Electronically delivered
June 14, 2022

Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: CCN: 245516
Cycle Start Date: May 25, 2022

Dear Administrator:

On May 25, 2022, a survey was completed at your facility by the Minnesota Departments 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, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 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 August 25, 2022 (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 November 25, 2022 (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) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 05/25/2022

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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E 000	Initial Comments On 5/23/22-5/25/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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.	E 000		
F 000	INITIAL COMMENTS On 5/23/22-5/25/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5516075C (MN80027), with a deficiency cited at F677. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 that substantial compliance with the regulations has been attained.	F 000		
F 568	Accounting and Records of Personal Funds	F 568		6/24/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2022

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.

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F 568 SS=B	Continued From page 1 CFR(s): 483.10(f)(10)(iii) §483.10(f)(10)(iii) Accounting and Records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide quarterly statements for resident personal fund accounts for 1 of 1 residents (R25) who indicated he hadn't been notified of account balance. Findings include: R25's quarterly Minimum Data Set (MDS) dated 4/1/22 indicated R25 was cognitively intact and understands and is understood. During interview on 5/23/22, at 12:43 p.m., R25 indicated he only gets notice when his personal fund account level is low and does not receive a monthly or quarterly statement with the balance. R25 added he has no idea how much money is in the account. During interview on 5/25/22, at 1:16 p.m., receptionist (R-A) indicated she maintains a separate spreadsheet for each resident and	F 568	Plan of Correction□Accounting and Records of Personal Funds Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility has reviewed R25□s personal funds and has given him an updated accounting of his funds. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that	

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F 568	Continued From page 2 maintains deposits, and withdrawals for personal fund accounts. R-A indicated she is not sending out quarterly or monthly statements, but does send reminders to residents and families when their account balance is low. R-A indicated she is working with facility corporate office who will be teaching her how to do this but it just hasn't happened yet. R-A indicated she started her duties in December 2021 and has not sent out any statements since that time. During interview on 5/25/22, at 1:56 p.m., the administrator indicated he was aware monthly or quarterly statements were not being sent to residents directly from the facility but would check with the corporate office to see if they were sending statements to residents but doubted it Did not receive any further information from the facility.	F 568	the problem will be corrected and will not occur: The facility has completed an audit on all residents with trust accounts to assure their accuracy. The facility has provided all residents and/or representatives with an updated balance of their accounts. The facility has completed education with the appropriate staff r/t management of trust accounts and delivery of monthly statements Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. QAPI will review that statements went out for the next two quarters Completion date: 6/24/2022	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide grooming for 1 of 3 residents (R25) reviewed for activities of daily living (ADL) who was dependent on staff for nail care, incontinent cares and bathing. Findings include:	F 677	Plan of Correction—ADL Care Provided for Dependent Residents Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in	6/24/22

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F 677	Continued From page 3 R25's face sheet printed 5/25/22, indicated diagnosis including hemiplegia (immobility) and hemiparesis (partial paralysis restricted to one side of the body) following cerebral infarction (disrupted blood supply due to blood clot or hemorrhage) affecting right dominant side, anxiety, chronic obstructive pulmonary disease (COPD) (constriction of the airways) and hepatic failure (liver is unable to perform its normal metabolic function) without coma. R25's quarterly Minimum Data Set (MDS) dated 4/1/22 included R25 was cognitively intact, requires extensive assist of 1-2 for dressing, personal hygiene and toileting, does not walk, requires extensive assistance of 1 person for locomotion and has range of motion impairment on one side. R25's plan of care dated 2/10/21, included self care deficit related to respiratory failure, hemiplegia, and stroke. Goal of care included R25 will be dressed, groomed and bathed per preferences. Interventions included assist with bathing, personal hygiene with 1 assist and R25 prefers day time shower. During observation and interview on 5/23/22, at 12:28 p.m. R25 stated he would like his finger nails trimmed down. R25 indicated staff do not cut them on a regular basis because they are thick and can be challenging. R25 indicated he can go 2-3 months without them being trimmed and would like them trimmed more often. Nails were yellowed, approximately 1/8 inch thickness and 1/4 to 1/2 inch long extending from nail bed. During observation and interview on 5/24/22, at	F 677	response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility has completed nail care for R25, and insured that he received his showers. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated nursing staff on nail care, call light response time, and completing showers per schedule. The facility has created an audit tool to insure compliance with nail care, call light response time and completing showers per schedule. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor för compliance. Completion date: 6/24/2022	

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9:23 a.m., R25 again indicated it has been 2-3 months since his nails were last trimmed and indicated he often requests them to be cut but guesses no one wants to do it. R25 added he has a podiatrist who trims his toenails every two weeks, and is unsure if someone special needs to come trim his fingernails. R25's fingernails remain unchanged from previous day.

During interview on 5/24/22, at 1:59 p.m., nursing assistant (NA)-B indicated she thought R25 was diabetic and that requires a nurse to trim them. NA-B then checked electronic medical record (EMR) and indicated he was not diabetic so it is the NA's responsibility to complete this task and should be done weekly with their bath or per their preference.

During interview and observation on 5/24/22, at 2:05 p.m., the director of nursing observed R25's fingernails and R25 stated he would like someone to cut them today. The DON indicated she thought they were talking about sending him somewhere to get them cut, but the nails are to long and need to be addressed.

During interview on 5/24/22, at 2:47 p.m., registered nurse (RN)-D indicated she was aware R25 had long fingernails and needed to find the correct nail clipper to complete the task.

During interview on 5/24/22, at 3:31 p.m., R25 indicated he has gone 2 weeks without a shower or bath and added staff told him they didn't have enough staff to complete it. R25 added approximately 3 weeks ago, he had a bowel movement (BM) in his pad on the night shift and he waited three hours for someone to answer his call light. R25 indicated since he sat in his stool

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F 677	Continued From page 5	F 677		

so long his skin got red and irritated so staff had to put a cream on which has helped.

