ordered it. The DON confirmed daily weights should be completed as ordered also.</p> <p>On 8/21/24 at 3:10 p.m., LPN-B provided progress notes that included weight refusal on 8/16/24 and 8/17/24.</p> <p>The facility Hemodialysis policy dated 11/22/19, included:</p> <ul style="list-style-type: none"> - The facility will ensure that residents who require dialysis, receive such services consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. - Resident will be monitored for complications before and after dialysis treatment. <p>(continued on next page)</p>		

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 08/21/2024
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 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Ongoing assessment/evaluation of the resident's condition and monitoring for complications should occur before and after dialysis treatments. -The resident's representative, if applicable, primary provider and dialysis coordinator/nephrologist, will be kept informed of any change in the resident's status or observations of potential complications. - Canceling or postponing dialysis: The nephrologist/dialysis team, resident's primary provider and resident representative must be notified of the canceled or postponed dialysis treatment. - The resident's condition will be monitored closely for changes, such as fluid gain, changes in vital signs, respiratory issues, changes in lab results and any other complications that may occur until dialysis can be rescheduled. - The resident's psychosocial status should be evaluated with further services and interventions provided as needed. - Initiate the refusal of care/risk and benefit procedure if applicable. - Residents plan of care will be modified accordingly. - Documentation: Documentation should include but is not limited to pre and post dialysis assessment/observation, daily check of the access site, evaluation for signs and symptoms of infection and fluid intake amounts for each shift with a 24 hour total if a fluid restriction is in place. If dialysis is missed or canceled, documentation should include, but is not limited to, notifications made, response to missing dialysis, medical management required, completion of the risk and benefit procedure if indicated, interventions to manage psychosocial wellbeing, and any other pertinent information that should be included in the resident's medical record.

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 08/21/2024
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 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>44630</p> <p>Based on observations, interview, and document review the facility failed to ensure the required nursing staffing information was posted daily. This had the potential to affect all 51 residents residing in the facility and the visitors who may wish to view the information.</p> <p>Findings include:</p> <p>On 8/19/24, 8/20/24, and 8/21/24, review of the document titled Todays Total Nursing Staffing was dated 6/7/24, and posted on a bulletin board at the entrance of the facility. The facility failed to provide evidence of the nursing staff posting for 8/19/24, 8/20/24, and 8/21/24.</p> <p>On 8/21/24 at 10:41 a.m., the director of nursing (DON) confirmed the nurse staff posting was not current and stated the facility was expected to post the nurse staff information daily and ensure the information was available for residents or visitors. The DON stated the previous receptionist was to post the nursing staffing information and had changed roles at the facility. The DON stated the facility did not have a policy regarding posting of the nursing hours.</p>

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 08/21/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>50761</p> <p>Based on observation, interview, and document review the facility failed to label insulin pens with opened and expiration dates for 3 of 3 residents (R10, R253, and R24). Further, the facility failed to label an insulin pen with clear, concise, and viewable resident identification for 1 of 1 resident (R10). Finally, the facility failed to dispose of expired eye drop medication for 1 of 1 resident (R4).</p> <p>Findings include:</p> <p>On 8/20/24 at 1:14 p.m., observation of medication storage with licensed practical nurse (LPN)-A, identified insulin pens for (R10, R253, and R24) were not labeled with the opened and expiration dates. Each insulin pen included the label to document the opened and expiration dates, however, it was left blank. During the same observation, a Novolog insulin pen for R10 was not labeled with clear, concise, and viewable resident information. The only resident identifier noted on the R10's Novolog insulin pen was a handwritten resident room number in permanent marker. Prednisolone-Bromfenac Ophthalmic Suspension 1-0.0075% eye drops for R4 was observed to not be discarded on the expiration date of 8/18/24 . The medication administration record (MAR) printed on 8/20/24 at 2:04 p.m. indicated R4 received the medication after it expired.</p> <p>On 8/20/24 at 1:14 p.m., an interview with LPN-A stated the insulin pens are typically used before it's expired but should have been labeled with the opened and expiration dates. LPN- A stated that medications also need to be labeled with resident information, not just a room number. LPN-A acknowledged the potential for a medication error and/or compromised resident safety.</p> <p>On 8/20/24 at 3:37 p.m., an interview with the director of nursing (DON) stated that insulin pens need to be labeled with resident information, opened date, and expiration date. DON also stated that anytime eyedrops are opened, it must be dated. If eye drop medications come from the pharmacy, they will be in a separate bag with an expiration date and if the expiration date is missing, the eye drops are to be discarded on day 28 after opening or per facility policy.</p> <p>The facility Medication Storage in the Facility-Pharmacy Services for Nursing Facilities policy revised January 2018, indicated drugs dispensed in the manufacture's original container will carry the manufacturer's expiration date. Once opened, these will be good until the manufacturer's date is reached unless the medication is in a multi-dose injectable vial, an ophthalmic medication, or an item for which the manufacturer has specified a usable life after opening. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The nurse will check the expiration date of each medication before administering it. No expired medication will be administered to a resident. All expired medications will be removed from the active supply and destroyed in the facility, regardless of the amount remaining.</p> <p>(continued on next page)</p>		

