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	09/11/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to assess and determine safety for self-administration of medications (SAM) for 5 of 5 residents (R68, R25, R28, R11 and R66) who were observed to have medications at bedside. Findings include: R68's facesheet received on 9/11/25, included diagnosis of gastroesophageal reflux (when stomach acid flows back into the esophagus causing heartburn). R68's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R68 was independent or required supervision with activities of daily living. R68's physician orders did not include an order for antacid, or self-administration of an antacid. R68's care plan did not include self-administration of antacid. During an observation and interview on 9/9/25 at 2:30 p.m., observed a bottle of TUMS (over-the counter medication that neutralizes excess stomach acid) located on an open shelving unit below R68's TV. There were two tablets left in a 72-tablet bottle. R68 stated he brought them from home and took them on his own. During an interview on 9/10/25 at 9:49 a.m., licensed practical nurse (LPN)-C, who was also the care coordinator for the wing R68 resided on, was not aware R68 had TUMS in his room. LPN-C stated R68 would sometimes get things he was not supposed to have. LPN-C verified via electronic medical record (EMR), R68 did not have an order for TUMS, was not assessed for self-administration of TUMS, nor was self-administration of TUMS on his care plan. LPN-C stated she would remove them from his room and explain reason to R68. Durning an interview on 9/11/25 at 7:58 a.m., the director of nursing (DON) stated she had been informed R68 had TUMS in his room and acknowledged he should not have without an order and an assessment for safe administration. R25 R25's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated R25 was cognitively intact, dependent on staff with personal hygiene, toileting, required set up with eating, oral hygiene, and utilized a wheelchair. MDS indicated diagnoses included depression, peripheral vascular disease, (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and diabetic. R25's care plan dated 6/26/25, indicated alteration in comfort related to lower back pain, spinal stenosis, gout, pain in right hip, generalized arthritis, osteomyelitis to right ankle/foot, and osteoporosis to the ankle/foot. Care plan directed staff to monitor for potential medication side effects related to pain medication usage including constipation, nausea and vomiting, sedation, lethargy, anorexia and increased confusion. On 9/8/25 at 9:16 a.m., R25 was observed lying in bed. On R25's bedside table was a bottle labeled Equate Calcium Carbonate Chewable Tablets (antacid) 1000 mg (milligrams). The bottle was approximately half full. R25 stated she takes the tablets for acid reflux and did not believe staff were aware she was taking them. R25 reported taking a couple of tablets at a time, but not on a daily basis. On 9/8/25 at 4:55 p.m., R25 was in her room seated in her wheelchair with the bedside table in front of her. The bottle of antacid tablets remained on the bedside table. On 9/9/25 at 9:52 a.m., R25 bottle of antacids continued to be present on the bedside table. On 9/9/25 at 1:07 p.m., trained medication aide (TMA)-A confirmed R25 did not have a provider order for medications to be kept at bedside or for self-administration. TMA-A acknowledged the antacid tablets were not supposed to be in the resident's room as there was not an order on the electronic medical record (EMR) and stated they would remove the medication and inform the nurse manager. On 9/9/25 at 1:09 p.m., registered nurse (RN)-A stated a provider order was required for residents to have medications at the bedside. On 9/9/2025 at 1:12 p.m., TMA-A removed the antacid tablets from R25's room. On 9/10/25 at 11:39 a.m., nurse practitioner (NP)-A stated R25 did not have an order to have medications at the beside and would expect the facility to contact her if R25 wanted an order to take the antacids. On 9/10/25 at 2:17 p.m., the director of nursing (DON) confirmed R25 did not have a self-administration of medication order and stated the medication was not supposed to be in R25's room. The DON confirmed R25 did not have a self-administration medication assessment. R28: R28's facesheet received on 9/10/25, included diagnoses type 2 diabetes mellitus, pneumonia, obsessive-compulsive disorder, seborrheic dermatitis (itchy, flaky and scaly patches on skin) and pancreatic insufficiency (pancreas fails to produce enough digestive enzymes). R28's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, understood others and was understood. R28 required supervision to partial/moderate assist with activities of daily living. R28's physician orders initially dated 7/17/25 included: 1. Ciclopirax Olamine external cream 0.77%, apply to face/chest topically two times a day every other (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	day for prevention. 2. Clobetsaol Proplonate external gel 0.05% apply to scalp topically at bedtime every Wednesday or Friday for rash. 3. Hydrocortisone external cream 2.5%, apply to armpit topically two times a day for 14 days on and 14 days off for rash. 4. Pimecrollmus external cream 1%, apply to face topically every morning and at bedtime related to seborrheic dermatitis. On observation 9/8/25 at 12:18 p.m., R28 had creams in his bathroom including Triamcinolone acetonide external cream 0.1%, ciclopirox olamine external cream 077%, and hydrocortisone external cream 2.5%. On record review, no self-administration assessment, care plan or provider order was present on 9/8/25. On record review 9/9/25, an order was placed that R28 may keep at bedside and self-administer for all four creams ordered above. A self-administration assessment was completed 9/9/25 by licensed practical nurse (LPN)-B, also identified as care coordinator deeming R28 capable of self-administrating topical medication and treatment. On interview 9/10/25 at 10:31 a.m., R28 stated he was using those creams in his bathroom at home for years for a skin condition. R28 stated they have been in his room since he was admitted and he has been self-administering them since that time. A care plan dated 9/9/25, included resident chooses to self-administer topical and external creams. R11: R11's facesheet received 9/11/25, included diagnoses malignant neoplasm (tumor) of esophagus, respiratory failure and morbid (severe) obesity. R11's admission MDS dated [DATE], indicated R11 understood others and was understood with intact cognition. R11 required partial to moderate assist with activities of daily living. Physician orders included nystatin external powder 100000 units/gm (Gram) topical, apply to affected areas topically three times a day for rash irritation dated 8/25/25. On observation and interview 9/8/25 at 2:23 p.m., R11 had a bottle of nystatin powder 100000 units/gm, instructions on bottle included to apply to affected areas topically three times a day for rash/irritation, on his dresser next to his bed. R11 stated he doesn't apply it but staff are supposed to apply it a few times a day but that doesn't always happen. Review of R11's medical record on 9/8/25, did not include a plan of care, orders or assessments for medications to be kept at bedside. On observation 9/9/25 at 7:19 p.m., nystatin powder remains on the dresser next to R11's bed. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On observation and interview 9/11/25 at 9:01 a.m., R11 continued to have nystatin powder on the bedside table. R11 stated he isn't sure why staff have been keeping it on his dresser. Review of R11's medical record on 9/11/25, did not include a plan of care, orders or assessments for medications to be kept at bedside. R66: R66's facesheet, received 9/11/25, include diagnoses bronchiolitis obliterans (constrictive, chronic inflammation and scarring of the small airways), acute respiratory failure, chronic obstructive pulmonary disease (COPD) and anxiety disorder. R66's 5-day MDS assessment completed and dated 9/4/25, (admission MDS still in progress) indicated R66 understood others and was understood with intact cognition. R66 required supervision or touching assistance to partial to moderate assistance with activities of daily living. Physician's orders dated 8/29/25, included orders for fluticasone-salmeterol 250-50 mcg (micrograms) per activation of aerosol powder, breath activated one puff inhaled orally two times a day for COPD and rinse mouth after use and Spiriva Respimat 2.5 mcg/act (activation) aerosol, solution two puffs inhale orally in the morning for COPD. On observation and interview 9/8/25 at 12:12 p.m., R66 was seated in his wheelchair in his room. On his bedside table were two inhalers: Fluticasone-Salmeterol 250-50 mcg/activation aerosol powder and Spiriva Respimat 2.5 mcg/activation aerosol. R66 stated the inhalers have been there since shortly after he was admitted a few weeks ago and he administered them himself. Review of medical record on 9/8/25, R66's record did not include physician orders, plan of care or self-administration assessments for inhalers. On observation 9/9/25 at 7:04 p.m., R66's above inhalers remained on his bedside table. On record review, R66's record included a physician order for self-administration of medicated dated 9/9/25, and medication administration assessment indicating resident is capable of self-administration of inhalation medication (including nebulizer). On interview 9/11/25 at 8:14 a.m., trained medication assistant (TMA)-A stated medications including creams, powders and inhalers can only be kept in the resident's room if a physician order is present and the resident has been assessed to be capable of self-administration. TMA indicated she was not aware R66 had medications in his room without a provider order. On interview 9/11/25 at 9:45 a.m., licensed practical nurse (LPN)-A stated medications cannot be kept at bedside or in a resident room without a physician order and completed assessment. LPN-A indicated she wasn't aware R66 had medications present in his room without a provider order. On interview at 12:11 p.m., LPN-B, also identified as care coordinator, stated she was not aware multiple residents had medications at the bedside or in their room until 9/9/25, at which time she completed assessments and obtained provider orders. She would expect staff to notify her if a resident requested medications at the bedside so an order could be requested from the provider and an assessment could be completed. LPN-B stated she wasn't aware R11 had nystatin powder at the (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedside and she would ensure it was removed from the room or a provider order was received. On interview 9/11/25 at 12:41 p.m., the director of nursing (DON) stated medications could only be self-administered and kept at bedside if a provider order and assessment was completed. The DON added it needed to be communicated to the care manager on the floor for those items to be completed. A Self-Administration of Medications policy, undated included: 1. As part of the evaluation comprehensive assessment, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident. 