DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OGDG

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00035

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245516**

2. STATE VENDOR OR MEDICAID NO. (L2) **896340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAURELS PEAK REHABILITATION CENTER**
(L4) **700 JAMES AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: 7

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/30/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **65** (L18)

13. Total Certified Beds **65** (L17)

10. THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 65 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Kathryn Serie, Unit Supervisor — 04/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 06/19/2015 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21.
1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 06/19/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **04/28/2015** (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 245516

June 19, 2015

Ms. Erin Aanenson, Administrator
Laurels Peak Rehabilitation Center
700 James Avenue
Mankato, Minnesota 56001

Dear Ms. Aanenson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective April 21, 2015 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered
April 30, 2015

Ms. Erin Aanenson, Administrator
Laurels Peak Rehabilitation Center
700 James Avenue
Mankato, Minnesota 56001

RE: Project Number S5516023

Dear Ms. Aanenson:

On March 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 12, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 30, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 28, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 12, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 21, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 12, 2015, effective April 21, 2015 and therefore remedies outlined in our letter to you dated March 27, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245516 | A. Building<br>B. Wing | 4/30/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>MANKATO, MN 56001 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix **F0253**<br>Reg. # **483.15(h)(2)**<br>LSC | **04/21/2015** | ID Prefix **F0276**<br>Reg. # **483.20(c)**<br>LSC | **04/21/2015** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | **04/21/2015** |
| ID Prefix **F0312**<br>Reg. # **483.25(a)(3)**<br>LSC | **04/21/2015** | ID Prefix **F0315**<br>Reg. # **483.25(d)**<br>LSC | **04/21/2015** | ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | **04/21/2015** |
| ID Prefix **F0428**<br>Reg. # **483.60(c)**<br>LSC | **04/21/2015** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | **04/21/2015** | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | KS/kfd | 04/30/2015 | 03048 | 04/30/2015 |
| CMS RO | | | | |

**Followup to Survey Completed on:** 3/12/2015

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** YES NO

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245516 | A. Building 01 - MAIN BUILDING 01<br>B. Wing | 4/28/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>MANKATO, MN 56001 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0050 | 04/02/2015 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0144 | 04/21/2015 | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
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| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | PS/kfd | 04/30/2015 | 35482 | 04/28/2015 |
| CMS RO | | | | |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 3/10/2015 | | | |

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

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit |
|---|---|---|
| 245516 | 02 - 2008 NEW WING | 4/28/2015 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>MANKATO, MN 56001 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

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|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0050 | 04/02/2015 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0144 | 04/21/2015 | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
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| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | KS/kfd | 04/30/2015 | 03048 | 04/28/2015 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO |
|---|---|
| 3/10/2015 | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OGDG
Facility ID: 00035

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245516**

2. STATE VENDOR OR MEDICAID NO. (L2) **896340100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAURELS PEAK REHABILITATION CENTER**
(L4) **700 JAMES AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/12/2015** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 65 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 04/25/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/28/2015 (L20)

## PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **02/01/1988** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7010 1670 0000 8044 4455

March 27, 2015

Ms. Erin Aanenson, Administrator
Laurels Peak Rehabilitation Center
700 James Avenue
Mankato, Minnesota 56001

RE: Project Number S5516023

Dear Ms. Aanenson:

On March 12, 2015, a standard 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

**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.**

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> <u>Opportunity to Correct</u> **- the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> <u>Plan of Correction</u> **- when a plan of correction will be due and the information to be contained in that document;**
>
> <u>Remedies</u> **- the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not**

**attained at the time of a revisit;**

**Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

**Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.**

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

**DEPARTMENT CONTACT**

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233
Fax: (507) 537-7194

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 21, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 21, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

**PLAN OF CORRECTION (PoC)**

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Include signature of provider and date.

If an acceptable PoC 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:

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

• Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

**VERIFICATION OF SUBSTANTIAL 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

**Original deficiencies not corrected**

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

**Original deficiencies not corrected and new deficiencies found during the revisit**

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

**Original deficiencies corrected but new deficiencies found during the revisit**

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

**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 June 12, 2015 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 12, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

**INFORMAL DISPUTE RESOLUTION**

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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245516 | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED 03/12/2015 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS PEAK 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 |
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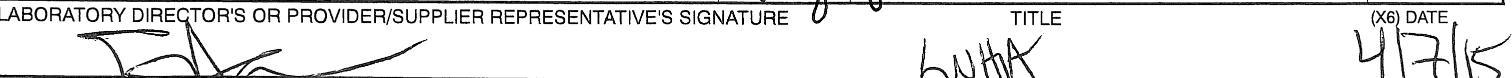
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 253 SS=E | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide housekeeping services in a manner that maintained a orderly, sanitary and odor free environment this practice affected 11 of 59 residents (R73, R45, R5, R52, R20, R28, R40, R24, R88, R70 and R1) who reside in the facility.<br><br>Findings include:<br><br>During the initial tour and throughout the survey from 3/9/15 through 3/12/15, the facility had multiple rooms and common areas in the facility that were noted to have strong urine/body odor. The facility was also noted to have multiple resident wheelchairs that were soiled with food | F 253 | F253<br>• Facility will develop and establish clear cleaning patterns including documentation of units cleaned. Wheelchairs will be washed on a routine basis as needed.<br>• Administrator and Maintenance Director to have a mechanical engineer evaluate air exchange system.<br>• R73, R45, R5, R52, R20, R28, R40, R24, R88, R70 and R1 rooms have all deep cleaned.<br><br>Resident R73's carpet has Been professional cleaned.<br><br>approved Kmt 4/10/15<br>1pm Erin Aarenson, admin indicated audits reported @ qtly CQI mtg. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE LNHA | (X6) DATE 4/7/15