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 08/21/2024
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 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy, Preparation and General Guidelines-Pharmacy Services for Nursing Facilities revised January 2019, indicated five resident rights: right resident, right drug, right dose, right route, and right time are applied for each medication being administered. Triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication is put away. Further, the policy indicated once the medication is selected, check the label, container, and contents for integrity then it's compared against the MAR by reviewing the five rights.</p>		

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 08/21/2024
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40614</p> <p>Based on interview and observation, the facility failed to ensure all residents were consistently offered and provided a nutrient and/or calorie-substantive snack after the dinner meal and before bedtime for 19 of 19 residents (R43, R2, R5, R37, R39, R34, R16, R25, R10, R29, R7, R19, R42, R6, R31, R99, R22, R202, R4) who voiced a concern. This had the potential to affect all 51 residents who resided in the facility.</p> <p>Findings include:</p> <p>Record review for R43, R2, R5, R37, R39, R34, R16, R25, R10, R29, R7, R19, R42, R6, R31, R99, R22, R202, R4 Minimum Data Set (MDS) indicated:</p> <ol style="list-style-type: none"> 1. R43's significant change MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 2. R2's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included chronic obstructive pulmonary disease (COPD). 3. R5's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included epilepsy. 4. R37's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 5. R39's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included hypertension. 6. R34's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 7. R16's admission MDS dated [DATE], indicated intact cognition and diagnosis included epilepsy. 8. R25's quarterly MDS dated [DATE], indicated moderately impaired cognition and diagnosis included COPD. 9. R10's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 10. R29's admission MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 11. R7's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 12. R19's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. 13. R42's annual MDS dated [DATE], indicated intact cognition and diagnosis included hypertension. 14. R6's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes. <p>(continued on next page)</p>		

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 08/21/2024
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>15. R31's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes.</p> <p>16. R99's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included diabetes.</p> <p>17. R22's quarterly MDS dated [DATE], indicated intact cognition and diagnosis included congestive heart failure.</p> <p>18. R202's quarterly MDS dated [DATE], indicated moderately impaired cognition and diagnosis included stroke.</p> <p>19. R4's admission MDS dated [DATE], indicated intact cognition and diagnosis included hypertension.</p> <p>During an interview on 8/19/24 at 12:45 p.m., R22 stated no snacks were offered after dinner and before bedtime. R22 stated she would like coffee at that time and did not know if she asked for something if she would receive it. R22 stated she would like chips or fruit with her coffee.</p> <p>During an interview on 8/19/24 at 12:46 p.m., R202 stated no snacks were offered at any time, and would like staff to ask if he wanted a snack.</p> <p>During an interview 8/19/24 at 2:20 p.m., R99 indicated she is not offered a snack in the evening and would like to have one before bed.</p> <p>During an interview on 8/19/24 at 2:31 p.m., R4 stated she did not receive snacks at any time and would like to be offered a snack.</p> <p>On 8/20/24 at 10:37 a.m., an interview the dietary manager (DM)-A stated they have a snack bin at each nurses station and when it is empty, the nursing assistants (NA) bring it to the kitchen to be refilled. Everything is prepackaged in the bin and includes things like pretzels, animal crackers, jello and pudding. DM-A added they go through a lot of snacks.</p> <p>During observation and interview 8/20/24 at 10:42 a.m., a snack bin was located at both nurses stations. Each had 4 pudding containers present. NA-A indicated sometimes the kitchen staff come down and restock it and NA's will take it to the kitchen if they have time. NA-A indicated they will pass out snacks if the resident asks for one but many times residents prefer to have something out of the vending machine which the NA's go get for them.</p> <p>During interview on 8/20/24 at 10:48 a.m., NA-B stated if residents ask for a snack they will get it for them at the vending machine which the resident has to pay for. NA-B stated sometimes will offer snacks from the bins but many times there isn't much in the snack bin. NA-B stated sometimes dietary staff will come and fill it. NA-B has never taken the snack bin to the kitchen to be refilled.</p> <p>On 8/20/24 at 11:40 a.m., during interview the dietary director (DD)-B indicated snacks are provided for the residents and diabetics should be offered a snack in the evening.</p> <p>On interview 8/20/24 at 1:29 p.m., DD-B stated after speaking to the NA's, there are inconsistencies with all residents being offered a snack in the evenings.</p> <p>(continued on next page)</p>		