2. The IDT considers the following factors when determining whether self-administration of medications is safe and appropriate for the resident: a. The medication is appropriate for self-administration; b. The resident is able to read and understand medication labels; c. The resident can follow directions and tell time to know when to take the medication; d. The resident comprehends the medication's purpose, proper dosage, timing, signs of side effects and when to report these to the staff; e. The resident has the physical capacity to open medication bottles, remove medications from a container and to ingest and swallow (or otherwise administer) the medication; and f. The resident is able to safely and securely store the medication. 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is re[1]assessed periodically based on changes in the resident's medical and/or decision-making status. 4. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluates options which allow residents to safely participate in the medication administration process if they wish to do so. 5. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If safe storage is not possible in the resident's room, the medications of residents permitted to self-administer are stored on a central medication cart or in the medication room. 6. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to maintain the physical environment in good repair to ensure a safe and homelike setting for resident's when baseboard heating register covers were detached or not repaired for 6 of 23 resident rooms (R29, R34, R5, R14, R25, and R49) reviewed for environment. Findings include: R29: R29's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, no rejection of care, extensive assistance with bed mobility, dependent for transfers, and diagnoses of bed bound, urinary incontinence, edema, and morbid obesity. During observation and interview on 9/9/25 at 1:45 p.m., R29's heat register cover was observed on the floor next to her heat register. R29 stated it had been like that for a long time and no attempt had been made to fix it or replace it. R29 stated maintenance would sometimes put it back on, but it would be back on the floor the next day. R29 further stated the staff sometimes stepped on the cover when they came around that side of her bed. During observation and interview on 9/102/25 at 1:20 p.m., R29's heat register cover was again on the floor next to her vent. R29 stated it looked awful and she wished someone would have fixed it. R34: R34's facesheet received on 9/3/25, included a diagnosis of multiple sclerosis (a disease that affects the protective covering of nerves). R34's significant change MDS dated [DATE], indicated intact cognition, clear speech, could understand and be understood. During an observation and interview on 9/9/25 at 3:03 p.m., R34 was seated in her recliner. On the base-board heat register below the window, the outer panel which was about a foot in height and extended along the lower wall had a number of horizontal dark scratches along the surface, was pulled away from the heat coils and buckled. R34 stated it had been that way for a long time and yesterday someone from maintenance stopped in her room to look at it and stated it would be fixed. R34 stated it didn't bother her but it should be fixed. During an interview and observation on 9/09/25 at 4:48 p.m., together with maintenance director (MD)-A, looked at the heat register in R34's room. Although there was no bed in the room (R34 slept in a recliner), MD-A stated the register was likely struck by a bed at one time, causing the heat register cover to buckle. MD-A stated he was unaware of this and stated he would expect housekeeping staff to inform him when they see things that needed repair by either telling him directly or contacting him via walk-talkie. R5 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, required substantial/maximal assistance with transfers, and diagnoses included Parkinsons, diabetes, and aftercare following surgical amputation. R5's progress note dated 6/7/25 at 2:15 p.m., scratches noted to right hand were not actively bleeding on day shift. Only light scratches noted, no open areas. Updated wife, who was in the facility visiting regarding right hand. Informed wife that the night nurse had put in a TELS (workorder) to maintenance to fix the cover to the vents next to bed. Also updated CNAs (certified nursing assistance) to keep bed pulled away from vents some. Document titled work order dated 6/7/25, indicated room [ROOM NUMBER] (R5) wall heater needed to be replaced, the metal cover came off, and further indicated completed by MD-A on 6/9/25. R5's weekly skin inspection dated 6/10/25, indicated old scab on the right wrist area, area clean, and dry. Lotion applied to resident skin. R5's progress note dated 6/12/25 at 1:32 p.m., indicated monitor R5's wrist for bleeding, clean with saline, apply bacitracin and cover if needed, ensure resident's bed is not too close to the wall, every shift for skin cares for 5 Days, no open areas or bleeding noted. Washed/dried scratches, applied bacitracin, and left open to air R5's progress note dated 9/10/25 at 8:54 a.m., licensed practical nurse (LPN)- C, the care coordinator, indicated contacted resident's wife and explained about the heater and about the body pillows being taken away due to the heater getting fixed, wife was happy with this result. R14 R14's admission MDS dated [DATE], indicated severe cognitive impairment, and R14 required substantial/maximal assistance with transfers. Diagnoses included diabetes and Parkinson's. R25 R25's quarterly MDS dated [DATE], indicated cognitively intact, dependent on staff with personal hygiene, toileting, required set up with eating, oral hygiene, utilized a wheelchair. Diagnoses included depression, peripheral vascular disease, and diabetes. R49 R49's quarterly MDS dated [DATE], indicated severe cognitive impairment, and R49 required partial/moderate assistance with transfers. Diagnoses included diabetes and hemiplegia following cerebral infarct affecting right side (paralysis of the right side of the body after stroke) Resident Council Departmental Response form dated 6/16/25, heater covers broken. Maintenance director (MD)-A written response undated, indicated repaired heater covers. Resident Council Departmental Response form dated 8/18/25, indicated residents would like furnaces in room fixed. MD-A written response on the form dated 9/8/25, indicated no they are not going to replace furnaces but covers replaced. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review did not reflect any other documentation on work orders for R5, R14, R25, R29, R34, R49, and R77. On 9/8/25 at 9:33 a.m., R5 was seated in a recliner speaking on the telephone with family member (FM)-A. FM-A reported the heat register cover in R5's room frequently falls off. FM-A stated R5's arm often hangs over the bed and has sustained scratches from the exposed metal edges of the heat register. Both FM-A and R5 stated the facility was aware of the problem, but the current solution was to place a pillow over the heat register to prevent further injury. On 9/8/25 at 5:04 p.m., MD-A acknowledged missing or loose heat register covers were a known, ongoing issue at the facility, though the cause of the covers falling off was unknown. MD-A inspected R5's heat register, confirmed it was unsecured, and identified it as a safety hazard due to exposed sharp metal edges. MD-A stated routine walk-throughs were not performed and was unsure if he had previously repaired R5's heat register cover, although R5 stated MD-A had attempted repairs multiple times. On 9/8/25 at 5:12 p.m., the director of nursing (DON) observed R5's room and confirmed the heat register cover should not be missing. DON stated staff should report such issues and initiate a work order promptly. DON also confirmed placing a pillow over the heat register was an inappropriate and unsafe temporary solution. The DON stated she was not aware of the scratches that occurred on R5's arm and would expect staff to make her aware and ensure R5 heater was fixed to not get scratched. On 9/8/25 at 5:15 p.m., RN-C stated that it was common for heat register covers to fall off, staff were expected to submit a TELS order (computerized work order) when this occurred. On 9/9/25 at 8:15 a.m., R5 was observed seated upright in bed eating breakfast. The heat register cover remained hanging off the register with exposed metal slats. The pillow was still positioned over the exposed area between the bed and wall. On 9/9/25 at 10:20 a.m., nursing assistant (NA)-B stated that staff had repeatedly requested nursing and management to fix the heat registers. NA-B indicated it was an ongoing issue. NA-A reported MD-A was aware but often only placed the covers loosely without securely attaching them. On 9/9/2025 at 10:25 a.m., LPN-C, care coordinator, stated she first became aware of R5's unattached heat register cover the previous day (9/8/25) and was educated pillows should not be placed over the registers. On 9/9/25 at 10:58 a.m., RN-D stated she was aware of R5's broken heat register vent for several months but was unaware staff had been placing pillows over it. RN-D became aware of R5's scratches caused by the heat register on 9/8/25 and stated she would expect staff to submit work