During interview on 5/24/22, at 3:47 p.m., NA-C indicated they used to have bath books to indicate who needed a bath that day, but have changed their process recently so she asks the nurse which residents need to be done that shift. NA-C added they do not have a person just assigned to baths and the NA's working that day are required to give baths in addition to their other duties and sometimes baths/showers do get canceled if they can't complete them during their shift.

During interview on 5/25/22, at 9:13 a.m., licensed practical nurse (LPN)-A indicated she is not sure what residents get baths during her shift and is unsure where to locate that information. LPN-A indicated R25 does have ongoing redness and irritation from his stools, but was not aware of any issues with staff not answering his call light timely.

During interview on 5/25/22, at 9:39 a.m., NA-D indicated they no longer have a list of who gets baths and isn't really sure how they find out who needs one.

During interview on 5/25/22, at 9:43 a.m., registered nurse (RN)-A indicated they do still have a bath list for the NA's and they are responsible for documenting when complete in the EMR. When questioned if R25 missed a shower/bath, RN-A indicated another RN is responsible for his care.

During interview on 5/25/22, at 9:47 a.m., RN-C indicated she just assumed responsibility for R25

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F 677	Continued From page 6	F 677		

about 2-3 weeks ago and has never actually spoken to him. She added she is not aware R25 didn't get a bath or shower for 2 weeks and was not aware of any redness or skin irritation from a call light not being answered timely.

During observation and interview 5/25/22, at 10:08 a.m., NA-D with assist of NA-C were providing incontinent cares after R25 had loose, yellow, liquid stool. Skin under scrotum was slightly reddened along with 2 spots on left upper buttock. NA-D indicated most of the red areas has shown improvement over the past three weeks and indicated R25's whole buttock area was previously red and irritated. NA-D further indicated R25 has redness and irritation that comes and goes. Barrier cream was applied along with new pad placed. R25 denied any discomfort with red areas.

Review of "Skin Inspection" for R25 included:
4/3/22: Skin is warm, dry and flaky. Vanicream (sensitive skin care product) applied. Scab to right outer shin, under treatment. No other skin issues noted.
4/10/22: No skin issues or open areas except ongoing swelling and redness in both legs.
4/17/22: Resident received shower this morning. Skin is warm and dry and flaky. Scab to right outer shin, no other concerns.
4/27/22: Groin area is very raw, including bottom of scrotum. Skin is dry and flaky. No new skin conditions noted.
5/1/22: Resident received shower this morning. Skin is warm and dry. Edema noted to bilateral lower extremities. Redness to groin.
5/7/22: Skin remains dry and flaky. Vanicream and barrier cream applied. Redness to right groin and thigh.

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F 677	Continued From page 7 5/14/22: Resident received shower this morning. Redness to groin. Review of call log response times for 10 p.m. thru 6 a.m. for past 4 weeks over an hour included: 4/23/22 10:08 p.m. 1 hour and 29 minutes 4/26/22 10:15 p.m. 1 hour 14 minutes 5/3/22 1:04 a.m. 1 hour 1 minute During interview on 5/25/22, at 1:08 p.m., R25 indicated he got a bath this morning. R25 stated management was in here and made sure I got a bath since I hadn't had one in over 2 weeks and it felt so good. During interview on 5/25/22, at 3:29 p.m., the director of nursing indicated she was not aware R25 had not been given a bath in over two weeks and did have them do one today. DON indicated she was not aware of a specific incident with R25 lying in stool due to untimely answering of call light, but did state he recently filed a grievance report and we noticed a trend with him and longer than normal response times. DON indicated now doing daily audits on call lights. Requested bath documentation for R25 and none was received. A "Grievance/Concern Form" dated 4/7/22, indicated R25 reported a concern of waiting to long for cal light to be answered, concern about getting shirt changed only once per week and not been shaved every day. The Activities of Daily Living (ADLs), Supporting, policy and procedure, was included along with staff list indicating, please sign by your name if you have read and understand the ADL Policy. Six CNA's signatures were present and 12 were blank.	F 677		

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F 677	Continued From page 8 Review of Care of "Activities of daily living (ADL), Supporting", dated 5/2018, indicated: -Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. -Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming and oral care), mobility, elimination (toileting), dining and communication.	F 677		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F 725		6/24/22

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F 725	Continued From page 9 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide sufficient staffing to ensure residents received care and assistance as needed. These deficient practices had the potential to affect all 49 residents who resided in the facility. Findings include: Refer to F677. The facility failed to ensure activities of daily living (ADLs) were provided including; nail care, bathing care, timely toileting for 1 of 3 residents (R25) reviewed who needed assistance from staff for activities of daily living. R25's quarterly minimum data set (MDS) assessment, dated 4/1/22, indicated intact cognition; required extensive assist of 2 with bed mobility, transfers, toileting; extensive assist of 1 with dressing and personal hygiene; total dependence with eating. R25 had lower extremity impairment on one side, used wheelchair for mobility. When interviewed, on 5/23/22 at 12:44 p.m., R25 indicated insufficient staffing, can wait anywhere from 15 minutes up to 3 hours for staff assistance; some nights only had 1 person on each wing.	F 725	Plan of Correction□Sufficient Nursing Staff Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility has completed nail care for R25, and insured that he received his care in accordance with his plan of care. R25's and other idenfied residents will be included in daily audits for two weeks to insure that his call llight is being answered timely and all cares are being deliverd How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has educated nursing staff call light response time.	