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 253 | Continued From page 1<br>debris.<br><br>Throughout the survey the following sanitary environmental concerns were identified:<br>During observation of cares on 3/9/15, at 1:50 p.m. R73 had multiple cracks noted on the bilateral arm supports located on the wheelchair. The padding was exposed, making it difficult to clean the surface. A strong urine odor was present in R73's room at the time of observation.<br><br>During observation of cares on 3/9/15, at 5:15 p.m. R45's room was noted to have a strong urine odor.<br><br>During observation of cares on 3/9/15, at 5:20 p.m. R5's room was noted to have a strong urine odor. R5 was also noted to have a urinal hanging from his handrail in the bathroom that had residual urine in its base. The source of the odor could not be determined as it was present in the room and bathroom of R5.<br><br>During the initial tour on 3/9/15, at 6:32 p.m. R52's bed was noted to be without covering and the mattress was observed to be soiled and stained. The mattress had stained dark areas on it and had debris on it also.<br><br>During observations on 3/09/15, at 7:23 p.m. R20's wheel chair was noted to be heavily soiled on the seat, seat cushion, frame and wheels. During interview with R20 at the time of the observation R20 stated her chair had not been cleaned. R20's room was also noted to be cluttered with items stacked her bed, floor and nightstand by her bed. On 3/10/15, at 10:17 a.m. R20 was observed in her wheelchair going to a meeting. R20's chair continued to be heavily | F 253 | • Resident R73 will be issued a new wheelchair.<br><br>• Resident R45 discharged from facility on 3/15/2015.<br><br>• Resident R5 is independent. With use of urinal, staff will check and empty resident's urinal upon rising, before and after meals, and H.S., and prn.<br><br>• R52 will be issued a new mattress.<br>• R20 wheelchair has been cleaned and resident moved to larger room to reduce clutter. Social Worker assisted resident in organizing her room. | |



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| F 253 | Continued From page 2<br>soiled with spills and food residue.<br><br>During observations on 3/10/15, at 8:30 a.m. R28 complained her toilet did not flush and that she had been having issues with it for the last couple of days. The toilet water tank on the toilet was observed to be cracked on the top left side and there was also noted a large chip out of the porcelain on the toilet base. R28 stated she had reported the concern, but there had been no follow up to the concern.<br><br>On 3/10/15, at 9:00 a.m. R40 was observed to have a heavily soiled wheelchair, wheelchair cushion and frame. R40's room was also noted to have a strong urine odor.<br><br>On 3/10/15, at 9:01 a.m. R 24 was noted to be seated in a wheelchair that was heavily soiled with food and debris. The wheelchair cushion, seat and frame was also soiled.<br><br>During observation of cares on 3/10/15, at 9:17 a.m. R88's room was noted to have stained carpeting. R88's room and bathroom had strong urine odors. R88's bathroom floor was also noted to have debris on it.<br><br>During observation of cares on 3/10/15, at 10:56 a.m. R 70's room was noted to have strong urine odors upon entrance into the room.<br><br>During observation of cares on 3/10/15, at 10:57 a.m. R1 was noted to have a heavily soiled wheelchair, wheelchair cushion, and floor mat. The floor mat was used beside the bed when R1 was in bed to reduce injury risk with falls. The floor mat had a 2 foot by 1 foot area of a white substance on it that looked like a nutritional | F 253 | • R28 is not an accurate reporter, was residing in different room at time of survey due to resident continuous flushing paper towels and other items down toilet, which results in overflow, and damaged original room.<br>• Toilet seat cover replaced in room 205B.<br>• Resident R40 wheelchair has been cleaned and added to routine cleaning list.<br>• Resident R24 wheelchair has been cleaned and added to routine cleaning list.<br>• Resident R88 carpets have been professional cleaned by outside source.<br>• Resident R88 care planned to have assistance with ADL care, but often times refused to allow staff to assist her. Will continue to work with resident in regards to ADL assistance and hygiene.<br>• Resident R1 wheelchair has been cleaned and added to routine cleaning list. Current floor mat cleaned, however, new floor mat has been ordered for resident. | |