orders for such repairs. RN-D described the heat registers as being in poor condition and noted that beds leaning against them contributed to covers falling off of the rooms throughout the facility. On 9/9/25 at 1:50 p.m., the regional director of operations (RDO) stated he reviewed the concerns from the resident council meeting from 8/1/25, that indicated the furnaces in the rooms needed fixing. The RDO stated MD-A stated all the furnace covers were fixed, and stated he had not checked himself, but expected the furnace covers were fixed and securely attached in all resident rooms. On 9/9/25 at 1:53 p.m., during observation with RDO in rooms for in rooms R5, R14, R25, R29, R34, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure basic infection control practices were followed when 1 of 1 resident (R38's) urinary drainage bag was observed resting on the floor, failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 resident (R68) when staff failed to wear personnel protective equipment (PPE) to empty urinary drainage bag, and failed to ensure proper glove use and hand hygiene was performed during wound care for 1 of 2 residents (R5) reviewed for pressure ulcers. Furthermore, the facility failed to ensure proper infection control practices were followed for 1 of 1 resident (R66) whose nebulizer machine and tubing were left on the floor.Findings include: R38: R38's facesheet received on 9/11/25, included a diagnosis neuromuscular dysfunction of the bladder (a condition where the nerves and muscles that control the bladder are impaired). R38's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R38 was dependent upon staff for most ADLs. R38 had an indwelling urinary catheter. R38's physician orders dated 6/27/25, indicated change foley catheter monthly and PRN (as needed), 16 French with 10 cc (cubic centimeter) balloon in the evening starting on the 27th and ending on the 27th every month. Orders dated 6/27/25, directed staff to follow EBP every shift for suprapubic catheter. R38's care plan dated 8/28/24, indicated R38 was on EBP related to suprapubic catheter. Staff to follow EBP and don/doff PPE per EBP when providing high contact cares. Care plan dated 2/12/25, indicated R38 had a suprapubic catheter related to neuromuscular dysfunction of bladder. During observations on 9/9/25 at 7:46 p.m., and on 9/10/25, at 8:52 a.m., observed R38's foley catheter bag hooked to the side pocket of his recliner with the entire bottom of the drainage bag resting on the floor. During an observation and interview on 9/10/25 at 11:42 a.m., together with trained medication aide (TMA)-B, observed the location of R38's urinary drainage bag resting on the floor next to the recliner. TMA-B stated, Thats where he wants it. TMA-B did not initially recognize the potential infection control concern until it was pointed out. During an observation and interview on 9/10/25 at 12:01 p.m., together with the assistant director of nursing (ADON) who was also the infection preventionist and LPN-C, observed the location of R38's urinary drainage bag resting on the floor next to the recliner. The ADON stated, it needed to be up off the floor, but below the level of R38's bladder and advised LPN-C to put a hook on the wall for staff to hang the drainage bag. The ADON stated it was an infection control concern resting on the floor. R68: R68's facesheet received on 9/11/25, included a diagnosis of benign prostatic hyperplasia (causes urination difficulties). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R68's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R68 was independent or required supervision with activities of daily living (ADLs). R68 had an indwelling urinary catheter. R68 did not walk and used an electric wheelchair for mobility. R68's physician orders dated 9/8/25, indicated change foley/suprapubic catheter bag on shower day in the morning every Friday. Staff to follow EBP every shift for foley catheter. R68's care plan dated 6/22/23, indicated R68 had an alteration in elimination. Care plan dated 4/18/25, indicated monitor foley catheter output, change foley catheter per policy and foley catheter care per policy. During an observation on 9/9/25 at 7:41 p.m., nursing assistant (NA)-E entered R68's room to empty his urinary leg bag. A sign on the door to R68's room indicated R68 was on EBP and staff must wear gloves and gown for device care, including urinary catheter. Outside R68's room was a three-drawer plastic PPE cart with disposable gowns in it. NA-E entered the room without donning a gown. NA-E donned gloves and obtained a plastic graduate, then emptied the urine from the leg collection bag into the graduate. When complete and outside of the room, NA-E admitted she did not wear a gown to empty R68's leg bag. NA-A stated she knew she should have worn a gown as well as gloves because R68 was in EPB but was in a hurry because she was told to go into his room and empty the collection bag. During an interview on 9/10/25 at 3:30 p.m., licensed practical nurse (LPN)-C who was also a care coordinator confirmed R68 was in EBP due to urinary catheter. LPN-C stated she would expect staff do wear a PPE gown when emptying R68's leg bag. When informed of observation, LPN-C stated staff had received training on EBP. Facility policy on managing urinary drainage bag was requested. An Indwelling Catheter Tubing Safety skills checklist was received dated 2018, which indicated: keep tubing and drainage bag from touching the floor. Facility Enhanced Barrier Precautions policy with revised date of 4/1/24, indicated it was the practice of the facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). Staff received training on enhanced barrier precautions upon hire and at least annually and were expected to comply with all designated precautions. Clear signage would be posted on the door or wall outside of the resident room indicating the type of precautions. Enhanced barrier precautions would be implemented for residents with any of the following: wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers); indwelling medical devices (e.g., central lines, hemodialysis catheters, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident was not known to be infected or colonized with a MDRO. High-contact resident care activities including dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting. Device care or use including central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes. Wound care: any skin opening requiring a dressing. R5 R5's quarterly [NAME] Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, required substantial/maximal assistance with transfers, and diagnosis included one stage (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three pressure ulcer. R5's care plan dated 7/1/25, indicated enhanced barrier precautions r/t (related to) wound care, staff to don/doff PPE per enhanced barrier precautions when providing high contact cares. R5's wound care orders with start date 1/21/25, included: wound care left first MTP (metatarsophalangeal joints, knuckle of the toe) 1. Wash hands 2. Remove old dressings 3. Cleanse left foot with VASHE (wound cleanser) and dab dry 4. Paint the incisional area and any calluses with Betadine (antiseptic) 5. Cover with 4x4s 6. Secure with Kerlix (bandage) roll 7. Further secure with loose Coban (self-adherent wrap) wrap in the morning. On 9/9/25 at 10:40 a.m., licensed practical nurse (LPN)-C was observed entering R5's room wearing a gown and gloves while carrying wound care supplies. R5 was seated in a recliner in his room. LPN-C removed R5's left shoe, and dressing from R5's left foot. LPN-C discarded her gloves, without performing hand hygiene, LPN-C reached into her right scrub pocket under her gown and retrieved clean gloves, which she applied. LPN-C then reached into her left scrub pocket and removed a bandage scissors, which she used to cut the new dressing. LPN-C then discarded her gloves, returned the used scissors to her left scrub pocket without disinfecting it, retrieved another pair of clean gloves from her right scrub pocket, and completed the dressing change, without performing hand hygiene between glove changes. LPN-C was only observed performing hand hygiene upon exiting R5's room. On 9/9/25 at 10:52 a.m., LPN-C confirmed she did not disinfect her hands between glove changes during the dressing change. LPN-C stated it was her normal practice not to perform hand hygiene between glove removal and re-gloving during dressing changes. LPN-C also stated she did not disinfect the scissors before placing them back in her pocket but typically would disinfect them prior to the next use. LPN-C acknowledged that hand hygiene was expected between glove changes, but this was not a standard part of her dressing change procedure. On 9/10/25 at 2:12 p.m., the director of nursing (DON) stated during a dressing change staff were expected to remove gloves, complete hand hygiene, and get new gloves prior to the clean dressing applied to prevent contamination. Facility Policy titled Wound Care Treatment procedure dated 2/24, indicated:Steps to complete addressing change:Prior to starting, wash your hands and prepare the dressing supplies in an established clean field. Apply clean gloves Remove the previous dressing. Dispose of previous dressing and designated container Remove your gloves and complete hand hygiene Evaluate the woundClean the wound Remove gloves dispose of them in the designated container and complete hand hygiene Apply clean gloves and complete dressing change while following the provider's order When the treatment is completed remove your gloves dispose of any additional items and complete hand hygiene R66: R66's Facesheet, received 9/11/25 included diagnosis of bronchiolitis obliterans (constrictive, chronic inflammation and scarring of the small airways), acute respiratory failure, and chronic obstructive pulmonary disease (COPD). R66's 5 days MDS assessment dated [DATE] (admission MDS in progress) included R66 understands (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and is understood with intact cognition. R66 required supervision or touching assistance to partial to moderate assistance with activities of daily living and received continuous oxygen. R66's plan of care included alternation in oxygen/gas exchange, respiratory