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F 725	Continued From page 10 R45's admission MDS assessment, dated 5/9/22, indicated intact cognition. R45 required limited assist of 1 with transfers, dressing, toileting, personal hygiene; supervision with ambulation. R45 had upper extremity impairment on one side, used walker for mobility. During an interview on 5/23/22 at 1:19 p.m., R45 indicated having to wait for staff assistance at least 30 minutes on a daily basis. R35's MDS prospective payment system (PPS) 5-day assessment, dated 4/23/22, indicated intact cognition; required extensive assist of 1 with transfers, dressing, toileting; limited assist of 1 with personal hygiene. R35 used walker and wheelchair for mobility. When interviewed, on 5/23/22 at 1:43 p.m., R35 indicated being short staffed; waited 45 minutes 2-3 times per week for staff assistance, one time had to wait one hour at 5:30 a.m. R10's quarterly MDS assessment, dated 2/23/22, indicated intact cognition; required limited assist of 1 with transfers, dressing, toileting, and personal hygiene. R10 had lower extremity impairment on one side, used a wheelchair for mobility. During an interview, on 5/23/22 at 1:46 p.m., R10 stated there was no adequate staffing, noticed more often having had only 1 aide for each wing, frequently waited an hour for staff assistance, bathing cares occasionally missed approximately every 3 weeks. R43's PPS 5-day MDS assessment, dated 5/5/22, indicated intact cognition; required extensive	F 725	The facility has created an audit tool to insure compliance with call light response time. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/24/2022	

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assist of 1 with transfers, dressing, toileting; and limited assist of 1 with personal hygiene. R43 had unilateral upper extremity and unilateral lower extremity impairment, used wheelchair and walker for mobility.

When interviewed, on 5/23/22 at 2:34 p.m., R43 indicated on overnight shift last week, had pressed call-light to use bathroom and waited for 4 hours for staff assistance; stated incident caused constipation.

R8's annual MDS assessment, dated 3/2/22, indicated intact cognition; required extensive assist of 1 with transfers, dressing, toileting; and set-up for personal hygiene. R8 was on oxygen therapy for pulmonary disease and used a wheelchair for mobility.

During an interview, on 5/23/22 at 3:34 p.m., R8 reported being inadequately staffed, had waited 90 minutes one time, common to wait for staff assistance more than 20 minutes. .

R31's quarterly MDS assessment, dated 4/15/22, indicated intact cognition; required supervision with transfers and ambulation, extensive assist of 1 with dressing and toileting, and limited assist of 1 with personal hygiene. R31 had bilateral upper extremity and unilateral lower extremity impairment, had unsteady gait with involuntary movements due to cerebral palsy; used wheelchair for mobility.

When interviewed, on 5/23/22 at 4:32 p.m., R31 reported facility was short staffed, especially in the morning hours; often had to wait longer than 20 minutes for staff assistance.

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F 725	Continued From page 12 Group Interview R3's quarterly MDS assessment, dated 2/18/22, indicated severe cognitive impairment; required supervision with toileting, independent of all other cares. Used a walker for mobility. R12's quarterly MDS assessment, dated 3/4/22, indicated intact cognition; required extensive assist of 2 with bed mobility, transfers, toileting; extensive assist of 1 for dressing, limited assistance with personal hygiene. Had impairment of bilateral lower extremities, did not ambulate, used wheelchair for mobility. R13's annual MDS assessment, dated 3/4/22, indicated intact cognition; required extensive assist of 1 with bed mobility, dressing, toileting, personal hygiene; extensive assist of 2 with transfers. Had impairment of unilateral upper extremity and unilateral lower extremity, used wheelchair for mobility. R15's quarterly MDS assessment, dated 3/11/22, indicated intact cognition; required extensive assist of 2 with bed mobility, transfers, toileting; extensive assist of 1 with dressing and personal hygiene. Had impairment to bilateral lower extremities, did not ambulate, used wheelchair for mobility. R19's significant change in status MDS assessment, dated 3/19/22, indicated intact cognition; required extensive assist of 2 with bed mobility, transfers; extensive assist of 1 with dressing, personal hygiene; total dependence of 2 with toileting. Had impairment of upper and lower extremities bilaterally, did not ambulate, used wheelchair for mobility.	F 725		

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A resident group interview was completed, on 5/24/22 at 1:09 p.m., with residents R3, R12, R13, R15, R19, and R25; stated concerns the facility was short staffed. The residents indicated on a consistent basis they wait 40 minutes and up to one hour for staff assistance. The residents further indicated staff hurry and rush with cares related to dressing, bathing, and toileting. The residents stated due to the shortage of staff, staff were not available to assist with resident needs and have missed baths.

During an interview on 5/24/22, at 3:31 p.m., R25 indicated he has gone 2 weeks without a shower or bath and added staff told him they didn't have enough staff on to complete it. R25 added approximately 3 weeks ago, he had a bowel movement (BM) in his pad and because there were only 2 staff on the night shift he waited three hours for someone to answer his call light. R25 indicated since he sat in his stool so long his skin got red and irritated so staff had to put a cream on which has helped.

When interviewed on 5/24/22, at 3:47 p.m., nursing assistant (NA)-C indicated they do not have a staff person that is just assigned to baths and the NA's working that day are required to give baths in addition to their other duties. NA-C indicated sometimes baths do get canceled if they can't complete them during their shift.

During an interview on 5/25/22, at 9:47 a.m., registered nurse (RN)-C indicated she just assumed responsibility for R25 about 2-3 weeks ago and has never actually spoken to him. She added she is not aware R25 didn't get a bath or shower for 2 weeks and was not aware of any

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redness or skin irritation from a call light not being answered timely.

Review of "Skin Inspection" for R25 included:
4/10/22: No skin issues or open areas except ongoing swelling and redness in both legs.
4/17/22: Resident received shower this morning. Skin is warm and dry and flaky. Scab to right outer shin, no other concerns.
4/27/22: Groin area is very raw, including bottom of scrotum. Skin is dry and flaky. No new skin conditions noted.
5/1/22: Resident received shower this morning. Skin is warm and dry. Edema noted to bilateral lower extremities. Redness to groin.
5/7/22: Skin remains dry and flaky. Vance and barrier cream applied. Redness to right groin and thigh.
5/14/22: Resident received shower this morning. Redness to groin.

