

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 08/05/2026
NAME OF PROVIDER OR SUPPLIER Laurels Peak Health Care, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 700 James Avenue Mankato, MN 56001	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 document review, the facility failed to provide the necessary assistance with activities of daily living (ADL) to maintain oral hygiene for 1 of 1 resident (R36) reviewed for ADL assistance. Findings include: R36's face sheet provided on 8/5/26, included diagnoses of malignant neoplasm (cancerous tumor) of right bronchus or lung, and palliative care (specialized medical care during serious illness). R36's admission Minimum Data Set (MDS) assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R36 had no rejection of care and required partial-moderate assistance with oral hygiene. R36's care plan dated 6/25/26, indicated a self-care deficit related to multiple diagnoses, including neoplasm of lung and required staff assistance of one with personal hygiene in the morning, evening and as needed. The care plan did not specify what personal hygiene entailed and if it included oral care. Review of the TASK tab in POC (point of care - the part of the electronic medical record [EMR] where NAs documented completion of resident cares) indicated a task titled personal hygiene which further identified oral hygiene. The document indicated from 7/6/26 to 8/4/26, oral hygiene had been provided 38 times. On 7/15/26, 7/23/26, 8/1/26, and 8/2/26, documentation indicated no oral care had been provided. The document did not indicate how often oral hygiene was to be provided. R36's Kardex (quick reference summarizing a resident's care needs) dated 8/4/26, indicated a category titled grooming, which included: personal hygiene -A-1, meaning R36 required assistance of one staff for personal hygiene. The Kardex didn't specifically identify oral care or brushing teeth as being part of personal hygiene, or the frequency of providing personal hygiene. During an observation and interview on 8/3/26 at 11:35 a.m., R36 was lying in bed and stated staff did not help her clean her teeth; adding she had her own teeth, top and bottom. R36 stated she couldn't recall the last time her teeth had been cleaned by staff. R36 stated two friends had cleaned her teeth twice since she had been here. R36's top teeth looked dull. During an interview on 8/4/26 at 10:30 a.m., R36 was lying in bed and stated no one had brushed her teeth that morning. During an interview on 8/4/26 at 1:42 p.m., nursing assistant (NA)-A described morning cares that were provided to R36, however the description did not include oral care or brushing teeth. NA-A stated when he was going to brush R36 teeth, hospice came in so he left but admitted he didn't go back and offer/provide oral care. NA-A stated oral care should be offered to residents twice a day and stated clean teeth would make a resident feel better. During an interview on 8/5/26 at 12:03 p.m., R36 had been lying in bed with her eyes closed. R36 stated she could not remember if anyone had brushed her teeth that morning. During an interview on 8/5/26 at 1:19 p.m., NA-B stated she performed morning cares on R36 but did not do oral care. NA-B stated the visitor in her room had asked her too, but she didn't and stated she would do it now. NA-B did not offer a reason why she had not provided oral care. During an interview on 8/5/26 at 1:27 (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 245516	Facility ID: 245516
		If continuation sheet Page 1 of 5

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	p.m., registered nurse (RN)-A, who was also a nurse manager, stated oral care/brushing teeth or dentures should be offered in the morning and at bedtime and any other time a resident requested, but at least twice a day. Looking in the EMR, RN-A verified according to the documentation, R36's teeth had not been cleaned twice a day and on some days, not at all. During an interview on 8/5/26 at 2:29 p.m., the director of nursing (DON) stated she would expect residents to be offered/provided oral care twice a day, either setting up supplies for a resident who could perform the task independently, or to provide total oral care for a resident if needed. The DON acknowledged R36 was not able to perform oral care without assistance of staff. Interviews with RN-A and the DON, indicated R36 should have been offered/assisted with oral care twice a day. Out of 60 opportunities, oral care had been documented as being performed 38 times. Facility Activity of Daily Living/Maintain Abilities policy dated 3/31/23, indicated the facility would provide care and services for oral care. A resident who was not able to carry out ADLs would receive the services to maintain oral hygiene		

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to provide appropriate services to ensure 1 of 1 resident (R10) reviewed for abuse maintained his highest practicable psychosocial well-being, specifically dignity. Findings include: R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, no behaviors or rejection of care, lower extremity impairment on both sides, use of wheelchair, partial assistance for toileting, dressing, and personal hygiene, and diagnoses high blood pressure, obstructive uropathy (blockage in urinary tract), and dementia. R10's care plan reviewed 5/2026, indicated resident may have an alteration in mood and behavior related to diagnoses of urinary tract infection, malnutrition, and sepsis. Resident has a history of attempting to masturbate in common areas with the potential of exposing himself to others. Resident has demonstrated unsafe wandering behaviors characterized by entering other resident rooms, creating potential safety and privacy concerns. Due to cognitive impairment, resident has difficulty recognizing boundaries and has entered other resident rooms without awareness of privacy. Interventions: ensure private room, identify triggers, provide clear privacy cues, modify seating in common areas, placing resident in staff view, seat resident in staff-visible areas during communal events, provide structured daily activities, maintain clothing that is harder to remove, provide calm redirection, use consistent staff, reassure, offer alternatives, document all occurrences, implement toileting schedule, increase staff observation. During interview on 8/3/26 at 1:17 p.m., R10's family member (FM)-A stated R10 exposed himself to a female resident in the dining room a few days ago. FM-A stated R10 had not done something like that for quite some time, but the facility had told her they might have to look for a memory care facility for him if the behavior continued. During observation on 8/3/26 at 5:03 p.m., R10 was seated in the dining room with other residents, no staff were present. During observation on 8/4/26 at 8:25 a.m., R10 was seated in the dining room with other residents, no staff were present. During observations on 8/4/26 at 9:17 a.m. and 9:48 a.m., R10 was seated in the facility common area/day room with other residents, no staff were present. During observation on 8/4/26 at 1:36 p.m., R10 was by the main entrance and then propelled himself in his wheelchair toward the 100 hall. No staff were present. R10 then went outside into a courtyard independently with no staff present to observe him. During observation on 8/5/26 at 9:48 a.m., R10 was seated in the dining room with other residents, no staff were present. During observation on 8/5/26 at 1:20 p.m., R10 was seated outside in the courtyard with another resident, no staff were present. During interview on 8/4/26 at 8:27 a.m., activities director (AD)-A stated she had heard about R10 exposing himself to a female resident. AD-A stated she was not aware of any special instructions for R10's care or any new interventions since the exposure incident. AD-A stated R10 liked to be in the facility day room. AD-A stated she was not aware of any extra supervision R10 needed while in the day room or during group activities. During interview on 8/4/26 at 8:31 a.m., registered nurse (RN)-B stated she worked with R10 often. RN-B stated she was not aware of any specific interventions for R10's behaviors and nothing had changed since the recent exposure incident. RN-B stated they were supposed to keep an eye on him and chart any behaviors, but he was not always in sight of a staff member. RN-B stated she did not have the ability to provide one-on-one supervision to R10. RN-B stated she had to check off behavior monitoring on R10's treatment administration record (TAR) but was not able to actively see him or monitor him at all times. RN-B stated she would expect nursing assistants to monitor him and report any behavior. During interview on 8/4/26 at 8:44 a.m., (continued on next page)		

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