status with diagnosis of congestive heart failure, acute respiratory failure, and COPD. Interventions included continuous oxygen at 2-3 liters via nasal cannula, monitor oxygen saturations as ordered, monitor for cyanosis (bluish coloration of the skin), accessory muscle use, shortness of breath, increased respirations and difficulty coughing up sputum. Keep physician informed of changes. R66's provider orders included ipratropium-albuterol inhalation solution 0.5-2.5 3milligrams/milliliters. Inhaled orally as needed for wheezing and shortness of breath four times a day. On interview and observation 9/8/25 at 11:23 a.m., R66 sat in his wheelchair. A nebulizer machine and tubing sat on the floor next to the bed. R66 states that is where they put it because the only outlet is behind the bed. R66's bedside table sat next to him but full of personal items. R66 stated he has been doing a nebulizer treatment generally four times a day since he was admitted to the facility. On observation 9/9/25 at 7:04 p.m., the nebulizer machine with tubing was sitting on the floor next to R66's bed. Again, R66 stated that is the only place they have to plug it in. On observation 9/10/25 at 7:44 a.m., R66 sat on the edge of his bed receiving a nebulizer treatment. Nebulizer machine sat on the floor and tubing was ran from nebulizer machine to the nebulizer cup which R66 was inhaling medication from. Date on tubing indicated 9/4/25. On observation and interview 9/10/25 at 11:36 a.m., registered nurse (RN)-E was observed in R66's room completing dressing change on lower leg. The nebulizer machine sat on the floor, but tubing was wrapped around the window handle and not on the floor. RN-E stated she wrapped the tubing it around the window handle as there is no other place to put it but the floor which it shouldn't be on. On interview 9/10/25 at 10:57 a.m., registered nurse, also identified as infection preventionist and assistant director of nursing (ADON)-C stated a nebulizer machine, and tubing should not be housed on the floor as the floor is not clean. On interview 9/11/25 at 9:45 a.m., licensed practical nurse (LPN)-A stated a nebulizer machine and tubing should never be on the floor of a resident's room as the floor is not clean. On 9/11/25 at 12:20 p.m., LPN-B, also identified as care coordinator, stated a nebulizer machine and the tubing should not be on the floor. Stated there are portable stands they could put it on if his bedside table is full. On 9/11/25 at 12:41 p.m., the director of nursing stated she would not expect a nebulizer machine nor the tubing to be on the floor and that it is an infection issue.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to follow their grievance process for 1 of 1 resident (R28) who reported missing property. Findings include: R28's facesheet received 9/10/25, included diagnoses Type 2 diabetes mellitus, obsessive-compulsive disorder, generalized anxiety and mood disorder. R28's admission Minimum Data Set (MDS) assessment dated [DATE], identified R28 had intact cognition, understands and is understood and has no behaviors.On interview 9/8/25 at 10:54 a.m., R28 stated he lost a couple shirts that meant a lot to him when he was first admitted . R28 states it isn't uncommon for the laundry not to return. R28 stated no one has followed up with him after he reported them missing even when he periodically asks again about them. R28 stated he has told many different staff about his missing clothes but was not able to identify any by name. Review of grievance logs did not include a grievance form for R28's missing clothing. Review of R28's progress notes did not include a note on his missing clothing. During interview on 9/9/25 at 2:01 p.m., R28 stated licensed practical nurse (LPN)-B, also identified as care coordinator, gave him some extra clothes to wear but does not believe it was in response to his lost shirts. R28 stated no one has offered to replace his missing shirts nor could they replace them as they were from vacation places he visited and held sentimental value. R28 stated he had the shirt on when he came and they took it off when he showered the next day and he hasn't seen it since. R28 stated they won't mark your clothes until they are clean so he believes many things get lost initially due to that. R28 reported he is also missing a couple pairs of socks that were labeled and it has been over a week and they haven't come back from laundry. R28 stated he has told staff right away when his clothes/socks go missing and he never gets a response back even when asking about them multiple times. During interview on 9/9/25 at 6:14 p.m., trained medication assistant (TMA)-A and nursing assistant (NA)-C stated when residents inform them of missing belongings including clothing, there is a form that gets filled out. TMA-A stated the forms were at the nurses' station. NA-C stated if they report it to her she generally goes to the laundry room and takes a look around for it. NA-C stated if not found will tell the nurse who will complete the missing belongings report. On 9/9/25 at 3:07 p.m., LPN-B stated if residents are missing clothes, staff should inform the nurse or report it to her. LPN-B stated they do have a form for missing belongings but aren't consistently using it. LPN-B stated they do not know why they have so many missing belongs at the facility. During interview on 9/10/25 at 8:17 a.m., laundry staff (LS)-A, also identified as supervisor, stated this morning she found R28's hoodie in the laundry room but is unsure of the rest of his missing clothes. LS-A stated generally she gets an electronic mail (E-mail) from staff when things are missing but prefers it on paper to communicate with the other laundry staff. LS-A stated they do laundry for three other facilities besides this one so things can get lost. LS-A stated many times they find out belongings are missing when they deliver clothes to the resident's room from the residents, or sometimes from social services or the manager. LS-A confirmed clothes have to be clean before the front desk staff will label the clothing with a name but they generally will put them in a separate bag with the name in the bag. During interview on 9/11/25 at 12:38 p.m., the director of nursing (DON) stated she would expect staff to look for any missing belongings first and if can't find them should fill out a grievance form and turn into social services who will follow-up with the housekeeping supervisor. Facility Lost, Missing or Damaged Items policy dated 2/23, included: 1. A Grievance Form will be completed for all missing valuables of residents, visitors, employees and facility, regardless of item value. 2. The facility employee who received the original missing valuables communication is responsible for initiating the Grievance form. 3. Forms are available at the nurse's station or Social Services office. 4. The written form should be signed and dated by the person making the missing item. 5. The form should be completed and returned to the Administrator's or Social Services office. 6. The grievance process will be followed to (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	determine appropriate next steps. Conducting an Investigation 1. The Administrator or designee shall conduct an investigation to determine the details involved with the missing/damaged item. 2. The Administrator shall respond to the owner/resident representative of the missing/damaged item regarding the investigation outcome and the suggested resolution within 5 business days of receiving the reports

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to address urinary catheter/drainage bag/leg bag, and CPAP (continuous positive airway pressure) machine in the care plan for 1 of 3 residents (R68) reviewed for care plans. Findings include: R68's facesheet received on 9/11/25, included diagnoses of pneumonia, obstructive sleep apnea (intermittent airflow blockage during sleep), chronic obstructive pulmonary disease (lung disease that blocks airflow making it difficult to breathe), and diagnosis added 6/23/25: hydronephrosis with ureteral stricture (narrowing in the ureter, a tube carrying urine from kidney to bladder, obstructs urine flow, causing affected kidney to swell with urine). R68's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R68 was independent or required supervision with activities of daily living (ADLs). R68 had an indwelling urinary catheter. R68 did not walk and used an electric wheelchair for mobility. R68's physician orders dated 9/8/25, indicated change foley/suprapubic catheter bag on shower day in the morning every Friday. Staff to follow EBP (enhanced barrier precautions) every shift for foley catheter. R68's care plan dated 6/22/23, indicated R68 had an alteration in elimination. Care plan dated 4/18/25, indicated monitor foley catheter output, change foley catheter per policy and foley catheter care per policy. R68's physician orders at time of survey did not include leg bag or urinary drainage bag monitoring/care, or CPAP use or maintenance. R68's care plan dated 6/21/23, indicated nursing care plan for sleep apnea was directed at supporting the infant's cardiopulmonary status, improvement in gas exchange and breathing pattern, attainment of an optimal level of parental coping, knowledge on the treatment program and home care, and absence of complications. Resident does refuse to wear CPAP and allow staff to assist with cleaning and setting up. In addition to some of the language not being for an adult in a nursing home, it did not include if or how staff were to assist R68 to apply the CPAP at night, how to maintain and clean the CPAP and what to do if R68 declined to wear the CPAP. Further, the care plan did not indicate R68 used a urinary leg bag and did not include frequency of emptying, cleaning and maintenance of the leg bag, nor of the overnight urinary drainage bag. R68's Kardex (a quick reference tool usually used by nursing assistants that summarized key resident information) printed 9/9/25, did not include cares for urinary catheter or urinary leg bag, other than foley catheter output. R68's TAR (treatment administration record) dated 12/17/24, indicated: CPAP on at HS (bedtime) per provider. For the month of August 2025, out of 31 days, documentation indicated R68 used CPAP 