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| F 253 | Continued From page 3<br>supplement or milk product had been spilled on it and dried. The soiled mat remained in R1's room throughout the survey and was observed during the facility tour with the administrator and housekeeping/maintenance staff on 3/11/15, at 1:00 p.m.<br><br>On 3/11/15, at 1:00 p.m. an environmental tour of the facility was conducted with the administrator, maintenance director (interim), housekeeping director, and occupational health staff. During the tour the areas of concern were addressed with the staff conducting the tour.<br><br>During interview with the administrator during the tour it was stated that some of the residents were messy and did not maintain good hygiene. The administrator attributed that to some of the concerns of odors.<br><br>During interview with the housekeeping director, during the facility tour, on 3/11/15, it was stated the housekeeping staff cleaned each room daily and would clean some rooms more frequently. The housekeeping manager stated she was unsure why the odors existed. Further when interviewed about the resident wheelchair cleaning the housekeeping director stated each week staff would wash wheelchairs for 1 of 4 wings. The director stated there was not a schedule of which chairs were cleaned which day and there was no evidence to support if the chairs had been cleaned. The director verified the wheelchair concerns and fall mat concern.<br><br>The facility submitted a quarterly round sheet identifying rooms were checked on a quarterly basis. The sheet did not have documentation to when last the check was conducted. During | F 253 | • Education will be provided to employees on the importance of wheelchair cleanliness. Wheel chair washing schedule will be created and maintained by the Environmental Services Director. This process in complete compliance by April 21th 2015. Continuous CQI Audits to be completed. — reported to CQI mtg quarterly. | |



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| F 253 | Continued From page 4<br>interview with the administrator on 3/11/15, at 1:30 p.m. it was stated the facility had been without a maintenance director related to a change in staffing and the corporate maintenance director was trying to cover for the facility. She acknowledged there had been some lapses in maintenance. | F 253 | | |
| F 276 SS=D | 483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS<br><br>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure a decline in urinary continence was comprehensively assessed so that interventions could be implemented to maintain as much urinary continence as possible for 1 of resident (R88) in the sample reviewed for urinary incontinence.<br><br>Findings include:<br><br>R88, who was admitted on 10/9/14, had an initial comprehensive assessment (Minimum Data Set-MDS) dated 10/15/14, which identified that R88 had a trial toileting program on admission with a result of R88 being completely dry (continent).<br><br>Further review of the medical record identified a Bowel and Bladder Screening (3-day void) was completed on 10/10/14, 10/11/14 and 10/12/14, | F 276 | F276<br>• A Proper 3 day bowel and bladder will be completed when a change in continence is noted.<br>• Staff will be educated at the nursing, NAR, and April All Staff meeting. Staff to notify NM of any changes in continence noted.<br>• Nurse Manager will initiate 3 day bowel and bladder if change noted in continence on MDS from previous assessment.<br>• Nurse Manager will complete comprehensive reassessment and make appropriate changes to care plan as needed. | |



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| F 276 | Continued From page 5<br>and identified R88 as being independent in toileting. The screening did not identify if R88 was continent or incontinent. A Bladder Evaluation For Incontinent Resident was completed for R88 on 12/15/14. The Summary and Plan Placement Decision for the evaluation indicated, "Resident is currently continent of bladder at this time" and the record lacked evidence that any further assessment had been conducted to prevent and/or address the decline in urinary incontinence.<br><br>During a review of a quarterly MDS assessment dated 1/15/15, it identified R88 was occasionally incontinent of bladder with no toileting program.<br><br>Interview with the director of nursing on 3/11/15, at 12:03 p.m. confirmed R88 had not been assessed after her urinary incontinence had been identified and R88 should have had an assessment done when the incontinence was noted on the 1/15/15, MDS. | F 276 | • Resident R88 to have bowel and bladder completed. Staff continues to work with resident in order to manage her incontinence and hygiene due to resident refusing staff assistance.<br>• This process will be in complete compliance by April 21th 2015. Random audits will be conducted by the Administrator and DON to assure timely completion of the assessments. - reported to CQI @ qtrly mtgs. | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to follow the plan of care related to personal hygiene for 1 of 3 residents (R33) reviewed for activities of daily living (ADL's). | F 282 | | |



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| F 282 | Continued From page 6 | F 282 | | |

Findings include:

On 3/10/15, at 11:36 a.m. R33 was observed seated in her wheelchair (w/c) in room attempting to file the fingernails on her right hand. The fingernails on both hands were observed to be long and jagged. R33 was holding a fingernail file in her left hand using her thumb and forefinger; the 3rd, 4th and 5th digits of the left hand were curled in towards her palm. The resident's right hand was also observed to have the 3rd, 4th, and 5th digits curled in towards the palm; the resident was struggling to manipulate the nail file with minimal success at filing her fingernails. R33 was asked by the surveyor if she could open the fingers on her hands. The resident was able to move the thumb, forefinger, and pinkie finger on each hand while the 3rd and 4th digits stayed curled in with fingertips pushing into her palm. R33 confirmed not being able to voluntarily open the 3rd and 4th digits of each hand.