When interviewed, on 5/25/22, at 12:36 p.m., LPN- A indicated the staffing schedule was consistently not filled and she could pick up a shift anytime she wanted. LPN-A indicated on a routine basis she stayed late to complete resident treatments. LPN-A further indicated twice a day treatments/cream would get missed because of staffing shortage and staff "hoped" the cream would get applied the next shift. LPN-A stated residents would self-transfer due to the extended wait time of staff answering the call light. LPN-A further stated residents received medications late and treatments delayed.

During an interview, on 5/25/22 at 12:45 p.m., NA-F indicated she has been at facility for 3 yrs, stated staffing was challenging at times. NA-F indicated the goal is to have 6-7 aides working on

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floor for all units on day/evening shift, typically had only 5-6. NA-F stated she occasionally will have to stay past scheduled shift time, usually to help answer call-lights, finish toileting someone, charting, or waiting for next staff member to arrive for shift. NA-F indicated recently incentive bonuses offered for staff to pick up open shifts or work last minute for call-ins, which has been nice. NA-F stated the busiest units was the 300-400 wing, residents required more NA cares and more frequently. NA-F indicated nursing staff will help NAs on floor if asked, stated nursing is busy too with their own tasks. NA-F stated they had an in-service meeting recently, discussed call-lights and long wait times, management team now sharing job of rounding on call-lights at various times throughout the day to assist in meeting resident care needs.

When interviewed, on 5/25/22 at 12:51 p.m., NA-A stated residents may not get a bath when there was a shortage of staff on that shift. NA-A further discussed residents who needed assistance with meals were delayed in eating due to the short staffing. NA-A stated three days last week she was required to work past her scheduled shift, because of the lack of nursing staff. NA-A further indicated call lights were not answered timely, and residents not toileted per the schedule due to the facility shortage of staff. NA-A stated she felt bad for the residents because of the facility's shortage of staff and resident's activities of daily living care were not consistently completed.

During an interview, on 5/25/22 at 12:54 p.m., NA-E indicated facility needed more staffing; most days felt pressed for time, would like management to assist more on the floor. NA-E

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indicated non-nursing staff helped out by answering call lights in an attempt to reduce long resident wait times, but it had created more problems in other ways. NA-E stated they felt frustrated as some non-nursing staff would respond to call-lights, clear lights, find NA, tell them to go to resident room after they finished doing what they were doing because they couldn't assist resident with some needs; staff would forget to go to that resident room, as busy/distracted with other resident cares, residents would be upset and waited very long time for staff assistance. NA-E indicated was able to get assignments done during shift, might stay late/pick up shift for staff call-in or running late, stated a lot of call-ins occur on evenings. NA-E stated was aware facility trying to hire new staff, had been difficult to keep staff because orientation training had been chaotic; training quick, non-efficient in preparing NAs to independently care for residents, especially if new staff had never had any NA experience before. NA-E indicated was aware of new staff recently hired had quit. NA-E stated no pool/agency staff used.

When interviewed, on 5/25/22 at 2:49 p.m., staffing coordinator (SC)-A indicated with facility census of 50, would like to have six NAs scheduled for day/evening shift, minimum needed was five; night shift, minimum need was three NAs. SC-A stated licensed nursing needed to have an RN in building at least eight hours per day, tried to consistently schedule two nurses and one TMA for day/evening shift, one nurse on overnights. SC-A indicated facility used a star system, staff aware if star was placed next to name, they may have to stay late or cover a shift for call-ins, short staffing for that day starred; staff

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were notified of star system upon hire. SC-A indicated was aware of short staffing, especially on overnights, long call light wait times, new employees hired quitting right away; had brought concerns to director of nursing (DON). SC-A stated they've tried to problem solve issues by rearranging nursing schedules to cover gaps in schedules, offer incentive bonuses, care managers on-call and scheduled to work if staffing issue for day, planning to improve new employee training. SC-A indicated administrator aware of staffing concerns, which was why a rounding book was implemented; all of management are scheduled to assist on floor, thirty minutes each day, to answer call-lights and assist nursing staff as needed.

During an interview, on 5/25/22, at 3:29 p.m., the director of nursing (DON) indicated had at least 5 NAs for day/evening shift and 3 NAs on overnights; for licensed nursing, had 2 staff for days/evenings and one on overnights; always had a licensed nurse on each shift 24 hours per day/7 days per week, RN in building 8 hours each day of week. DON indicated if short staffed for shift, used star system. DON confirmed awareness of resident long call-light wait times reported by staff/resident grievances, indicated expectation is for staff to answer call-light within 10 minutes, any staff member can assist with answering call-lights. DON confirmed management now completing daily audit on resident call-light wait times; management staff expected to assist on floor with call-lights 30-60 minutes each day scheduled. DON indicated unawareness of resident missing bathing cares or untimely toileting cares due to short staffing; stated was unaware R25 had not been given a bath in over two weeks, ensured it would be completed today,

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which was verified per surveyor. DON did confirm receiving a grievance report filed per R25 and admitted response to R25's call-light was longer than should have been.

Review of the alarm history report provided by the facility revealed numerous occasions residents waiting for staff assistance longer than 20 minutes. The following were examples of the long wait times, included, not limited to:

Room 202-A reviewed on 5/10/22-5/22/22, longest wait times were: 21 minutes, 25 minutes, 32 minutes, 34 minutes, 37 minutes, 58 minutes, and 1 hour 3 minutes.

Room 208-A, reviewed on 5/10/22-5/22/22, longest wait times were: 24 minutes, 28 minutes, 29 minutes, 47 minutes 48 minutes, and 57 minutes.

Room 212-A, reviewed on 5/10/22-5/22/22, longest wait times were: 1 hour 19 minutes, 1 hour 1 minute, 57, minutes, 47 minutes, 48 minutes, 46 minutes, 40 minutes, 39 minutes 37 minutes, 36 minutes, 29 minutes and 28 minutes, 24 minutes.

