



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 28, 2026

Administrator

LAURELS PEAK HEALTH CARE, LLC

700 JAMES AVENUE

MANKATO, MN 56001

RE: CCN: 245516

Cycle Start Date: August 5, 2026

Dear Administrator:

On August 5, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Heath Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 5, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 5, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(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, Minnesota, 56001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 8/3/26 - 8/5/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			09/16/2026	
F0000	INITIAL COMMENTS On 8/3/26 - 8/5/26, a standard recertification survey (S5516039) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000				
F0676 SS = D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not		F0676				

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0676 SS = D	Continued from page 1 diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is NOT MET as evidenced by: 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			F0676	Continued from page 1 2. Identification of Other Residents: All residents requiring assistance with oral care have the potential to be affected. These residents have been reviewed to ensure that oral care is being provided as outlined in each care plan. 3. Systemic Changes: Nursing staff were re-educated by the DON/designee on assisting residents with oral care per their individualized care plans and documenting completion. The ADL policy and procedure for oral care was reviewed and reinforced with staff. 4. Monitoring / Quality Assurance: The DON or designee will conduct audits of 5 residents requiring oral care weekly ×4 weeks, then monthly ×3 months to ensure oral care is provided per the care plan. Findings will be reported to the QAPI Committee for review and follow-up. 5. Completion Date: The facility will achieve and maintain compliance by 9/16/26.		09/16/2026

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F0676 SS = D	Continued from page 2 (specialized medical care during serious illness). R36's admission Minimum Data Set (MDS) assessment dated 6/29/26, 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			F0676			09/16/2026

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F0676 SS = D	Continued from page 3 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 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			F0676			09/16/2026
F0744 SS = D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.			F0744	Corrective Action for Affected Resident(s): R10 was immediately reassessed the residents behaviors, cognitive status, psychosocial needs, supervision needs, and current interventions to ensure dignity following identification of the concern.		09/16/2026

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F0744 SS = D	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: 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 5/20/26, 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.			F0744	Continued from page 4 Identification of Other Residents: All residents with dementia and/or identified behaviors that may affect their dignity or psychosocial well-being have the potential to be affected by this deficient practice. All residents were reviewed with no other like residents identified. Female residents were interviewed regarding potential concerns related to R10's behaviors, with no additional concerns identified. Systematic Changes: The facility reviewed R10's 07/28/26 incident to identify potential contributing factors and determine whether additional interventions were indicated. R10's comprehensive care plan and Kardex were reviewed and updated to reflect current behavioral interventions and monitoring needs. Hourly checks were reimplemented on 08/04/26. Staff from all departments were educated regarding R10's current behaviors, individualized interventions, appropriate redirection, monitoring expectations, protection of resident dignity and privacy, dementia care, and documentation/reporting expectations. Monitoring/Quality Assurance: The Director of Nursing, Administrator, Social Services Director, or designee will audit residents with identified dementia related behaviors to verify that appropriate assessments have been completed, individualized interventions are reflected in the care plan/Kardex, staff are knowledgeable of interventions, and interventions are being implemented as written. Random audits weekly x4 weeks, monthly x2 months, and will be reported to QAPI committee for further review and recommendations. Completion Date: The facility will achieve and maintain compliance by 9/16/26.		09/16/2026

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F0744 SS = D	Continued from page 5 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., nursing assistant (NA)-C stated she had heard about R10 exposing himself to a female resident a long time ago but was not aware of a recent incident. NA-C stated she was not given any education to do anything different with R10 and was not sure if R10 had any increased supervision or monitoring needs. During interview on 8/4/26 at 8:50 a.m., NA-D stated she had heard about R10 exposing himself to			F0744			09/16/2026