On 3/12/15, at 1:45 p.m. R33 was observed lying on her right side in bed with the fingers on both hands curled in; the fingernails on both hands continued to be long and jagged. R33 allowed surveyor to open her fingers enough to visualize the palms of both hands. R33's left hand had indentations in the palm from the 3rd and 4th fingertips pushing into the hand; there was also a crusty substance observed along the top crease of the inside of the right hand that was amber colored. R33's right hand also had indentations from the 3rd and 4th fingers pushing into the palm. The right hand also had a crusty amber colored substance in the top crease of the inside of the hand; more so than the left hand. There was also an odor present. R33 stated, "Ow"

F282

- Staff will complete personal hygiene according to care plan and care sheets. Nursing assistants will turn in care sheets to nurses to review at end of shift.
- Education will be provided to the NAR's on the importance of personal hygiene.
- Routine audits to be completed on charting for 3 months, which will be completed by DON and Administrator.
- Resident R33 fingernails have been trimmed; will have hand hygiene done in am, before and after meals, and at bedtime. This was added to care plan and care sheets.
- On-going CQI audits will be completed. – reported @ quarterly CQI mtg
- This process in complete compliance by April 21st 2015



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| F 282 | Continued From page 7<br>when surveyor opened the fingers enough to visualize the inside of the hand.<br><br>Review of the quarterly Minimum Data Set (MDS) dated 1/26/15 indicated R33 had functional limitation in range of motion to the upper and lower extremities bilaterally. The MDS further indicated R33 was totally dependent with transfer and locomotion on/off the unit and required extensive assistance with bed mobility, toilet use, dressing and personal hygiene.<br><br>The care plan with last revision noted 3/10/15, included a focus of ADL self care deficit. The interventions included: "BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse."<br><br>Review of the Bath/Shower Skin Audit form dated 3/2/15 indicated R33's fingernails were not trimmed. The prior Bath/Shower Skin Audit forms dated 2/16/15 and 1/26/15 each indicated fingernail trimming was "Not necessary.<br><br>When interviewed on 3/12/15, at 2:10 p.m. the director of nursing (DON) indicated R33's fingernails should be trimmed by staff as needed and hands should be cleaned with cares and prn (as needed). During subsequent observation surveyor and DON observed R33 lying in bed in her room. DON confirmed the residents fingernails were long and in need of trimming. DON attempted to visualize the palms of R33's hands but stopped opening her fingers when the resident stated, "Ow." DON did not attempt to open R33's fingers further due to the resident's discomfort. DON placed her finger between the fingers and palm of R33's left hand and stated she really didn't feel anything. Surveyor prompted | F 282 | | |



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| F 282 | Continued From page 8<br>the DON to do the same with R33's right hand. DON placed her finger between the fingers and palm of R33's right hand and verified feeling the debris in the resident's hand. R33 was interviewed at that time and confirmed her fingernails were too long stating, "I don't like it."<br><br>When interviewed on 3/12/15 (following the above observation), at approximately 2:15 p.m. the DON confirmed the plan of care had not been followed related to nail care and hand cleanliness for R33. The DON further indicated that with R33's discomfort with opening her hands due to the contracture's perhaps nursing should be responsible for hand cleanliness. | F 282 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and documents review the facility failed to provide personal hygiene care to 1 of 3 residents (R33) reviewed for activities of daily living (ADL's) who had soiled hands and long fingernails.<br><br>Findings include:<br><br>On 3/10/15, at 11:36 a.m. R33 was observed seated in her wheelchair (w/c) in room attempting to file the fingernails on her right hand. The | F 312 | F312<br>• Resident R33 will have hands cleaned upon rising, before and after meals and HS. This will be added to the care plan and staff care sheets. Effective April 2nd 2015.<br>• Resident R33 will have nail care perform on bath day.<br>• Education will be provided to NAR's will be provided education on the importance of hand hygiene.<br>• Continuous CQI audits to be conducted with complete compliance by April 21th 2015 – will be reported @ 3rd Qtr CQI mtg. | |



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| F 312 | Continued From page 9 | F 312 | | |

fingernails on both hands were observed to be long and jagged. R33 was holding a fingernail file in her left hand using her thumb and forefinger; the 3rd, 4th and 5th digits of the left hand were curled in towards her palm. The resident's right hand was also observed to have the 3rd, 4th, and 5th digits curled in towards the palm; the resident was struggling to manipulate the nail file with minimal success at filing her fingernails. R33 was asked by the surveyor if she could open the fingers on her hands. The resident was able to move the thumb, forefinger, and pinkie finger on each hand while the 3rd and 4th digits stayed curled in with fingertips pushing into her palm. R33 confirmed not being able to voluntarily open the 3rd and 4th digits of each hand.

On 3/12/15, at 1:45 p.m. R33 was observed lying on her right side in bed with the fingers on both hands curled in; the fingernails on both hands continued to be long and jagged. R33 allowed surveyor to open her fingers enough to visualize the palms of both hands. R33's left hand had indentations in the palm from the 3rd and 4th fingertips pushing into the hand; there was also a crusty substance observed along the top crease of the inside of the right hand that was amber colored. R33's right hand also had indentations from the 3rd and 4th fingers pushing into the palm. The right hand also had a crusty amber colored substance in the top crease of the inside of the hand; more so than the left hand. There was also an odor present. R33 stated, "Ow" when surveyor opened the fingers enough to visualize the inside of the hand.