Room 407-A (R25), reviewed on 4/23/22-5/24/22, longest wait times were: 30 minutes, 31 minutes, 32 minutes, 33 minutes, 34 minutes, 39 minutes, 40 minutes, 41 minutes, 42 minutes, 45 minutes, 47 minutes, 36 minutes, 37 minutes, 38 minutes, 39 minutes, 53 minutes, 54 minutes, 55 minutes, 58 minutes, 61 minutes, 68 minutes, 74 minutes, 85 minutes, 83 minutes, 89 minutes, 85 minutes, and 99 minutes.

Room 412-A, reviewed on 5/10/22-5/24/22,

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longest wait times were 21 minutes, 22 minutes, 23 minutes, 24 minutes, 26 minutes, 30 minutes, 36 minutes, 37 minutes, 38 minutes, 41 minutes, 43 minutes, and 44 minutes.

Room 419-A was requested, but not received from facility

Room 425-A, reviewed on 5/10/22-5/24/22, longest wait times were 21 minutes, 22 minutes, 23 minutes, 24 minutes, 26 minutes, 28 minutes, 29 minutes, 34 minutes, 35 minutes, 38 minutes, 41 minutes, 43 minutes, 44 minutes, 49 minutes, 53 minutes, 64 minutes, and 81 minutes.

Facility's nurse staffing schedule was reviewed from 4/27/22-5/24/22, scheduled need listed one NA for transitional care unit (TCU) for day/evening/night shifts, two NA's for 300 wing on day/evening shift and one NA for night shift, two NA's for 400 wing on day/evening shift and one NA for night shift. Multiple days including; 4/25/22, 4/29/22, 5/3/22, 5/5/22, 5/6/22, 5/7/22, 5/8/22, 5/9/22, 5/10/22, 5/11/22, 5/12/22, 5/13/22, 5/14/22, 5/16/22, 5/18/22, 5/21/22; were noted on staffing schedule of NA's being short staffed; with having only one NA to cover part or all of shift on the 300 and 400 wings during evening shifts, and only one NA to cover both 300 and 400 wings during night shift. Licensed nursing staff observed to be at appropriate staffing needed for unit coverage on all shifts. Refer to staffing schedule for further review.

Resident Matrix printed 5/23/22, indicated 3 resident falls with injury and 9 residents with falls. In addition, there was one resident with excessive weight loss without prescribed weight loss program, one resident with infection w/catheter,

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F 725	Continued From page 20 and one resident w/UTI. Review of the Facility Assessment Tool, dated 1/18/22, provided by the facility indicated staffing plan was to ensure adequate amount of staff; the resident population, case mix index (CMI) and census are taken into account daily to determine sufficient staffing needs. The facility assessment revealed the average daily census ranged from 48-52 residents, CMI level was 1.07; indicated residents had clinically complex conditions per CMS guidelines. Bath documentation for R25 was requested from facility, was not received. A Grievance/Concern Form, dated 4/7/22, indicated R25 reported at a care conference concern of waiting to long for call light to be answered. Facility Policy, Staffing, revised 10/17, consisted of; -Policy Statement: our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment. -Policy interpretation and implementation: staffing numbers and the skill requirements of direct staff are determined by the needs of the residents based on each resident's care plan.	F 725		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental	F 758		6/24/22

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CENTER	**700 JAMES AVENUE MANKATO, MN 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
F 758	Continued From page 21	F 758		

processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

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F 758	Continued From page 22 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a gradual dose reduction (GDR) was attempted or an adequate medical justification for the use of psychoactive medications for 1 of 5 residents (R6) who was reviewed for unnecessary medications. Findings include: R6 was admitted on 3/26/21. R6's diagnosis (identified on the diagnosis sheet in the medical record) dated 3/26/21, included; insomnia, obstructive sleep apnea and major depressive disorder. R6's quarterly Minimum Data Set (MDS) assessment dated 2/5/22, identified R6 as having a brief interview for mental status (BIMS) score of "15" (no cognition impairment). The assessment indicated R6 received 7 days of antidepressants. R6 exhibited mood behaviors of feeling tired 12-14 days and feeling depressed 7-11 days during the assessment period. Review of a Psychoactive Medication Review assessment dated 2/25/22, indicated R6 has a diagnosis of major depressive disorder and insomnia. R6 has orders for bupropion (antidepressant), venlafaxine (antidepressant), Trazadone (antidepressant) and escitalopram (antidepressant). R6 has has no documented mood or behaviors.	F 758	Plan of Correction□Free from Unnec Psychotropic meds/PRN use Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility has completed an additional psychotropic review with no changes in medication from her provider. The facility has audited other like residents to insure they are in compliance. The facility has followed up with R6's provider for a GDR with no new orders The facility has educated RN-A on appropriate follow up with providers. The facility has educated staff on monthly reviews of psychotorpic medication How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur:	

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F 758	Continued From page 23 Review of the current physicians orders dated 5/25/22, included Trazodone 200 mg daily, escitalopram oxalate 5 mg daily, venlafaxine 150 mg daily and bupropion 450 mg daily. R6 was admitted with these orders on 3/26/21. Review of the progress notes from 11/1/21 to 5/25/22, did not include documentation of mood or behaviors for R6. R6's care plan dated 11/26/21, identified R6 as having an alteration in mood and behavior, related to adjustment to the facility and having a diagnosis of major depressive disorder, insomnia and failure to thrive. Interventions included; be alert to mood and behavior changes, monitor and document mood and behaviors upon occurrence, monitor sleep patterns and administer medications per provider order. Observation and interview on 5/24/22, at 2:55 p.m. R6 indicated she was unsure what medications she had been receiving. R6 stated she did not realize she was taking an antidepressant. R6 also stated she did not realize she was taking a medication for sleep. R6 indicated she becomes tired a lot, because she has sleep apnea. R6 indicated she has been feeling well and does not feel depressed. During interview R6 was very pleasant and talkative. R6 smiled a lot during the conversation and her outlook was positive during this time. Review of current physician progress note visit dated 5/12/22, did not address R6"s psychoactive medications or mood or behaviors, nor did the previous physician visits since admission. The visits did not included a justification for continued	F 758	The facility has created an audit tool to insure compliance with psychotropic medications. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/24/2022	

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F 758	Continued From page 24	F 758		

use that benefits outweighed the risk for continued use.

