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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y9SR

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) **508613200**

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

4. TYPE OF ACTION: **7** (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) **07/01/2015**

6. DATE OF SURVEY **6/6/2016** (L34)

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

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	

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

B.IIINotIinICmplianceIwithIProgram Requirements and/or Applied Waivers:

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

* 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): **YES** (L15)

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 6/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/20/216 (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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245516

June 20, 2016

Ms. Erin Aanenson, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 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 May 31, 2016 the above facility is certified for:

65 Skilled Nursing Facility/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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 20, 2016

Ms. Erin Aanenson, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: Project Number S5516024v

Dear Ms. Aanenson:

On May 6, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 21, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 10, 2016 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 April 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 21, 2016, effective May 31, 2016 and therefore remedies outlined in our letter to you dated May 6, 2016, 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
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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245516 Y1	A. Building B. Wing Y2	6/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CENTER	700 JAMES AVENUE 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0159	Correction	ID Prefix F0160	Correction	ID Prefix F0278	Correction
Reg. # 483.10(c)(2)-(5)	Completed	Reg. # 483.10(c)(6)	Completed	Reg. # 483.20(g) - (j)	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	05/31/2016
ID Prefix F0279	Correction	ID Prefix F0314	Correction	ID Prefix F0323	Correction
Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	05/31/2016
ID Prefix F0412	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.55(b)	Completed	Reg. # 483.65	Completed	Reg. #	Completed
LSC	05/31/2016	LSC	05/31/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	06/20/2016	03048	6/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245516 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	6/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CENTER	700 JAMES AVENUE 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	05/31/2016	LSC K0021	05/31/2016	LSC K0029	05/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	05/31/2016	LSC K0046	05/31/2016	LSC K0050	05/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	05/31/2016	LSC K0144	05/31/2016	LSC K0147	05/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL /kfd	6/20/2016	35482	6/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/19/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245516 Y1	A. Building 02 - 2008 NEW WING B. Wing Y2	6/10/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CENTER	700 JAMES AVENUE 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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0011	05/31/2016	LSC	K0046	05/31/2016	LSC	K0050	05/31/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Completed
LSC	K0052	05/31/2016	LSC	K0144	05/31/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL /kfd	6/20/2016	35482	6/10/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
4/19/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y9SR

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) **508613200**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAURELS PEAK CARE & 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) **07/01/2015**

6. DATE OF SURVEY **04/21/2016** (L34)

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

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**	

FISCAL YEAR ENDING DATE: (L35) **09/30**

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:

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

* Code: **B*** (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): **YES** (L15)

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

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 05/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/27/2016 (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. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 6, 2016

Ms. Erin Aanenson, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

RE: Project Number S5516024

Dear Ms. Aanenson:

On April 21, 2016, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - 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
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: 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 May 31, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- 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 ePoC 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 ePoC 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 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, 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 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.

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 July 21, 2016 (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 October 21, 2016 (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 an ePoC 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

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 _____	04/21/2016

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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an 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 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate	F 159		5/31/16

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

Electronically Signed | 05/16/2016

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 159	Continued From page 1 accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure residents' personal funds in excess of $50.00 were maintained in an interest bearing account for 23 of 47 residents (R4, R57, R24, R28, R51, R71, R49, R56, R8, R15, R9, R95, R41, R43, R14, R10, R3, R31, R68, R23, R69, R53, and R18) whose personal funds were managed by the facility. Findings include: On 4/21/16, at 1:25 p.m. R57's personal funds account transaction history was reviewed. No	F 159	The 23 residents that were affected during the survey and all residents since then that have money greater than $50 have been placed in an interest bearing account. Administrator conducted an audit through the corporate office and documentation to prove that current and future residents will have interest bearing accounts. Administrator to verify solutions are sustained with corporate office quarterly.	

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F 159	Continued From page 2 interest had been deposited into R57's account and it was noted the balance on the account dated 12/31/15 was $54.00, 1/31/16-$81.00, 2/29/16-$87.00 and 4/21/16- $87.00. When interviewed on 4/21/16, at 1:25 p.m. the human resource director (HRD) stated that as of 1/1/16, the facility no longer had interest bearing accounts for resident personal fund accounts. These resident accounts had signed permission forms, allowing the facility to manage their fund. During review of resident personal fund accounts on 4/21/16, the following balances were identified on the document: R4=$1,654.87; R57= $87.00; R24- $69.75; R28= $3,475.73; R51=$2,305.53; R71= $261.55; R49= $113.17; R56=$74.29; R8= $203.07; R15= $252.73; R9= $99.36; R95= $243.85; R41= $123.47; R43= $115.66; R14= $50.00; R10= $5,844.96; R3= $114.70; R31= $142.00; R68= $90.97; R23= $1,381.81; R69= $300.00; R53= $725.57 and R18= $377.94. Although residents had personal fund managed by the facility and the balances ranged from $50.00 to $5,844.96, none of the identified residents had been receiving interest on their individual accounts.	F 159		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.	F 160		5/31/16

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F 160	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to convey a final accounting of personal funds within 30 days of death for 2 of 2 residents (R122, R123) reviewed who had personal funds deposited with the facility. Findings include: R122 expired on 10/6/15 and at the time her personal fund account balance with the facility was $276.00. Review of R122's transaction statement indicated the funds were given to the R122's family on 2/25/16 (142 days later). R123 expired on 11/6/15. At the time of death, R123 had an account balance of $54.10 in the personal fund account deposited with the facility. Review of R123's trust transaction statement indicated the remaining funds in the account were conveyed to the individual responsible for R123's estate on 2/18/16 (104 days later). During interview on 4/21/16, at 8:43 a.m. the human resource director (HRD) stated she was responsible for overseeing the resident's personal funds accounts. HRD stated once a death affidavit was received, she would receive an email from the corporate office with approval to convey the remaining personal funds to the appropriate entity. Facility policy Resident Trust Account, dated 11/06, reads; "Upon the death of a resident, the center will release the personal trust account funds to an individual or county human services.	F 160	Affected residents were issued their personal funds. Upon death, all residents will receive their personal funds within 30 days moving forward. Since our survey, we will conduct an audit to ensure all residents that have expired received their money within 30 days. Policy will be updated to reflect this change. Administrator will conduct audits through corporate office and will report to QA.	