24 times. For September 2025, documentation indicated R68 used CPAP two nights before being hospitalized on [DATE].During an interview and observation on 9/8/25 at 1:15 p.m., in his room, R68 stated he had just returned from a four-day hospitalization for pneumonia. Observed R68's CPAP unit on the dresser next to his bed. A SoClean brand CPAP mask cleaner was also on the dresser. Water and condensation were visible in the reservoir window on the CPAP unit. An undated jug of distilled water was on the floor. R68 stated he filled the CPAP reservoir himself with the distilled water. R68 stated the water reservoir was never cleaned or rinsed out that he was aware of and had never seen his CPAP mask in the SoClean machine. During an interview and observation on 9/9/25 at 2:30 p.m., R68 stated he did not use the CPAP every night but felt better when he did. R68 stated he would like to use it every night but had trouble adjusting the mask himself.During an interview on 9/9/25 at 4:39 p.m., nursing assistant (NA)-D stated NAs did not have anything to do with a resident's CPAP machine - only the nurses did - this included applying, removing and cleaning. During an interview on 9/9/25 at 7:20 p.m., R68 stated his urinary leg bag was full of urine, adding no one had emptied it, not even after he got out of bed this morning. R68 pulled up his pant leg to reveal a leg bag completely full of urine. During an interview and observation on 9/9/25 at 7:34 p.m., in R68's room, trained medication aide (TMA)-A stated nurses or NAs filled R68's CPAP machine with distilled water and cleaned the mask (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but wasn't sure how often the mask was cleaned or if cleaning was documented in the EMR. R68 informed TMA-A his leg bag had not been emptied. TMA-A stated his leg bag should be emptied regularly and he should not have to ask. TMA-A stated she would inform the NA. During an interview and observation on 9/9/25 at 7:41 p.m., NA-E arrived to empty R68's leg bag of 750 milliliters of urine. NA-E stated she had not been aware R68 had a leg bag, as she did not usually work on the wing R68 resided on.During an interview on 9/10/25 at 9:49 a.m., licensed practice nurse (LPN)-C who was also the care coordinator for the wing on which R68 resided, stated as care coordinator, it was her responsibility to add areas of focus to a residents care plan and should have added both R68's CPAP and urinary leg bag use with instructions for care and maintenance to guide the staff. During an interview on 9/11/25 at 7:58 a.m., the director of nursing (DON) was informed of the absence of CPAP and urinary leg bag on R68's care plan. The DON stated she expected care coordinators to monitor and update a resident's comprehensive care plan to include all pertinent focus areas.Facility Care Planning policy, with revised dated of 11/2024, indicated the interdisciplinary team (IDT), in conjunction with the resident and the resident representative, would develop and implement a comprehensive individualized care plan. Care plan interventions were derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan would be used in developing the resident's daily care routines and would be utilized by staff personnel for the purposes of providing care or services to the resident. The plan of care would be utilized to provide care to the resident. The care plan would be modified and updated as the condition and care needs of the resident changed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist with oral care as directed by the plan of care for 1 of 4 resident (R65) reviewed for activities of daily living (ADLs).Findings include:R65's face sheet provided on 9/10/25, included diagnoses of diabetes mellitus type II, protein-calorie malnutrition, cellulitis (common bacterial infection that affects skin and tissue beneath) of left lower leg and sepsis (blood infection). R65's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R65 had intact cognition, clear speech, could understand and be understood. R65 required assistance with transfers. For oral care, the MDS indicated: supervision or touching assistance. R65's care plan dated 8/22/25, indicated R65 had a self-care deficit related to multiple health care issues. R65's care plan interventions included: bathing assist of one, dressing assist of one, and personal hygiene assist of one. R65's electronic medical record (EMR), under the TASK tab, included a personal hygiene tab but did not include a specific category for oral care. The hygiene tab was documented on seven of 14 opportunities and required limited to extensive assistance from staff. During interview and observation on 9/9/25 at 6:32 p.m., R65 stated, he has his own teeth yet and since his admission, no one has offered to assist him with brushing his teeth. R65 stated he can brush them himself, but staff need to bring the supplies to him including a basin to spit into when done. Present on the TV stand was a toothbrush and toothpaste that is unopened and in the original packaging. No basin was visualized in his room or bathroom. During interview and observation on 9/10/25 at 8:20 a.m., nursing assistant (NA)-A assisted R65 with a bed bath. R65 was transferred to wheelchair and taken to the scale for his weight and then returned to the room and sat in his chair. Oral care was not set up or offered to the R65. R65 stated he generally brushes his teeth in the morning, but no one has offered to set him up to do it since he has been at the facility, about three weeks. During interview on 9/11/25 at 9:50 a.m., NA-A stated she generally sets residents up to complete oral care but was distracted yesterday so maybe she didn't. NA-A stated R65 was assisted with dressing this morning, but she didn't offer oral care yet and will take care of that right away. During interview on 9/11/25 at 9:45 a.m., licensed practical nurse (LPN)-A stated oral care should be offered at least daily to all residents who require assistance with set up. During interview on 9/11/25 at 12:23 p.m., LPN-B, also identified as care coordinator, stated R65 is supposed to be encouraged to be more independent with his own cares, but should have a basin, toothbrush and toothpaste available for him to use to brush his teeth. During interview on, 9/11/25 at 12:37 p.m., director of nursing (DON) stated she would expect staff to assist with set up for oral care if that is what the MDS states.

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	245516	A. Building B. Wing	09/11/2025

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

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to complete a comprehensive skin assessment and monitoring of impaired skin integrity for 1 of 2 residents (R65) reviewed for skin care. Findings include:R65's face sheet provided on 9/10/25, included diagnoses of diabetes mellitus type II, protein-calorie malnutrition, cellulitis (infection) of left lower leg, Pilonidal cyst (fluid filled sac that forms typically near the tailbone often due to infection of a hair follicle) without abscess and pressure ulcer of unknown site, stage II (partial-thickness tissue loss, shallow open wound caused by pressure) . Resident also had malignant neoplasm (cancerous tumor) of colon. R65's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R65 had intact cognition, clear speech, could understand and be understood. R65 required assistance with transfers. R65 had an open lesion other than ulcers, rashes, cuts and had a stage II pressure ulcer (PU) present on admission. R65's care plan dated 8/26/25, indicated R65 had a self-care deficit related to multiple health care issues. R65's care plan interventions included: bathing assist of 1, dressing assist of 1, and personal hygiene assist of 1. R65 also had an alternation in skin integrity related to open area to coccyx and bilateral wounds to lower extremities upon admission. Interventions included monitor skin integrity daily during cares and weekly skin inspection by the nurse; treatment to open areas per order; pressure redistribution mattress to bed, wheelchair and chair; weekly measurements and assessment of wounds; monitor for skin breakdown for signs/symptoms of infection; document on skin condition and keep physician informed of changes; followed by wound care provided by the facility. A Care Area Assessment (CAA) dated 8/28/25 included pressure ulcer/injury. R65 had alteration in skin integrity related to cellulitis (skin infection), complicated by immunodeficiency, diabetes, metastatic colon cancer, biventricular heart failure and history of malnutrition. R65 had a Pilonidal cyst with daily treatment and skin shear/excoriation (injury that occurs when tissue layers shift laterally to each other causing damage to the skin). Staff routinely assist with skin care, toileting and repositioning, encourage optimum activity levels within limits of safety. Staff provide treatments as ordered, diabetic cares per protocol, observe for adequate intake of fluid and nutrients. Skin audit and documentation per protocol. Update provider if evidence of infection or non-healing. Wound assessment from hospitalization dated 8/19/25 included: Perianal/Posterior thigh: Thigh wound was on right posterior identified as ulcers of unclear etiology with length of 20 centimeters (cm) , width of 1cm and depth of 0.2 cm. Pink yellow and granulation tissue was 100%. Perianal (area that contains the external genitalia and anus) ulcers, length 5 cm x 1 cm with depth of 0.2 cm. Wound # 3 was identified as cyst to the coccyx area with length of 1 cm, width 0.1 cm and depth 0.2cm. 100% granulation tissue present with skin around wound clean, dry and intact. R65's Discharge summary dated [DATE] did not include a skin assessment or wound care treatments or orders. Wound care orders dated 8/21/25, included: Pilondal Cysts - cleanse wounds with acetic acid 0.25% or wound cleanser and pat dry. Put hydrogel (treatment to maintain hydrated environment for proper wound healing) into a med cup and cut strip of 1/4 plain packing gauze strip. Put the gauze strip into the hydrogel. Gently pack the packing gauze infused with hydrogel into the cyst opening. Cover with a 4x4 gauze and cover with border foam dressing. Change daily and as needed in the morning for wound care. For perianal wound