R6's Consulting Pharmacist's Medication Review dated 11/17/21, 12/17/22 1/19/22, 2/17/22, 3/17/22 and 4/17/22, indicated R6's psychoactive medications were reviewed. The review notes indicated R6 has not had a trial reduction since admission on 3/26/21. Each review, recommendations were made for the provider to assess whether R6 could tolerate a trial reduction and if a reduction is contraindicated, please provide a rationale. These recommendations were provided and reviewed by the physician each month for the past 6 months, with no response from the provider. The recommended medications listed for review were Trazodone 200 mg daily, escitalopram oxalate 5 mg daily, venlafaxine 150 mg daily and bupropion 450 mg daily.

Interview on 5/24/22, at 3:00 p.m. nurse manager (NM)-A indicated she had been aware R6 had not had a dose reduction in her psychoactive medications, since admission. RN-A indicated each month she has faxed the provider the pharmacists recommendations, but has not received a response. RN-A stated she was going to make a phone call next time, instead of sending a fax. RN-A verified R6's provider had not given a contraindication for a GDR.

Interview on 5/25/22, at 3:35 p.m. the director of nursing (DON) indicated she would expect if the provider does not response to the pharmacist recommendation, facility staff should call the provider instead of continuing to fax the provider.

Review of the facility policy Medication Monitoring

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F 758	Continued From page 25 and Management dated 4/18, indicated in order to optimize the therapeutic benefits of medication therapy and minimize or prevent potential adverse consequences, the facility staff, the attending physician, and the consulting pharmacist perform ongoing monitoring for appropriate, effective, and safe medication use. When selecting medications and non-pharmacological interventions, members of the interdisplinary team participate in the care process to identify, assess, address, advocate for, monitor and communicate the residents needs and changes in condition. The medication regimen is re-evaluated to determine whether prolonged or indefinite use of a medication is indicated and if the same medication is given from the same class (duplicate therapy) the clinical rationale and benefits are documented in the residents record. During the first year in which a resident is admitted on a psychoactive medication, the facility attempts a GDR during at least 2 separate quarters unless clinically contraindicated. After the first year, annually.	F 758		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 804	Plan of Correction—Nutritive	6/24/22

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F 804	Continued From page 26 review, the facility failed to ensure food was prepared, maintained and served at warm, palatable temperatures for 7 of 8 residents (R8, R16, R26, R31, R36, R40, R42) who were observed to be served and/or complained about inappropriate food temperature and food taste. Findings include: During interview and observation during the supper meal service on 5/23/22, at 5:14 p.m., R29 was seated in the dining room and when questioned how her food was stated she ate part of it but quit eating as she wasn't going to risk breaking her teeth. R29 added "the potatoes are hard and the chicken will break my teeth if I try to eat more." During interview on 5/23/22, at 5:15 p.m., R16 indicated her chicken was over cooked and her potatoes were hard. R16 added "I can't eat this." During interview on 5/23/22, at 5:15 p.m., R202 stated her chicken was harder than a rock, picked it up and tossed it back down on plate stating "I'm not eating it." R36's admission Minimum Data Set (MDS), dated 4/25/22, identified R36 had intact cognition, demonstrated no rejection of care(s) behaviors, and was independent with eating once the meal is placed before the resident. On 5/23/22, at 5:32 p.m. the supper meal service was observed and R36 was observed seated a wheelchair in his room and his evening meal was on a tray on R36's bed. On the tray, a paper meal slip dated 5/23/22, indicated evening meal 2 gm (gram) Sodium -Reg (regular) the following items	F 804	Value/Appear, Palatable/Preferred Temp Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The facility has re educated culinary staff on following recipes and insuring that all food served is at the appropriate temperature and palatable. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has created an audit tool to ensure that food is palatable and served at appropriate temperatures. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor för compliance. Completion date: 6/24/2022	

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F 804	Continued From page 27	F 804		

were circled on the paper: entrée baked chicken breast, oven browned potatoes, shredded lettuce/dressing, mandarin oranges, milk, lemonade, coffee, Splenda, creamer, Jell-O. R36 indicated being served chicken strips and not a chicken breast, no dressing, no creamer, and no jello. R36 indicated "They [staff] don't even read." R36 further took the cover off the plate of food, and no visible steam was observed. R36 indicated the chicken strips were cold, and the browned potatoes were not edible due to the poor taste. The chicken strips were thin and had dark brown spots that represented burnt/overcooked food . R36 stated the quality and taste of the food was progressively getting worse.

On 5/24/22, at 9:58 a.m. during an interview with DM-A and the cook, they stated residents menu choices were expected to be served to them and were expected to be served warm, tasteful, and appear appetizing. The DM-A stated she felt there needed to be better communication between the dietary staff and residents, so residents receive the menu options they selected and preferred. DM-A stated she expected the food to be served attractive, palatable, and if not the cook should not serve the food and dietary staff were expected to communicate to the residents and offer alternative menu items. DM-A indicated she was attempting to correct several issues with the meal service, kitchen preparation, and ordering items, and acknowledged the food service had "run out of things" before; however, DM-A voiced with the kitchen staff turnover education was needed and the kitchen staff were in the process of receiving more education and educate the cooks on palatable food.