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 08/21/2024
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 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During interview on 8/20/24 at 11:42 a.m., the registered dietician indicated all diabetic residents at a minimum should be offered a snack in the evening.</p> <p>42073</p> <p>During an interview on 8/21/24 at 2:30 p.m., 16 residents attending the resident council meeting stated they were not offered a snack after the dinner meal and before bedtime. R99 stated you could get a snack if you asked, and if there were snacks available.</p> <p>-R5 stated they were supposed to get a snack in the afternoon and after dinner but did not. R5 stated most residents did not know there was a snack bucket at the nurse's station, but it usually consisted of only Jello cups.</p> <p>-All residents were individually asked, and all stated they would like a snack after supper. About half of the residents thought they could get something if they asked, and the other half did not know if they could get something if they asked.</p> <p>-Diabetic residents (R43, R37, R34, R10, R29, R7, R19, R6, R31, R99) stated they did not receive a snack after dinner and before bedtime. R7 stated there used to be sandwiches at the nurse's station for anyone who wanted one, but not anymore.</p> <p>-R5 stated the dietary manager told her there was no money in the budget for resident snacks.</p> <p>A facility policy on snacks was not provided by the end of the survey.</p>

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 08/21/2024
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** 40614</p> <p>Based on observation, interview, and document review the facility failed to maintain a clean field, use clean supplies and scissors when performing wound care treatments to reduce the risk and/or prevent infections for 1 of 1 resident (R99) whose treatments were observed for venous ulcer wound care and treatment.</p> <p>Findings include:</p> <p>R99's face sheet, printed 8/21/24, included diagnoses of diabetes type 2, peripheral vascular disease (slow progressive disorder of blood vessels outside the heart), end stage renal disease (kidneys no longer work to meet the needs of the body), edema (swelling) and cellulitis (bacterial skin infection) of lower limb.</p> <p>R22's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R99 had intact cognition, end stage renal disease (ESRD), had 2 venous and arterial ulcers present and was receiving hemodialysis (a machine filters wastes, salts and fluid from the blood).</p> <p>R22's physician orders dated 8/16/24, included:</p> <p>-Check bilateral lower extremities (BLE), if drainage is seeping through, will need to change dressing; every shift.</p> <p>-Wound care: BLE - continue to apply 2x2 gauze between toes of L (left) foot; pad legs over the alginate with large ABD pads (absorbent abdominal pads for wounds); if large ABD pads are not available or resident is saturating through too quick may need to use incontinence pad liners to wick away the increased moisture; ensure that all areas that are draining/weeping are covered; secure all the dressing Kerlix (woven gauze wraps) and tape, make sure to cover toes on left foot every day shift AND as needed for wound care.</p> <p>-Wound care: BLE - apply barrier ointment/cream to skin surrounding to weeping areas to protect from drainage; moisturize intact skin of the rest of the leg with Vanicream, do not apply between toes; apply aquacel AG Advantage (antimicrobial primary dressings that are infected or at risk of infection) to cover all the open wounds and weeping skin of both legs as well as the L heel; apply betadine to ischemic areas on toes of left foot and allow to dry; every day shift AND as needed for wound care.</p> <p>During observation and interview on 8/19/24 at 2:35 p.m., R99 was sitting in her wheelchair and had just returned from dialysis. R99 had dressings present on BLE which were only partially visible under her pants but appeared dry with no drainage present. R99 stated staff change the dressings frequently due to drainage and she doesn't tolerate lying in bed or putting her legs up due to discomfort.</p> <p>(continued on next page)</p>