and posterior thigh, cleanse with 0.25% acetic acid wound cleanser (antimicrobial and antioxidant properties for treatment of wounds), pat skin dry and apply a nickel thick layer of zinc barrier cream directly to wound area. A Skin assessment dated [DATE] by registered nurse (RN)-C included [resident] received a shower this morning, skin is fragile and generalized bruising. Excoriated skin (caused by act of scratching or rubbing skin) to buttocks with small open area to intergluteal cleft. Ongoing open area/cyst to right thigh inner. No further wound measurements or wound assessments present. A Skin assessment dated [DATE] included Braden score (tool used to predict pressure ulcers) of 15-18 which is mild risk. Coccyx wound (cyst) had (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tunneling and one open spot. Serosanguineous (combination of clear thin watery fluid and blood) was present. No new wounds. Resident had turning and repositioning schedule, pressure redistributing ultra-foam mattress, and wheelchair cushion. No wound measurements or wound bed assessment present.A Wound Examination dated 9/4/25, completed by certified nurse practitioner, also wound, ostomy and continence certified nurse (CNP, WOCN) included ulcer of perianal area measuring 1.91 cm x 0.75 cm x 0.1cm. Pilonidal cyst area improving. Orders and plan for Pilonidal cyst included cleanse wounds with acetic acid 0.25% or wound cleanser, pat dry, place collagen powder into wound bed and apply a thin layer of Triad paste (zinc-oxide based hydrophilic paste used for wound care with light to moderate levels of wound drainage) over wound and powder. Repeat twice daily as needed. Wound care for perianal ulcer included cleanse wound and surrounding skin with acetic acid 0.25% , pat dry. Apply collagen powder to wound bed. Apply a thin layer of Triad paste over the wound and powder. Repeat twice daily as needed. On observation and interview 9/10/25 at 8:20 a.m., nursing assistant (NA)-A provided perianal care for R6. NA-A exposed the wounds on coccyx, perianal area and thigh which were open and covered with a white paste. NA-A stated the thigh wound has had some bleeding on occasion and R65 stated the area hurts when touched. On interview and observation on 9/10/25 at 12:17 p.m., registered nurse (RN)-E completed wound care treatment to R65's wounds. When asked to measure, RN-E stated they do not measure the wounds, the wound care staff do that. Their next scheduled visit was 9/11/25. RN-E wiped the wound on coccyx with acetic acid 0.25% on a sterile 4x4. RN-E repeated the process on perianal area that had 2 open wounds next to each other. RN-E repeated the process on the thigh wound. RN-E allowed all areas to dry and applied collagen powder (used to promote wound healing and tissue regeneration) to all the wound beds, then wound protector (Triad paste) to keep collagen in place. On interview and observation 9/10/25 at 2:36 p.m., licensed practical nurse (LPN)-B, also identified as care coordinator was requested to view R65's thigh wound. After examination of R65's wounds, LPN-B stated I wasn't aware that was there when referring to thigh wound. LPN-B stated she didn't see documentation of this wound on the skin/wound assessment forms. LPN-B placed a Mepilex (absorbent foam dressing) on top of the thigh wound to protect it and stated she would reach out to the provider and get an order and have them review the wound tomorrow. On interview 9/10/2025 at 3:51 p.m., RN-E stated R65 did not have a thigh wound on his initial admission but returned from the hospital 8/21/25 with it. RN-E stated he came back with orders to treat the Pilonidal cyst. RN-E identified the perianal area as the thigh area with all three areas related to the pilonidal cyst. RN-E identified the coccyx area as a pressure area. RN-E stated she has been treating the wounds per orders. On interview 9/11/25 at 8:50 a.m., certified nurse practitioner (CNP)-E, also identified as certified wound care specialist stated she was not aware of a thigh wound for R65 but has assessed and treated Pilonidal cyst areas and pressure ulcer identified on coccyx and perianal area. CNP-E stated she relied on staff to inform her of new wounds and no one at the facility had told her about a thigh wound. On interview and observation 9/11/25 at 11:32 a.m., CNP-E and LPN-B evaluated R65's wounds. CNP-E cleaned the pilonidal cyst area and measure 0.5 depth and now only 0.1 length. CNP-E stated this has showed good improvement. Coccyx ulcer measured 0.3 depth and was pinpoint which also has shown improvement. CNP-E visualized thigh wound and measured 0.5 cm x 2.6 cm with depth of 0.4cm with undermining (erosion beneath the visible edges of a wound) from 10 o'clock to 3 o'clock on the wound. CNP-E stated the wound appeared to be a skin tear of some kind and requested Xeroform (sterile non-adherent wound dressing) for the wound bed and covered with Mepilex. CNP-E stated she would not recommend collagen powder and Triad paste for this type of wound as it could dry it out which is not what the wound needed to heal. CNP-E confirmed she was not aware of this thigh wound until today and stated this was not part of the Pilonidal cyst or pressure ulcer area. On interview 9/11/25 at 12:23 p.m., LPN-B stated she asked RN-E yesterday what she called the thigh area and she stated perianal to her. LPN-B confirmed the thigh wound is not located in the perianal area. LPN-B stated she was not aware of R65's thigh wound as staff never communicated it to her until yesterday when requested to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	view it. LPN-B confirmed the wound has not been measured or documented and assessments completed on the thigh wound. On interview 9/11/25 at 12:45 p.m., the director of nursing (DON) stated she is not sure where the mix up of R65's wound came from. The DON stated the wound care specialist was made aware of the wound today. The DON stated the thigh wound was being assessed and treated per the orders. When asked to see the wound assessments and measurements, the DON did not provide them. A Skin Assessment and Wound Management policy, dated 2/25 included: Provide guidelines for assessing and managing wounds.1. A pressure ulcer risk assessment (Braden Scale) will be completed per facility Assessment Schedule/Grid.2. Implement appropriate preventative skin measures. Examples include, but are not limited to-nutritional interventions, mobility and repositioning plan, pressure redistribution plan.3. Skin Evaluation and Skin Risk Factors Form is completed before initial MDS, annually, and upon significant change.4. Staff will perform routine skin inspections (with daily care).5. Nurses are to be notified if skin changes are identified.6. A weekly skin inspection will be completed by licensed staff.New Skin Problem:When a significant alteration in skin integrity is noted; (i.e., large, or multiple bruising, large skin tear, or other non-pressure related wounds such as diabetic, venous, or arterial ulcers), the following actions will be taken:7. Notify Provider/Treatment Ordered8. Notify resident representative.9. Complete education with resident/resident representative includingrisks & benefits.10. Initiate Skin and Wound Evaluation11. Notify Nurse Manager/WoundNurse12. Referral to dietary, if appropriate13. Referral to therapies, if appropriate14. Review and update care plan including interventions.15. Update resident care lists16. Update Care Plan to identify risks for skin breakdown

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to follow up on a resident's request for vision care and failed to ensure timely scheduling of an eye appointment, resulting in a delay in care for 1 of 1 resident (R44) reviewed for vision services.Findings include:R44's significant change in status Minimum Data Set (MDS) assessment dated [DATE], indicated R44 was cognitively intact, vision was impaired sees large print but not regular print in newspaper/books, no corrective lenses, diagnoses included diabetes and coronary artery disease.R44's care plan dated 9/5/25, did not address R44's vision impairment.R44's care conference form dated 7/21/25, licensed practical nurse (LPN)-C indicated R44 would like to set-up eye care appointment. NM (nurse manager) will work of scheduling an eye exam.R44's document titled hearing/vision form dated 7/24/25, registered nurse (RN)-D, nurse manager indicated R44 had impaired vision and does not use corrective lenses, R44 requested to have appointment scheduled for ophthalmology and audiology. NM will work of scheduling appointments and update resident regarding appointment.R44's progress note dated 9/8/25 at 3:46 p.m., assistant director of nursing (ADON) indicated R44 stated that his vision has gotten worse, and he is unable to read the words on his TV which is a large screen. He has readers in his room, but he is requesting a vision appointment be made, writer updated his nurse manager regarding vision appointment needed.R44's progress note dated 9/8/25 at 3:47 p.m., RN-D indicated appointment scheduled 9/16/25 1:35 p.m., [name of eye clinic] for eye exam and to establish cares. Appointment added to calendar. Resident updated at this timeOn 9/8/25 at 8:46 a.m., R44 was observed seated in a recliner watching television. R44 reported that the television image was blurry and hard to see. He stated he had expressed concerns about his vision and requested an appointment with an eye doctor a few months ago, but had not yet been scheduled to see one.On 9/9/25 a.m., LPN-C stated she would attend R44's care conference if his nurse manager (RN-D) was not available. LPN-C stated she did not recall specifics about R44's care conference held on 7/21/25, and but believed she had relayed the request for an eye appointment to RN-C. LPN-C stated an eye appointment would have been expected scheduled prior to yesterday (9/8/25)On 9/9/25 at 11:01 a.m., RN-D, the assigned nurse manager for R44, stated she had not made any attempt to schedule an eye appointment for R44 prior to yesterday (9/8/25). RN-D acknowledged she was aware of R44's request and confirmed that an appointment should have been scheduled earlier.ON 9/10/25 at 9:05 a.m., nurse practitioner (NP)-A stated the facility to have made an eye appointment for R44 when requested in July 2025.On 