The policy titled Food and Nutrition Services

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F 804	Continued From page 28 dated 10/17, indicated Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the properties for each resident. Policy interpretation and implementation: 1. The multidisciplinary staff, including nursing staff, attending physician in the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits as well as a physical, functional, and psychosocial factors that affect eating and nutritional and taking utilization 4. Reasonable efforts will be made to accommodate resident choices and preferences 7. food and nutrition services staff will inspect food trays to ensure that the correct meals provided to each resident, the food appears palatable and attractive, and is served at a safe and appetizing temperature. a. If an incorrect meal provided to a resident, or a meal does not appear palatable, nursing staff will report to the food service manager so that a new tray can be issued.	F 804		
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced	F 806		6/24/22

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F 806	Continued From page 29	F 806		

by:
Based on observation, interview, and document review, the facility failed to ensure individual food preferences/choices were honored for 1 of 1 resident (R36) reviewed for food preferences.

Findings include:

R36's admission Minimum Data Set (MDS), dated 4/25/22, identified R36 had intact cognition, demonstrated no rejection of care(s) behaviors, and was independent with eating once the meal is placed before the resident.

On 5/23/22, at 5:32 p.m. the supper meal service was observed and R36 was observed seated a wheelchair in his room and his evening meal was on a tray on R36's bed. On the tray, a paper meal slip dated 5/23/22, indicated evening meal 2 gm (gram) Sodium -Reg (regular) the following items were circled on the paper: entrée baked chicken breast, oven browned potatoes, shredded lettuce/dressing, mandarin oranges, milk, lemonade, coffee, Splenda, creamer, Jell-O. R36 voiced frustration with being served chicken strips and not a chicken breast, no dressing, no creamer, and no jello. R36 indicated "They [staff] don't even read." R36 indicated last weekend, he did not receive creamer as requested, and for breakfast today he did not get his banana, and R36 further indicated daily the food items he wanted and/or requested were not received on his meal tray. R36 stated the quality and taste of the food was progressively getting worse.

On 5/24/22, at 9:58 a.m. during an interview with DM-A and the cook, they stated residents menu choices were expected to be served to them. The cook verified R36 had ordered the chicken breast

PPlan of Correction□Nutritive Value/Appear, Palatable/Preferred Temp
Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements.
How corrective action will be taken for those affected by the alleged deficient practice:
The facility has re educated culinary staff on following recipes and insuring that all food served is at the appropriate temperature and palatable, and appropriate alternatives are available for residents
How will the facility identify other residents having the potential to be affected by the same deficient practice?
All residents of the facility have the potential to be affected by the same alleged deficient practice.
The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Thei dietary manager reassessed R36's food preferences with no further concerns

The facility has created an audit tool to ensure that food is palatable and served at appropriate temperatures.
Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent:
Administrator or Designee will conduct

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F 806	Continued From page 30 and chicken strips were served, and the cook stated dressing was not given to the resident because he did not write what kind of dressing he wanted. The DM-A stated she felt there needed to be better communication between the dietary staff and residents, so residents receive the menu options they selected and preferred. DM-A indicated she was attempting to correct several issues with the meal service, kitchen preparation, and ordering items, and acknowledged the food service had "run out of things" before; however, DM-A indicated with the kitchen staff turnover education was needed and the kitchen staff were in the process of receiving more education. The policy titled Food and Nutrition Services dated 10/17, indicated Each resident is provided with a nourishing, palatable, well-balanced diet that meets his or her nutritional and special dietary needs, taking into consideration the properties for each resident. Policy interpretation and implementation: 1. The multidisciplinary staff, including nursing staff, attending physician in the dietitian will assess each resident's nutritional needs, food likes, dislikes and eating habits as well as a physical, functional, and psychosocial factors that affect eating and nutritional and taking utilization 4. Reasonable efforts will be made to accommodate resident choices and preferences 7. food and nutrition services staff will inspect food trays to ensure that the correct meals provided to each resident, the food appears palatable and attractive, and is served at a safe and appetizing temperature. a. If an incorrect meal provided to a resident, or a meal does not appear palatable, nursing staff will report to the food service manager so that a	F 806	daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/24/2022	

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F 806	Continued From page 31 new tray can be issued.	F 806		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the kitchen ceiling tiles and kitchen ceiling vents were kept in a clean and sanitary manner and free of dust and debris. This had the potential to affect all 49 residents residing in the facility. In addition, the facility failed to maintain 2 of 49 resident rooms in a clean and sanitary condition which had potential to affect 2 of 2 residents (R36 and R37) in these rooms. Findings include: During an observation and interview on 5/23/22, at 11:34 a.m. with the dietary manger (DM)-A and DM-B the ceiling tiles and ceiling vents observed in the kitchen were covered with thick dark fuzzy material. The vents were in operation. When asked who was responsible for cleaning the kitchen vents and ceiling tiles, the DM-A stated she was not sure. DM-A and DM-B confirmed the ceiling vents and tiles were unclean and was not acceptable. DM-A stated kitchen staff cleaned the kitchen, when staff had time as they were short staffed. DM-A and DM-B admitted dietary staff should clean the ceiling tiles and ceiling vents, during routine cleaning and when visibly dirty.	F 921	Plan of Correction□Safe/Functional/Sanitary/Comfortable conditions. Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: R36□ and r37s room was cleaned to his satisfaction. The kitchen vents were also cleaned and added to a monthly cleaning schedule. The facility has educated housekeeping staff on proper procedures for cleaning rooms. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not	6/24/22