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 08/21/2024
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>During observation and interview on 8/20/24 at 8:22 a.m., R99 indicated she had a procedure to increase blood flow a few weeks ago and has to go back for a second procedure in the near future. R99 indicated her legs weep through the dressings multiple times per day and she has to have them changed 3-4 times per day. R99 stated she was recently hospitalized due to infection in her lower legs.</p> <p>An After Visit Summary dated 8/8/24 indicated R99 was hospitalized [DATE] - 8/8/24 for peripheral vascular disease with BLE wounds and chronic limb-threatening ischemia (lack of blood flow).</p> <p>During observation and interview on 8/20/24 at 9:15 a.m., R99 was seated in her wheelchair in the middle of her room with legs prone. R99 stated she can't lay down as it causes pressure on her lower legs and is painful. The licensed practical nurse (LPN)-A removed bandage scissors from a basin present with other dressings in a drawer. LPN-A placed basin on the floor and sat on the floor to remove saturated dressings. Dressings once removed and bandage scissors was placed on the floor. LPN-A wrapped legs with Kerlix saturated with acetic acid. LPN-A picked up scissors from the floor and without cleaning the scissors placed them in the basin and discarded the old dressings and left the room. At 9:31 a.m., LPN-A returned to the room, sat on the floor, placed measuring tape on the floor, removed the same bandage scissors and removed acetic acid Kerlix from the BLE wounds. LPN-A placed the scissors on the floor. LPN-A using measuring tape began measuring open and scabbed areas of the wounds. LPN-A multiple times placed the measuring tape on the floor to write down measurements and used again to measure another area touching the edges of the wound. After measurements were completed, opened dressings and placed on the floor (still in the package) and using scissors off the floor cut Maxorb [NAME]-alginate dressing with antibacterial silver and cut it into small pieces placing them on different areas of the lower legs. LPN-A repeatedly placed the scissors on the floor and reused cutting alginate dressings in small pieces and placed on the wounds. After wound care was completed LPN-A placed bandage scissors back in basin and placed in lower drawer in R99's room. LPN-A did not clean the scissors after use or after being on the floor throughout the dressing change.</p> <p>During interview at 10:15 a.m., LPN-A confirmed the scissors and tape were placed on the floor but should not have been. LPN-A indicated she should have used a clean basin or chux (waterproof absorbent pad) or some protection on the floor. LPN-A confirmed the scissors were not cleaned throughout the wound care treatment or after completed.</p> <p>During interview on 8/21/24 at 2:40 p.m., registered nurse (RN)-A, also identified as infection preventionist confirmed items used during dressing change (tape measure and scissors) should not be placed directly on the floor and at a minimum a barrier placed down to set things on.</p> <p>The facility Infection Prevention and Control program policy dated 3/13/23, included:</p> <ul style="list-style-type: none"> - Prevention of Infection includes: <ul style="list-style-type: none"> -identifying possible infections or potential complications of existing infections -instituting measures to avoid complications or dissemination; -educating staff and ensuring they adhere to proper techniques and procedures. 		

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 08/21/2024
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>40614</p> <p>Based on observation, interview, and document review, the facility failed to ensure the kitchen ceiling tiles, tracks, lights and kitchen ceiling vents were kept in a clean and sanitary manner and free of dust and debris. This had the potential to affect all 51 residents residing in the facility.</p> <p>Findings include:</p> <p>During an observation and interview on 8/19/24 at 11:50 a.m., with the dietary manger (DM)-A, the ceiling tiles, ceiling tracks, overhead lights and ceiling vents observed in the kitchen was covered with thick dark fuzzy material. The vents were in operation. When asked who was responsible for cleaning the kitchen vents, lights and ceiling tiles and tracks, the DM-A stated she was not sure but thought maybe it was maintenance. DM-A stated kitchen staff clean the kitchen per the cleaning book which staff document when complete, but the ceiling isn't part of what is listed in the book. DM-A added they currently do not have a maintenance person for the facility as the last one left awhile ago. Review of kitchen cleaning book did not include the vents, lights or ceiling tiles and tracks.</p> <p>During observation and interview on 8/21/24 at 10:42 a.m., the light above the meal tray preparation area had black/brown debris present in the light and on the outside. The tiles were black on the edges and black/brown debris was on the track of the ceiling tiles with some areas with hanging debris present. The corner of the kitchen by the toaster, microwave and frying surface also had black/brown debris, some hanging down, present on the ceiling tiles and tracks. The vents over the food preparation area and also tray preparation area had black/brown debris present on the edges of the vent. DM-A confirmed the ceiling tiles, tracks, lights and vents needed to be cleaned or replaced, especially over areas where food prep, cooking and tray assembly was occurring for the safety of the residents.</p> <p>On interview 8/21/24 at 11:52 a.m., the dietary director (DD)-B confirmed the kitchen ceiling had debris present on vents, lights, tiles and track and is in need of cleaning and likely replacement.</p> <p>A policy on kitchen cleaning was requested and none received.</p>		