9/10/25 at 12:45 p.m., the director of nursing (DON) indicated in an email the facility does not have a policy on making eye appointments, we would just follow up as needed or upon request from the residentOn 9/10/25 at 2:23 p.m., the director of nursing stated would have expected an appointment scheduled when R44 brought up concerns at the 7/25, care conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure proper cleaning and storage of respiratory equipment (nebulizer and CPAP/BiPAP) resulting in improperly maintained respiratory devices, potential for cross-contamination, and increased risk for respiratory infection for 3 of 4 residents (R12, R44, R68) reviewed for respiratory equipment use. Findings include: R12 R12's annual Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, independent with dressing, eating, and required partial to moderate assistance with personal hygiene, utilized a wheelchair, and used a non-invasive mechanical ventilator, (CPAP/BiPAP). Diagnoses included respiratory failure, and chronic lung disease. R12's care plan dated 5/20/25, indicated alteration in respiratory status related to diagnosis of hyper carbic respiratory failure (occurs when the lungs cannot effectively remove carbon dioxide from the blood) BiPAP: on at bedtime, off when up, history of non-compliance with BiPAP usage, resident chooses to self-administer nebulizer treatments after nurse sets up. Resident is found to be competent to do so and interventions included: monitor usage of bedside medications, nursing to administer all other medications and monitor response and side effects as needed. R12's Treatment administration record dated 9/1/25-9/30/25, start date 9/9/25, indicated BiPAP: Cleanse BiPAP water chamber, mask and tubing with soap and water after use every day shift for sleep apnea and Ipratropium-Albuterol Inhalation Solution 3 ml (milliliters) 1 vial inhale orally three times a day related to acute respiratory failure ok for nursing to set up and then can self-administer. On 9/9/25 at 11:10 a.m., R12 had a BiPAP device located on the bedside table and with water visible in the chamber, also on the bedside table was a nebulizer device, which was fully assembled with: the tubing, nebulizer canister, and nebulizer mask. The nebulizer canister contained visible condensation. On 9/9/25 at 11:51 a.m., R12's BiPAP machine continued to be at the bedside table with the water chamber partially full, and an oxygen type face mask was attached to the tubing. A nebulizer machine was also located on the bedside table that was fully assembled with the tubing, nebulizer mask and canister were still hooked up and lying on the bedside table. There was no evidence the equipment had been rinsed, cleaned, or set out to dry after use. On 9/9/25 at 2:42 p.m., R12 stated the staff filled the water chamber on the BiPAP machine for him and stated was not sure if staffed rinsed or cleaned in the morning or daily, R12 also stated he was not sure if staff rinsed the nebulizer cannister after use. R12 confirmed so far no one had come and rinsed out the water chamber of his BiPAP machine today or the nebulizer cannister. On 9/9/25 at 2:47 p.m., trained medication aide (TMA)-A confirmed R12 used the nebulizer independently after set-up by staff. TMA-A stated the medication was put in the nebulizer cannister and she would set a timer and then rinsed the nebulizer cannister after use. TMA-A confirmed the facility had an ongoing issue with staff not rinsing and allowing the nebulizer cannisters to air dry after use. TMA-A stated there were instances when she went to administer nebulizer treatments, and (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the previous staff have not cleaned the nebulizer canister and would obtain new equipment or rinsed the cannister prior to the nebulizer treatment. TMA-A acknowledged staff had been educated on the importance of rinsing and drying the equipment. TMA-A stated the nurse was responsible for cleaning the BiPAP device. On 9/10/25 at 6:44 a.m., In R12's room, the nebulizer tubing and canister remained attached to the machine with condensation noted in the cannister. The BiPAP mask and tubing were found lying on the floor next to the bed, with the mask facing downwards touching the floor and the tubing attached to the BiPAP device. On 9/10/25 at 10:25 a.m., assistant director of nursing (ADON) observed the BiPAP mask on the R12's floor and stated this was not acceptable, the floor was contaminated and could contribute to infection. The ADON confirmed the nebulizer remained hooked up and was expected to have been rinsed and air-dried immediately after use. On 9/10/25 at 10:28 a.m., licensed practical nurse (LPN)-A confirmed R12's nebulizer should not remain connected after use and should be rinsed and left to air dry after use. On 9/10/25 at 10:25 a.m., assistant director of nursing (ADON) observed the CPAP mask on the R12's floor and stated this was not acceptable, the ADON stated the floor was contaminated and could contribute to infection. The ADON confirmed the nebulizer remained hooked up and was expected rinsed and air-dried immediately after use. On 9/10/25 at 12:01 p.m., LPN-A confirmed R12's BiPAP reservoir had not been cleaned or emptied today. LPN-A stated the evening nurse was responsible for emptying and replacing with clean water prior to R12's use at bedtime. LPN-A stated she had not been trained to do anything with the BiPAP reservoir and was not facility practice for her to empty or clean the reservoir in the morning or during the day shift. On 9/10/25 at 12:09 p.m., ADON stated she expected the day nurse to empty and clean the CPAP reservoir daily after use. ADON stated she was also the infection prevention nurse, and if not emptied, the reservoir could harbor bacteria and potentially cause respiratory infections. The ADON stated she had not been overseeing or auditing the cleaning of respiratory equipment. R44 R44's MDS dated [DATE], indicated R44 was cognitively intact and independent with personal hygiene and transfers. Diagnoses included chronic obstructive pulmonary disease (COPD). asthma, respiratory failure, and pneumonia. R44's care plan dated 9/5/25, indicated alteration in oxygen/gas exchange, respiratory status COPD. Interventions included to keep MD (medical doctor) informed of changes. R44's medication treatment record dated 9/1/25-9/30/25, indicated sodium chloride one vial inhaled orally via nebulizer two times a day related to COPD, Ipratropium-Albuterol Inhalation Solution 3 ml inhaled orally via nebulizer every four hours as needed for wheezing or SOB (shortness of breath) related to COPD. On 9/8/25 at 4:53 p.m., R44 was seated in a recliner in his room with a nebulizer device on the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside table next to R44's bed, this included the nebulizer machine, tubing and a cannister connected to the tubing. R44 stated he had finished his nebulizer treatment. R44 further stated some of the staff would unhook the cannister from the tubing and rinse out the nebulizer cannister and other staff did not rinse the cannister out prior to the next nebulizer treatment administered. On 9/9/25 at 8:19 a.m., R44 was observed lying in bed and nebulizer was on bedside table, the nebulizer was fully assembled with tubing, cannister and T-mouthpiece attached. Condensation was present in the nebulizer canister. R44 stated the cannister usually remained attached to the tubing on the nebulizer machine after use. On 9/9/25 11:01 a.m., registered nurse (RN)-D, also known as nurse manger, stated nebulizer canisters were expected rinsed out after every use and would not expect the nebulizer cannister to remain attached to the tubing. RN-D stated residents had an increased risk for infection if the nebulizer cannister was not rinsed and left to air dry after use On 9/10/25 at 9:01 a.m., nurse practitioner (NP)-A stated they would expect the nebulizer cannister rinsed out after each use and stated BiPAP devices were expected emptied and cleaned after each use, to prevent infections. On 9/10/25 at 2:12 p.m., the director of nursing (DON) stated nebulizers were expected rinsed after use and set to air dry. DON expected the BiPAP water chamber emptied and cleaned daily after use. This was important to help prevent possible infections. Facility Policy titled Oral Inhalation Administration dated 5/22, indicated When treatment is complete, turn off nebulizer and disconnect T-piece, mouthpiece and medication cup.Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or:1) Wash pieces (except tubing) with warm, water daily. Rinse with hot water. Allow to air dry completely on paper towel.2) Replace tubing weekly and as needed R68 R68's facesheet received on 9/11/25, included diagnoses of pneumonia, obstructive sleep apnea (intermittent airflow blockage during sleep), COPD (chronic obstructive pulmonary disease; a lung disease that blocks airflow making it difficult to breathe), and benign prostatic hyperplasia (causes urination difficulties). R68's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and be understood. R68 was independent or required supervision with activities of daily living. R68 did not walk and used an electric wheelchair for mobility. R68's physician orders dated 9/8/25, included nebulizer order: Albuterol Sulfate Inhalation Nebulization Solution (2.5 mg [milligram] / 3 ml [milliliter], 0.083%, 2.5 mg inhale orally via nebulizer three times a day for COPD. At time of survey, R68's orders did not include CPAP use. An order dated 12/17/24 and discontinued when R68 went to the hospital on 9/3/25, indicated: Assist resident with putting his CPAP on at HS (bedtime). There were no orders related to the maintenance, care and cleaning of the CPAP machine or mask. R68's care plan dated 6/21/23, indicated nursing care plan for sleep apnea was directed at supporting (continued on next page)

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	245516	A. Building B. Wing	09/11/2025