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F 921	Continued From page 32 On 5/23/22, at 12:05 p.m. the administrator went into the kitchen and looked at the kitchen ceiling vents and ceiling tiles and stated the cleanliness of the vent was not acceptable and expected the vents and tiles clean. When asked the risks of unclean kitchen vents and tiles, the administrators stated unclean vents were an environmental concern with staff preparing food under the unclean vents and tiles. On 5/24/22, at 11:35 a.m. the maintenance director (MD)-A indicated he was not sure who was responsible for the kitchen tile and vent cleaning, and further indicated maintenance had not cleaned them in the last year. MD-A confirmed the kitchen ceiling tiles and vents were dirty and needed to be cleaned. During an interview on 5/24/22, at 12:03 p.m., DM-A provided kitchen cleaning schedule sheets and indicated the kitchen vents and ceiling tiles were not on the cleaning schedule sheets. DM-A admitted she was ultimately responsible for making sure staff completed the cleaning and was aware it was not always being done. DM-A admitted that the lack of proper cleaning in the kitchen could impact the health of residents. During an interview and observation on 5/23/22, at 12:54 p.m. R36 indicated his room was cleaned once a week by housekeeping, and R36 stated the last weekend his garbage was not emptied. R36 further indicated if he wanted his bathroom or room cleaned more than weekly, he had to ask staff. R36 room was observed and towels were on the floor next entrance door, and R36 stated the towel had been on the floor since the weekend. On 5/24/22, at 9:43 a.m. R36s room was observed and the towels from the	F 921	occur: The facility has created an audit tool to ensure cleanliness in resident rooms and in the kitchen. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/24/2022	

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 _____	C 05/25/2022

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F 921	Continued From page 33	F 921		

previous day remained on the floor, and R36 confirmed it was the same towels from the previous day.

During an interview and observation on 5/23/22, at 1:58 p.m., R37 room was observed and a garbage can adjacent to R37's bed was overflowing with variety of food items and included: take out pizza boxes, pop cans, chicken wing bones, crackers, on the residents carpeted floor white crumbs were scattered throughout the floor, whole and half saltine crackers, cupcake wrapper. R37 indicated I don't understand the staff, when staff come in my room they see the condition and fail to take out my garbage or clean up the floor. When asked, R37 stated his room was cleaned once a week on Tuesdays, and his garbage was only emptied weekly.

On 5/24/22, at 10:24 a.m. R37's room was observed and a transparent garbage bag was full of various trash items and was observed adjacent to R37's bed. R37 indicated he had removed the garbage bag himself from the garbage can as it was full, and trash items were spilling onto his floor. R37's room remained with the same observations from the previous day and additional 2 takeout pizza boxes were observed on the floor. R37 further indicated staff come in and out of his room throughout the day and did not offer to empty his garbage or clean his floors.

On 5/24/22, at 10:30 a.m. registered nurse (RN)-B was observed in R37's room and was observed to empty R37's bedside urinal in the bathroom, and RN-B verified the garbage was full and the floor was dirty and RN-B failed to remove the garbage from the room.

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F 921	Continued From page 34	F 921		

On 5/24/22, at 10:40 a.m. with the director of nursing (DON) and RN-C, together observed the above environmental concerns in R37's room. The DON and RN-C confirmed the garbage was expected to be emptied daily or sooner if full by any facility staff and the floor was expected to be vacuumed if visibly dirty. The DON and RN-C indicated they would have housekeeping thoroughly clean R37's room and follow up with housekeeping. The DON and RN-C stated what they observed was not acceptable, and admitted it was not providing residents a sanitary and home-like environment. RN-C further indicated nursing staff were expected to remove laundry/linen from the floor of resident's rooms daily.

During an interview on 5/24/22, at 11:43 a.m., housekeeping supervisor (HS)-A stated he expected resident's garbage's emptied daily, deep clean of resident's rooms weekly, vacuuming if visibly dirty, and stated all rooms were to be checked every day. HS-A stated he was the housekeeper on duty on 5/23/22, and he cleaned and emptied all garbage's on 5/23/22, except R37's, as he knew R37 did not want men in his room. HS-A further indicated he failed to delegate the task to someone else.

A facility policy for cleaning kitchen ceiling vents and tiles was requested but not provided.

Facility policy titled Cleaning and Disinfecting Residents' rooms, dated August 2013, indicated
1. Housekeeping surfaces will be cleaned on a regular basis, when spells occur, and when surfaces are visibly soiled
2. environmental services will be disinfected or cleaned on a regular basis and when surfaces

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F 921	Continued From page 35 are visibly soiled	F 921		

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	245516	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/25/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual life safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/25/2022. At the time of this survey, Laurels Peak Care and Rehabilitation Center 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.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/24/2022

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.

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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 is separated from an assisted living facility by a 2-hour firewall, with opening protectives consisting of a labeled, self-closing, positive latching, 90-minute fire door assembly. This 1-story with partial basement facility was constructed in 1962, with building Additions in 1992 and 1998. The lowest construction is of Type V (111). The original building and the 2 Additions are fully sprinklered.	K 000		

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K 000	Continued From page 2 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 Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 65 beds and had a census of 47 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		6/24/22

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K 353	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5 and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 05/25/2022 between 10.30 AM to 12:30 PM, observation revealed hoses engaging the sprinkler system in the lower laundry room, above the washing machines. The hoses were zip-tied to sprinkler system piping. An interview with the Maintenance Director verified this finding at the time of discovery.	K 353	Plan of Correction Sprinkler system Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: The cable ties were removed and the water line was successfully relocated. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: The facility has created an audit tool to ensure nothing is attached to sprinkler lines. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/24/2022	
K 712 SS=C	Fire Drills	K 712		6/24/22

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K 712	Continued From page 4 CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6. These deficient findings could have a widespraead impact on the residents within the facility. Findings include: 1. On 05/25/2022 between 10:30 AM to 12:30 PM, during a review of the available fire drill reports, it was revealed that there was no second quarter, third shift fire drill conducted. 2. On 05/25/2022 between 10:30 AM to 12:30 PM, during a review of the available fire drill reports, it was revealed that there were no third quarter, second shift fire drill conducted. An interview with the Maintenance Director verified this finding at the time of discovery.	K 712	Plan of Correction Fire Drills Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: Staff has been re-educated regarding preforming fire drills prior to inspection, and the facility is currently in compliance. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents of the facility have the potential to be affected by the same alleged deficient practice. The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not	

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K 712	Continued From page 5	K 712	occur: The facility has added all fire drills into the TELS system and microsoft outlook calendars in order to insure no future ones are missed. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator or Designee will conduct daily audits for 2 weeks as needed to monitor för compliance. Completion date: 6/24/2022	