Review of the quarterly Minimum Data Set (MDS) dated 1/26/15, indicated R33 had functional limitation in range of motion to the upper and



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| F 312 | Continued From page 10<br>lower extremities bilaterally. The MDS further indicated R33 was totally dependent with transfer and locomotion on/off the unit and required extensive assistance with bed mobility, toilet use, dressing and personal hygiene.<br><br>The care plan with last revision noted 3/10/15, included a focus of ADL self care deficit. The interventions included: "BATHING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse."<br><br>Review of the Bath/Shower Skin Audit form dated 3/2/15, indicated R33's fingernails were not trimmed. The prior Bath/Shower Skin Audit forms dated 1/16/15 and 2/26/15, each indicated fingernail trimming was "Not necessary."<br><br>When interviewed on 3/12/15, at 2:10 p.m. the director of nursing (DON) indicated R33's fingernails should be trimmed by staff as needed and hands should be cleaned with cares and prn (as needed). During subsequent observation surveyor and DON observed R33 lying in bed in her room. DON confirmed the residents fingernails were long and in need of trimming. DON attempted to visualize the palms of R33's hands but stopped opening her fingers when the resident stated, "Ow." DON did not attempt to open R33's fingers further due to the resident's discomfort. DON placed her finger between the fingers and palm of R33's left hand and stated she really didn't feel anything. Surveyor prompted the DON to do the same with R33's right hand. DON placed her finger between the fingers and palm of R33's right hand and verified feeling the debris in the resident's hand. R33 was interviewed at that time and confirmed her fingernails were too long stating, "I don't like it." | F 312 | | |



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| F 312 | Continued From page 11<br><br>When interviewed on 3/12/15 (following the above observation), at approximately 2:15 p.m. the DON confirmed the plan of care had not been followed related to nail care and hand cleanliness for R33. The DON further indicated that with R33's discomfort with opening her hands due to the contracture's perhaps nursing should be responsible for hand cleanliness. | F 312 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide the necessary care and services for 1 of 1 resident (R88) in the sample who had a decrease in continence of urinary function.<br><br>Findings include:<br><br>During observation and interview of R88 on 3/10/15, at 9:15 a.m. a very strong urine odor was noted in the resident's room. R88 stated she did not like that she cannot control her urine, it | F 315 | | |



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| F 315 | Continued From page 12<br>comes at all times and it makes her very uncomfortable. Further observations on 3/11/15, at 7:30 a.m. noted no urine odor was noted while R88 was walking to breakfast. At 7:50 a.m. a check of R88's room was done and a very strong urine odor was noted. At 10:50 a.m. R88 was noted to be walking down the hall with staff. A very strong urine odor was detected.<br><br>R88 was admitted on 10/9/14, per the Admission Record. Review of the R88's care plan dated 10/22/14, identified diagnosis including dementia, anxiety and hypertension.<br><br>R88 had an initial comprehensive assessment (Minimum Data Set-MDS) dated 10/15/14, which identified R88 had a trial toileting program on admission with a result of R88 being completely dry (continent).<br><br>Further review of the medical record identified a Bowel and Bladder Screening (3-day void) was completed on 10/10/14, 10/11/14 and 10/12/14, and identified R88 as being independent in toileting. The screening did not identify if R88 was continent or incontinent. A Bladder Evaluation For Incontinent Resident was completed for R88 on 12/15/14. The Summary and Plan Placement Decision for the evaluation indicated, "Resident is currently continent of bladder at this time" and the record lacked evidence that any further assessment had been conducted to prevent and/or address the decline in urinary incontinence.<br><br>Review of the Resident Care Sheet undated, for R88 identified staff to toilet her every two hours, use a pull up style incontinent product, check for and dispose of soiled incontinent products. | F 315 | F315<br>• Staff will provide proper assistance according to care plan and care sheets for resident R88.<br>• Staff will be educated at NAR Meeting scheduled for 3/25/2015 in regards to resident R88's toileting plan.<br>• Resident R88 to be reviewed by nurse practitioner in regards to increase incontinence.<br>• Resident R88 to have bowel and bladder completed. Staff continues to work with resident in order to manage her incontinence and hygiene due to resident refusing staff assistance.<br>• Staff will turn in care sheets to Nurse at end of the shift for review and document resident refusal of assistance and/or cares.<br>• Continuous CQI audits to be completed. This process in complete compliance by April 21th 2015.<br>Audits ongoing + reported @ qtly CQI mtg. | |



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| F 315 | Continued From page 13<br><br>During a review of a quarterly MDS assessment dated 1/15/15, it identified R88 was occasionally incontinent of bladder with no toileting program.<br><br>Interview with the director of nursing on 3/11/15, at 12:03 p.m. confirmed R88 had not been assessed after her urinary incontinence had been identified and R88 should have been assessed for incontinence and interventions put into place.<br><br>On 3/11/15, at 12:20 p.m. registered nurse (RN)-C was interviewed and she stated R88 was incontinent and that was why staff helped her to the toilet every two hours, she cannot manage it herself.<br><br>Licensed practical nurse (LPN)-A was interviewed on 3/11/15, at 12:20 p.m. she stated resident was incontinent and cannot manage it herself. LPN-A stated R88 was incontinent at times and was resistant to staff assistance. LPN-A further stated at times R88 would have wet her bed and attempted to cover it up by pulling up the covers over the soiled bedding.<br><br>Nursing assistants (NA)-E and F were interviewed on 3/12/15, at 10:40 a.m. they stated they go in every so often and remind R88 to toilet. They also stated if R88 was incontinent they assist her to change if she will allow it. They also identified that some mornings R88's bed was wet from incontinence. | F 315 | | |
| F 329<br>SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any | F 329 | | |