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F0744 SS = D	Continued from page 6 a female resident. NA-D stated she had been told to do hourly checks for a couple of days after the incident but wasn't currently doing anything different. NA-D was not sure if R10 needed increased supervision and monitoring due to his behavior. R10's facility progress note dated 11/21/25, authored by social services director (SSD), indicated she followed up with R10's daughter regarding R10 entering other resident rooms and exposing himself. SSD recommended memory care, daughter in agreement. R10's facility progress note dated 7/28/26, authored by SSD, indicated R10 propelled his wheelchair up to a female resident in the dining room, exposed himself, and asked the female resident if she wanted to touch him. Female resident said no and reported to facility staff. No staff observed the incident. R10's facility progress note dated 7/28/26, authored by SSD, indicated SSD notified R10's daughter of the exposure incident and requested different clothing and a move to memory care. R10's daughter declined those interventions. Facility provide document titled (R10's name, 7/28/26), indicated the facility completed the following investigation after the exposure incident on 7/28/26: -Trauma assessment completed with female resident -R10's Brief Interview for Mental Status (BIMS) was completed and indicated a score of four, meaning severe cognitive impairment. -Hourly checks were completed on R10 for 48 hours. -No patterns were identified by staff that could have led to this event. No other documentation was provided. During interview on 8/5/26 at 1:30 p.m., licensed practical nurse (LPN)-A also known as nurse manager, stated she was aware of R10's exposure incident. LPN-A stated she did not think a new assessment was completed and was not aware of any new interventions other than hourly checks for 48 hours after the incident. LPN-A stated she had not investigated the root cause of R10's behavior and was unsure why it happened. LPN-A was unsure of a new intervention to maintain R10's dignity.			F0744			09/16/2026

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F0744 SS = D	Continued from page 7 During interview on 8/4/26 at 1:11 p.m., RN-C stated she was R10's hospice case manager. RN-C state R10 admitted to hospice 1/2026, and had not had any behaviors since admission. RN-C stated the facility informed her of his exposure incident on 7/28/26. RN-C stated she was not aware of any new assessments, care plan changes, or interventions for R10. RN-C stated she had not discussed R10's behavior with his hospice medical director and had not made any changes to his hospice plan of care. During interview on 8/4/26 at 10:16 a.m., SSD stated she was not sure if a new assessment of R10 was completed after he exposed himself to a female resident. SSD stated she thought new things were added to his TAR and his care plan but viewed both of those things and confirmed no new monitoring or interventions had been added since the exposure incident. All interventions and monitoring were from the 11/2025 incident. SSD stated she thought they monitored R10 for 48 hours but did not know of anything they were doing now as an intervention to ensure his dignity was maintained. SSD stated she did not know if any new education was provided to staff. During interview on 8/4/26 at 11:15 a.m., administrator stated she did not do a comprehensive investigation of R10's exposure incident because it was not reportable. Administrator stated she spoke to a few staff and no trend or cause of the incident was discovered. Administrator stated she put hourly checks in place for 48 hours and that meant staff would keep extra watch over him. Administrator stated she was not sure of anything new they were currently doing to ensure R10's dignity, other than what was previously on the care plan. Administrator stated she was unsure if a new intervention had been added to the care plan or if his Kardex was updated regarding this exposure incident. Administrator stated staff would know what to do for R10 based on his Kardex and care plan. Administrator stated no other residents had been interviewed, and no staff education had been completed. Administrator stated she was unaware how often R10 was unsupervised in the facility and expected staff to be monitoring him based on his care plan interventions. Administrator stated she was unsure how the facility was going to maintain R10's dignity, and R10's daughter had declined to have him moved to a memory care unit. A facility email provided on 8/5/26 at 2:06 p.m., indicated new all staff education was completed regarding R10's exposure behavior, hourly checks			F0744			09/16/2026

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NAME OF PROVIDER OR SUPPLIER LAURELS PEAK HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 700 JAMES AVENUE , MANKATO, Minnesota, 56001			
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F0744 SS = D	Continued from page 8 were reimplemented and added to R10's care plan, all female residents were interviewed with no concerns. Facility Care Planning policy revised 11/2024, indicated the following: In accordance with state and federal regulation, each resident will have a person-centered care plan developed by the interdisciplinary team for the purpose of meeting the resident's individual medical, physical, psychosocial, and functional needs. The care plan is to be modified and updated as the condition and care needs of the resident changes.			F0744			09/16/2026

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NAME OF PROVIDER OR SUPPLIER LAURELS PEAK HEALTH CARE, LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 700 JAMES AVENUE , MANKATO, Minnesota, 56001			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/03/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Laurels Peak Health Care, LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			09/16/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building 01 of Laurel's Peak Rehabilitation Center was constructed as follows: The original building was constructed in 1962, it is one-story, has a partial basement, is fully fire sprinkler protected and is of Type I(332) construction; The 1992 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 1998 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The 2008 and 2010 building additions. Both are 1-story with no basement, are fully sprinklered and were determined to be of Type V(111)construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life			K0000			09/16/2026