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the infant's cardiopulmonary status, improvement in gas exchange and breathing pattern, attainment of an optimal level of parental coping, knowledge on the treatment program and home care, and absence of complications. Resident does refuse to wear CPAP and allow staff to assist with cleaning and setting up. In addition to some of the language not being for an adult in a nursing home, it did not include if or how staff were to maintain and clean the CPAP machine and mask to prevent bacterial growth. Further, the care plan indicated safe self-administration of nebulized medication but did not include rinsing and drying the nebulizer set up after use to prevent bacterial growth. R68's TAR (treatment administration record) indicated out of 31 days in August, R68 used the CPAP 24 times: in September, twice before being hospitalized on [DATE]. R68's MAR (medication administration record) indicated R68 received a nebulization treatment on 9/8/25, (the day he returned from the hospital) in the PM (evening), on 9/9/25, in the AM (morning), noon, and PM, and on 9/10/25, in the AM. During interview and observation on 9/8/25 at 1:15 p.m., in his room, R68 stated he had just returned from a four-day hospitalization for pneumonia. Observed R68's CPAP unit and nebulizer unit on the dresser next to his bed. A SoClean brand CPAP mask cleaner was also on the dresser. Water and condensation were visible in the reservoir window on the CPAP machine. An opened and undated jug of distilled water was on the floor. R68 stated he filled the CPAP reservoir himself with the distilled water and that the water had been in the CPAP machine since before he left for the hospital on 9/3/25. R68 stated the water reservoir was never emptied, rinsed or cleaned that he was aware of. During an observation on 9/9/25 at 11:35 a.m., observed nebulizer mask with chamber and tubing attached to nebulizer machine. The chamber had condensation in it, indicative of not being rinsed out and dried after last use. The MAR indicated R68 had a nebulizer treatment that morning. During an observation on 9/9/25 at 2:30 p.m., observed nebulizer mask with chamber and tubing chamber attached to nebulizer machine. The chamber had condensation in it. The MAR indicated R68 had a nebulizer treatment at noon. R68 stated some staff rinsed the nebulizer set up; he had seen it in his bathroom sometimes, taken apart, but not very often. R68 stated he had never seen his CPAP mask in the SoClean machine. During an interview on 9/9/25 at 4:39 p.m., nursing assistant (NA)-D stated NAs did not have anything to do with a resident's CPAP machine - only the nurses did - this included applying, removing and cleaning. During an interview on 9/9/25 at 7:34 p.m., in R68's room, trained medication aide (TMA)-A stated nurses or NAs filled R68's CPAP machine with distilled water and cleaned the mask but wasn't sure how often the mask was cleaned or if cleaning was documented in the electronic medical record (EMR). TMA-A did not know how often R68 used the CPAP as she did not work the night shift. TMA-A stated when R68's nebulization was complete, she took the equipment to the bathroom, disassembled it, rinsed it and set it on paper towel to dry, adding she was aware not all nurses did that. TMA-A stated the nebulizer set-up should be dried to prevent bacteria. During an interview on 9/10/25 at 8:57 a.m., nurse practitioner (NP)-A was informed of finding with R68's nebulizer not being rinsed after use, his CPAP machine water reservoir not being emptied and rinsed, and his CPAP mask not being cleaned. NP-A stated those factors could have contributed to R68's recent pneumonia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/10/25 at 9:49 a.m., licensed practical nurse (LPN)-C who was also the care coordinator for the wing on which R68 resided admitted there was nothing in R68's orders or care plan to guide staff how to clean and maintain the CPAP machine and mask. LPN-C stated nurses knew to rinse nebulizer set-ups after use -- that is something all nurses were trained on but could not say if nurses knew how to clean and maintain CPAP equipment. When informed, LPN-C was not aware all nurses were not rinsing and drying the nebulizer set-up after use. During an interview on 9/10/25, at 10:57 a.m., assistant director of nursing (ADON), who was also the infection preventionist, stated if nebulizers and CPAP machines were not cleaned properly, that could lead to pneumonia or other infections. When informed of findings, ADON stated failure to properly clean this equipment could be a contributing factor to several residents acquiring pneumonia. ADON stated staff should clean a nebulizer after every use, wash out the mask and allow it to air dry it to prevent bacterial growth. The ADON would expect the CPAP masks to be cleaned daily with soap and water and air dried, and the CPAP water reservoir emptied daily and air dried to prevent bacterial growth. During an interview on 9/11/25, at 7:58 a.m., the director of nursing (DON) stated she had been made aware of the concern of improper cleaning and maintenance of nebulizers, CPAP machines and masks, and stated the ADON had gone to resident rooms to audit the equipment and to educate staff on expectations. The DON stated nursing care coordinators were responsible for ensuring orders were entered into the EMR and onto care plans to prompt and guide nursing staff to clean and maintain nebulizers, CPAP machines and masks. In an email exchanged dated 9/10/25, the DON stated the facility did not have a CPAP policy and would follow manufactures guidelines. Page 8 of an untitled and undated document was provided. The guidelines indicated to regularly clean the tubing assembly, water tub and mask to prevent the grown of germs that could adversely affect health. The document included step by step instructions with illustrations including discarding remaining water. The device should be cleaned weekly as described. Refer to the mask user guide for detailed instructions (this was not provided). Wash the water tub and air tubing in warm water using mild detergent. Rinse the tub and air tubing thoroughly and allow to dry. Wipe exterior with a dry cloth. Facility Oral Inhalation Administration policy dated May 2022, indicated to rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or: 1) Wash pieces (except tubing) with warm water daily. Rinse with hot water. Allow to air dry completely on paper towel. 2) Replace tubing weekly and as needed. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. Change equipment and tubing every seven days and as needed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and document review, the facility failed to serve menu items as listed and planned for 1 of 3 residents (R37) reviewed for nutrition services.Findings include:R37's facesheet printed 9/10/25, indicated diagnoses of chronic pain syndrome, edema, liver transplant, and pain.R37's care plan dated 8/1/25, indicated potential for alteration in nutrition with interventions of low sodium diet, soft and bite sized textures, take orders at meals and offer alternatives.R37's physician's order dated 1/6/25, indicated low sodium diet, thin liquids, sit upright for all meals.R37's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, no rejection of care, independent with eating after setup assistance, and no weight loss.During observation and interview on 9/8/25 at 11:57 a.m., R37 stated she did not get the correct meal for supper on 9/7/25. R37 further stated she frequently got food other than what she requested on her facility provided meal selection ticket. R37 displayed a picture on her phone showing her plate on her meal tray from 9/7/25, which included only macaroni and cheese and cocoa. R37's picture showed her meal ticket on which she had selected milk, hamburger on bun, ketchup, macaroni and cheese, ranch dressing, cocoa, and oranges. R37 stated she turned on her light and requested her missing food items and was brought a dry hamburger on a bun with no condiments. R37 further stated she added her hamburger to her macaroni and cheese to make her own hotdish and gave up on requesting her additional items.During interview and observation on 9/9/25 at 12:34 p.m., R37 stated she had requested mashed potatoes as a substitute for rice for the noon meal on 9/9/25 but instead received cilantro rice. R37 showed her facility provided meal selection ticket which had a specific typed note on it indicating she should not be served rice.During interview and observation on 9/9/35 at 6:06 p.m., R37 was observed eating in her room. Her facility provided meal selection ticket was on her tray with her provided meal. The meal ticket order was for grilled chicken breast, pasta salad, and a peanut butter bar. Her tray included chicken nuggets, pasta salad, mandarin oranges, beets, cocoa, and chocolate ice cream. R37 stated the texture of the large chicken nuggets was too hard for her and that is why she requested the grilled chicken breast instead.During interview on 9/9/25 at 6:27 p.m., cook (C)-A stated she was unaware R37 had been served the wrong menu items for any of her meals. C-A stated usually she followed what the meal tickets had circled or written on them, put the food on the tray, and then it was delivered to R37. She did not give alternatives or add extra food without first discussing with the resident. C-A stated she had not talked to R37 recently.During interview on 9/10/25 at 9:47 a.m., culinary services director (CSD)-D stated she was unaware R37 was not getting her selected meals. CSD-D further stated she had just started her job one week ago and was going to work on improving things. CSD-D stated she would have expected R37 to get served her chosen meals unless they did not have something available. CSD-D stated she would talk to R37 to figure out a solution.During interview on 9/11/25 at 11:15 a.m., regional director of operations stated he was aware there had been some problems in the culinary department and they were working on fixing areas of concern and had hired a new culinary services director. Regional director of operations further stated he would expect residents to get their selected menu items or be offered a different choice if not available.A facility policy titled Resident Food Preferences dated 7/17, included the following:If the resident refuses or is unhappy with his or her meal, the staff will create a care plan that the resident is satisfied with. The Food Services Department will offer a variety of foods at each scheduled meal, as well as access to nourishing snack.