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| F 329 | Continued From page 14<br>drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to assure an antidepressant medication used for insomnia was monitored and reassessed for 2 of 5 residents (R73, R28) who were reviewed for unnecessary medications.<br><br>Findings include:<br><br>Review of R73's medical record did not include monitoring of the resident's sleep patterns with the use of Trazodone (an antidepressant medication sometimes used for insomnia). | F 329 | F329<br><br>• Nurse Manager to complete a Sleep assessment on any resident that is taking Hypnotic and/or medication to assist with sleep | |



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| F 329 | Continued From page 15<br>Review of the facility care plan initiated 2/7/14, identified diagnosis including dementia without behavioral disturbances, Alzheimer's disease, anxiety state and insomnia.<br><br>Review of the Physician's Order sheet dated 2/23/15, identified R73 as receiving Trazodone 50 mg (milligrams) at bedtime related to insomnia. Further review of the medical record did not include documentation of monitoring of sleep patterns with the use of Trazodone for insomnia.<br><br>During an interview with the director of nursing (DON) on 3/12/15, at 11:00 a.m. she verified sleep patterns had not been monitored for the use of the Trazodone. She stated the facility did generally not monitor sleep patterns unless a resident received a hypnotic medication.<br><br>R28 was admitted to the facility on 3/30/14, as documented in the most recent minimal data set (MDS) dated 1/6/15. Diagnoses at the time of admission included but were not limited to: Dementia with behavioral disturbances; hypothyroidism; hyperlipidemia; unspecified psychosis; and hallucinations<br><br>Review of the Physician Order Summary Report dated 2/23/15, indicated R28 was currently receiving the following medications: Synthroid 75 micrograms (mcg) daily for hypothyroidism which had been initiated 6/23/14, Trazodone HCL 25 mg daily at bedtime for insomnia and may repeat 1 time (X 1) before midnight PRN, initiated 12/22/14.<br><br>Review of R28's medical record revealed there had been no monitoring of the resident's sleep, | F 329 | • DON to Audit all residents and new admissions to ensure that assessment is completed and facility is compliant quarterly.<br>• Nurse Managers to add TAR for weekly charting on sleep patterns for those residents that are taking a sleep agent.<br>• Sleep patterns will be monitored for R73 and R28<br>• Sleep assessment will be completed for resident R73 and R28<br>• DON to develop an ongoing spreadsheet to track Discus in order to ensure compliance.<br>• Education will be provided to the nurses and Nurse Managers regarding this process.<br>• Annual labs to be ordered for resident R28. Residents will continue to have labs ordered per physician recommendations and/or annually during resident birthday month.<br>• This process in complete compliance by April 21th 2015 | |



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| F 329 | Continued From page 16<br>nor monitoring of laboratory values for the use of the Synthroid.<br><br>During interview on 3/11/15, at 1:44 p.m. registered nurse (RN)-B confirmed there had been no laboratory tests completed for R28 since admission to the facility.<br><br>During a subsequent interview with RN-B on 3/12/15, at 10:40 a.m. RN-B confirmed R28's sleep patterns had not been monitored for the use of the Trazadone. RN-B further indicated it was not the facility's practice to monitor sleep patterns. RN-B further stated she had contacted R28's primary physician's office and there had been no laboratory testing for R28 since 2012.<br><br>Interview with the DON on 3/12/15, at 11:00 a.m. confirmed the above information. | F 329 | | |
| F 428 SS=D | 483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the consultant pharmacist failed to identify | F 428 | | |



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| F 428 | Continued From page 17<br>irregularities in medication regimens for 2 of 5 residents (R28, R73) reviewed for unnecessary medications.<br><br>Findings include:<br><br>R28 was admitted to the facility on 3/30/14, as documented in the most recent Minimum Data Set (MDS) dated 1/6/15. Diagnoses at the time of admission included but were not limited to: dementia with behavioral disturbances; hypothyroidism; hyperlipidemia; unspecified psychosis; and hallucinations<br><br>Review of the Physician Order Summary Report dated 2/23/15, indicated R28 was currently receiving the following medications: Synthroid 75 micrograms (mcg) daily for hypothyroidism which had been initiated 6/23/14, Trazodone HCL (an antidepressant medication sometimes used for insomnia) 25 Milligrams (mg) daily at bedtime for insomnia and may repeat 1 time (X 1) before midnight PRN, initiated 12/22/14.<br><br>Review of monthly pharmacy consultant reports dated 9/29/14; 10/29/14; 11/22/14; 12/19/14; 1/17/15; and 2/24/15, did not identify the need for laboratory monitoring for the use of the synthroid nor documentation of sleep patterns/behaviors related to the use of Trazadone ordered for insomnia.<br><br>Review of R28's medical record revealed there had been no monitoring of the resident's sleep.<br><br>During interview on 3/11/15, at 1:44 p.m. registered nurse (RN)-B confirmed there had been no laboratory tests completed for R28 since admission to the facility. | F 428 | F428<br><br>• DON will meet with consulting pharmacist upon entry and review of charts in regards to recommendations and/or concerns.<br>• DON to forward recommendations made by pharmacists to nurse managers to follow through on recommendations with primary physician.<br><br>• Resident R73 Discus has been completed and medication has been discontinued d/t nonuse.<br>• Additional nurses have been trained on Discus.<br>• Resident R28 labs have been ordered for resident<br>• Sleep patterns will be monitored for R73 and R28<br>• This process in complete compliance by April 21th 2015 | |