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K0000 Bldg. 01	Continued from page 2 Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The nursing home is separated from an assisted living facility by a two-hour fire-rated wall assembly, with opening protectives appropriate to the rating. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has hardwired single station smoke alarms in resident rooms. The facility has a capacity of 60 beds and had a census of 53 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			09/16/2026
K0291 SS = F Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/03/2026 at 10:18 AM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested in the months of May, June, and July of 2026. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0291	1. Corrective Action for Residents Affected: All residents have the potential to be affected. 2. Corrective Action for Residents Potentially Affected: A full facility inspection was completed of all emergency lighting to ensure all units were tested and working appropriately. 3. Systemic Changes to Prevent Recurrence: Emergency lighting units will be tested monthly to verify proper operation and adequate illumination during loss of normal electrical power. The maintenance staff were educated on testing and maintaining emergency lighting. 4. Monitoring to Ensure Compliance: The Maintenance Director or designee will complete a full house audit monthly for 3 months. 5. Date of Completion:		09/16/2026

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K0291 SS = F Bldg. 01				K0291	Continued from page 3		09/16/2026
					All corrective actions will be completed by 9/16/26.		
K0347 SS = F Bldg. 01	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation, the facility failed to inspect and test smoke alarms per NFPA 101 (2012 edition), Life Safety Code Section 9.6.2.10.1.1 or NFPA 99 (2012 edition), Health Care Facilities Code, section 15.7.3.1, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code Sections 14.2.1.1.2, 14.4.5 and 14.4.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/03/2026 at 10:18 AM, it was revealed by a review of available documentation that the facility did not inspect or test battery-operated smoke alarms in September, October, November and December in 2025. An interview with the Maintenance Supervisor verified this deficient finding at the time of discovery.			K0347	1. Corrective Action for Residents Affected: All residents have the potential to be affected. 2. Corrective Action for Residents Potentially Affected: Facility smoke alarms have been inspected and tested. 3. Systemic Changes to Prevent Recurrence: Maintenance staff were educated on maintaining smoke detectors/alarms and inspecting/testing as needed. 4. Monitoring to Ensure Compliance: The Maintenance Director or designee will complete a full house audit monthly for 3 months. 5. Date of Completion: All corrective actions will be completed by 9/16/26.		09/16/2026
K0355 SS = F Bldg. 01	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is NOT MET as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed			K0355	1. Corrective Action for Residents Affected: All residents have the potential to be affected. 2. Corrective Action for Residents Potentially Affected: Facility fire extinguishers have been inspected. 3. Systemic Changes to Prevent Recurrence:		09/16/2026

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K0355 SS = F Bldg. 01	Continued from page 4 to inspect fire extinguishers per NFPA 101 (2012 edition), Life Safety Code sections 19.3.5.12 and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/03/2026 between 10:00 AM and 12:00 PM, it was revealed by observation that multiple extinguishers in the facility were not inspected monthly. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0355	Continued from page 4 Maintenance staff were educated on inspecting fire extinguishers. 4. Monitoring to Ensure Compliance: The Maintenance Director or designee will complete a full house audit monthly for 3 months. 5. Date of Completion: All corrective actions will be completed by 9/16/26.		09/16/2026
K0363 SS = D Bldg. 01	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and			K0363	1. Corrective Action for Residents Affected: Residents within the Therapy Room could have the potential to be affected. 2. Corrective Action for Residents Potentially Affected: The Occupational Therapy Room door was addressed and fixed. The door now latches appropriately. 3. Systemic Changes to Prevent Recurrence: Maintenance staff were educated on ensuring all facility doors latch appropriately. 4. Monitoring to Ensure Compliance: The Maintenance Director or designee will complete a full house audit monthly for 3 months. 5. Date of Completion: All corrective actions will be completed by 9/16/26.		09/16/2026

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K0363 SS = D Bldg. 01	Continued from page 5 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 08/03/2026 at 11:30 AM, it was revealed by observation that the door to the Therapy Room would not latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0363			09/16/2026