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| F 428 | Continued From page 18<br><br>During a subsequent interview with RN-B on 3/12/15, at 10:40 a.m. RN-B confirmed R28's sleep patterns had not been monitored for the use of the Trazadone. RN-B further indicated it was not the facility's practice to monitor sleep patterns.<br><br>Interview with the director of nursing (DON) on 3/12/15, at 11:00 a.m. confirmed the above information.<br><br>The pharmacy consultant was not available for interview for R28 during the survey period, and four separate attempts to contact the consultant pharmacist via telephone were not successful.<br><br>Review of R73's medical record did not include monitoring of the resident's sleep patterns with the use of Trazadone. The consultant pharmacist did not identify that irregularity in monthly pharmacy reviews.<br><br>Review of the facility care plan initiated 2/7/14, identified diagnosis including dementia without behavioral disturbances, Alzheimer's Disease, anxiety state and insomnia.<br><br>Review of the Physican's Order Summary Sheet dated 2/23/15, identified R73 as receiving Trazodone 50 mg at bedtime related to insomnia.<br><br>Further review of the medical record did not include documentation of monitoring of sleep patterns with the use of Trazodone for insomnia. Review of the consutltant pharmacist reports From September 2014 to February 2015 no recommendation for monitoring sleep patterns with the use of Trazodone were made. | F 428 | | |



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| F 428 | Continued From page 19<br><br>During interview with the DON on 3/12/15, at 11:00 a.m. she verified sleep patterns had not been monitored for the use of the Trazadone. She stated that the facility did generally not monitor sleep patterns unless a resident receives a hypnotic medication.<br><br>Interview with the consultant pharmacist on 3/12/15, at 12:20 p.m. he verified that he had not identified the lack of monitoring sleep for R73's Trazodone use. | F 428 | | |
| F 465 SS=D | 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation interview and document review the facility failed to maintain a comfortable and sanitary environment for residents, staff and the public which had to potential to affect all residents, public and staff that entered the facility.<br><br>Findings include:<br><br>Throughout the survey from 3/9/15 to 3/12/15, there was a strong urine odor noted at the junction of the 200 and 300 hallways. The urine odor was significant and was able to be detected throughout the facility. Further, the public bathroom outside the facility conference door and across the hall, was noted to have a strong urine | F 465 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING ______<br>B. WING ______ | 03/12/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>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 465 | Continued From page 20<br>odor. The odor could be detected outside of the bathroom door. The odors remained even after housekeeping had performed daily cleaning.<br><br>During interview with the administrator, maintenance staff, and occupational health staff on 3/11/15, at 1:00 p.m. during the environmental tour staff stated they had not noted the urine odor. The odor was evident to all five surveyors on the survey and was a topic of discussion each day. | F 465 | F465<br>• Room turn checklist established for Nursing, Maintenance, and Housekeeping departments to ensure rooms are properly prepared for new admissions and or readmissions.<br>• Environmental Services Director will establish cleaning routines for housekeeping staff in which will be turned in at end of each shift in order to maintain clean and odor free environment.<br>• Environmental Service Director will speak with vendor in regards cleaning product currently being used and questioning if better alternative available<br>• Administrator and Maintenance Director to have a mechanical engineer evaluate air exchange system.<br>• Odors to be addressed in public restrooms.<br>• Continuous CQI audits to be conducted with complete compliance by April 21th 2015<br>reported @ gtly CQI mtg | |



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F5516024



| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **03/10/2015** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAURELS PEAK REHABILITATION CENTER** | **700 JAMES AVENUE**<br>**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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 10, 2015. At the time of this survey, Building 01 of Laurel's Peak Rehabilitation Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101-5145, or | K 000 | POC ok 4-25-15<br><br>Life Safety Code<br><br>Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift. The Staff at Laurels Peak will be aware of the drills and this will be documented properly. OHL Director will be responsible for conducting fire drills. CQI audits to be completed. Expected compliance is April 2[1st] 2015.<br><br>Generator will be inspected weekly and exercised under load for 30 minutes per month by the Maintenance Director of Laurels Peak and this will be documented properly. Expected compliance is April 21[st]2015. | |

EXIT: 3-10-15 DC: 4-21-15

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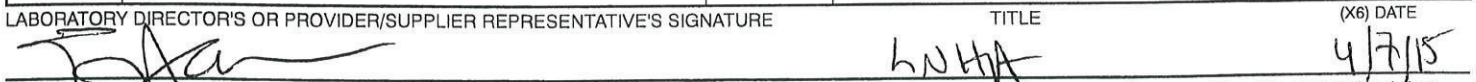

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: LNHA | (X6) DATE: 4/7/15

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING | 03/10/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAURELS PEAK REHABILITATION CENTER** | **700 JAMES AVENUE**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br>By eMail to:<br>Marian.Whitney@state.mn.us,<br>Angela Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Building 01 of Laurel's Peak Rehabilitation Center was constructed as follows:<br>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;<br>The 1992 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction;<br>The 1998 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction.<br><br>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.<br><br>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 a | K 000 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING ______ | **03/10/2015** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAURELS PEAK REHABILITATION CENTER** | **700 JAMES AVENUE**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>capacity of 65 beds and had a census of 58 at time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on review of records and interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 58 residents.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 12:00 PM on 3/10/2015, a review of the available fire drill reports in 2014 and 2015 revealed that the facility had only conducted two months of fire drills not in accordance with Section 19.7.1.2. | K 050 | | |



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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/27/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 03/10/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>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 |
|---|---|---|---|---|
| K 050 | Continued From page 3<br>This deficient practice was confirmed by the Maintenance Supervisor. | K 050 | | |
| K 144<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and interview, the facility failed to provide documentation of the required inspections of the emergency generator in accordance with NFPA 99 and NFPA 110. This deficient practice could affect all 58 residents, staff and visitors in the event of a loss of power and generator failure.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 12:00 PM on 3/10/2015, it was revealed during documentation review and an interview with the Maintenance Supervisor that the facility in the past year had not documented the required weekly and monthly test information in accordance with NFPA 110 (99). | K 144 | | |



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Marshall

Printed: 03/16/2015
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OMB NO. 0938-0391

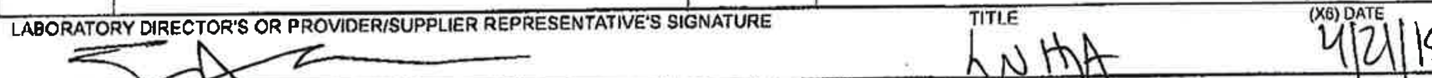
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F 5516024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING 02 - 2008 NEW WING<br>B. WING ______ | 03/10/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>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.<br><br>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.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on March 10, 2015. At the time of this survey, Building 02 of Laurel's Peak Rehabilitation Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota Street, Suite 145<br>St. Paul, MN 55101-5145, or<br><br>By eMail to: | K 000 | POC ok 4-28-15<br><br>Fire drills will be held at unexpected times under varying conditions at least quarterly on each shift. The Staff at Laurels Peak will be aware of the drills and this will be documented properly. OHL Director will be responsible for conducting fire drills. CQI audits to be completed. Expected compliance is April 21st 2015.<br><br>Generator will be inspected weekly and exercised under load for 30 minutes per month by the Maintenance Director of Laurels Peak and this will be documented properly. Expected compliance is April 21st 2015.<br><br>RECEIVED<br>APR 21 2015<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
|  | LNHA | 4/21/15 |

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING 02 - 2008 NEW WING<br>B. WING ______ | 03/10/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>MANKATO, MN 56001 |

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>Marian.Whitney@state.mn.us, and<br>Angela Kappenman@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Building 02 of Laurel's Peak Rehabilitation Center consists of two (2) building additions to the original nursing home, and were constructed as follows:<br>The 2008 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction;<br>The 2010 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction.<br><br>The nursing home is separated from an assisted living facility by a 2-hour fire-rated wall assembly, with opening protectives appropriate to the rating.<br><br>Building 02 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. All resident rooms have automatic, hard-wired smoke detectors which are interconnected with the nurse call system, with visual notification in the corridors. The facility has a capacity of 65 beds and had a census of 58 at | K 000 | | |

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245516 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - 2008 NEW WING B. WING | (X3) DATE SURVEY COMPLETED 03/10/2015 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: LAURELS PEAK REHABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE: 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 |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>time of the survey. | K 000 | | |
| K 050<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2<br><br>This Standard is not met as evidenced by:<br>Based on review of records and interview, it was determined that the facility failed to conduct the required number of fire drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1,2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 58 residents.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 12:00 PM on 3/10/2015, a review of the available fire drill reports in 2014 and 2015 revealed that the facility had only conducted two months of fire drills not in accordance with Section 19.7.1.2.<br><br>This deficient practice was confirmed by the Maintenance Supervisor. | K 050 | | |
| K 144<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in | K 144 | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245516 | A. BUILDING 02 - 2008 NEW WING<br>B. WING ______ | 03/10/2015 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAURELS PEAK REHABILITATION CENTER | 700 JAMES AVENUE<br>MANKATO, MN 56001 |

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|---|---|---|---|---|
| K 144 | Continued From page 3<br>accordance with NFPA 99. 3.4.4.1.<br><br>This Standard is not met as evidenced by:<br>Based on documentation review and interview, the facility failed to provide documentation of the required inspections of the emergency generator in accordance with NFPA 99 and NFPA 110. This deficient practice could affect all 58 residents, staff and visitors in the event of a loss of power and generator failure.<br><br>Findings include:<br><br>On facility tour between 9:30 AM and 12:00 PM on 3/10/2015, it was revealed during documentation review and an interview with the Maintenance Supervisor that the facility in the past year had not documented the required weekly and monthly test information in accordance with NFPA 110 (99). | K 144 | | |