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F 160	Continued From page 4 This is determined by information received by county human services."	F 160		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code the	F 278	Affected R65 MDS was modified on 4/2/16 to reflect correct urinary status.	5/31/16

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F 278	Continued From page 5 resident status on Minimum Data Set (MDS) assessments for 5 of 21 residents (R65, R102, R4, R30, R24) reviewed related to urinary incontinence, weight loss and depression. Findings include: R65 Review of the order summary report from 11/1/15 to 11/30/15 identified that R65 was admitted to the facility 11/18/15. R65 was readmitted to the hospital on 11/20/15 and returned to the facility 11/25/15. During record review the admission Minimum Data Set (MDS) assessment dated 12/1/15, identified R65 as being continent of bladder. The quarterly MDS dated 3/2/16, identified R65 as being occasionally incontinent of bladder. Review of the facility bowel and bladder screening (3-day void) from 11/26/15 to 11/28/15, identified R65 as being incontinent 3 times. However, the bladder evaluation for incontinence dated 12/1/15, identified R65 as being continent (0) of bladder. During interview with nurse manager (NM)-A at 10:38 a.m. on 4/21/16, she verified the admission MDS was coded incorrectly. She stated she had not reviewed the 3-day bowel and bladder screening and R65 was occasionally incontinent of bladder. R102 R102 was admitted to the facility on 12/31/15, following hospitalization for a right hip fracture per the 1/6/16 admission Minimum Data Set (MDS) assessment. The MDS further indicated an admission weight (wt) of 219 pounds (lbs) with no known wt loss. R102 was discharged to the hospital with return	F 278	Affected R4 MDS will be modified to accurately reflect use of antipsychotic medication. Affected R102 was discharged from facility on 3/11/16. Affected Resident□s R4, R30, R24 will ensure PHQ-9 is up to date. All residents will have PHQ-9□s completed with each MDS and as needed going forward. Staff responsible for coding this section will be re-educated on accurate coding and what to do if an ARD is missed. Audits will be conducted by DON or designee at random weekly until next QA meeting. Audits will be continued at discretion of DON.	

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F 278	Continued From page 6	F 278		

anticipated on 1/8/16 and returned to the facility on 1/11/16. The 14-day MDS dated 1/17/16 included a wt of 198 lbs (which is 21 lbs less than at admission or a 9.6% loss). The MDS indicated- no known wt loss. The 30-day MDS dated 2/10/16 included a wt of 191 lbs (which is 28 lbs less than at the time of admission or a 12.79% loss). The MDS again indicated- no known wt loss.

The Nutrition Risk Evaluation dated 1/11/16, indicated an admission wt of 219.2 lbs and a current wt of 219.2 lbs. Review of R102's record revealed a wt of 206 lbs on 1/11/16 upon readmission to the facility (which is 13 lbs less than previous admission wt on 12/31/15 or a 5.9% loss). The evaluation further indicated: "Resident is at low nutritional risk. Appetite and intakes below baseline, though improving. No wt loss reported."

When interviewed on 2/21/16, at 12:26 p.m. the certified dietary manager (CDM) confirmed R102 had a significant wt loss which should have been reflected on the 1/17/16, 14-day MDS and the 2/10/16, 30-day MDS.

R4
R4 was re-admitted to the facility on 3/18/15, with diagnoses including schizophrenia, depression, anxiety, and paranoid personality disorder per the facility Diagnosis Report.

The quarterly MDS dated 2/2/16, indicated, "not assessed" related the PHQ-9 (an assessment for mood/depression) resident interview and staff assessment for mood. The MDS further indicated the resident had received an antipsychotic and antidepressant medication 7

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F 278	Continued From page 7 out of 7 days during the look back period. When interviewed on 4/20/16, at 7:03 p.m. the licensed social worker (LSW)-A confirmed R4's 2/2/16, quarterly MDS did not include completion of the PHQ-9 resident interview nor documentation of the mood assessment by staff. The MDS assessment had not been accurately coded. R30 R30 was re-admitted to the facility 2/19/16, with diagnoses including depression and anxiety per the facility Diagnosis Report. The admission MDS dated 2/25/16, indicated, "not assessed" related the PHQ-9 resident interview and staff assessment for mood. The MDS further indicated R30 had received an antidepressant medication 7 out of 7 days during the look back period. When interviewed on 4/20/16, at 7:03 p.m. licensed social worker (LSW)-A confirmed R30's 2/25/16 admission MDS did not include completion of the PHQ-9 resident interview nor staff assessment of mood. The MDS had not been correctly coded. The discharge/return anticipated MDS dated 8/24/15, indicated R4 had not received antipsychotic medication during the look back period of 8/18/15 through 8/24/15, but was incorrectly coded. Medication Administration Record (MAR) dated 8/1/15, through 8/24/15, revealed R4 did receive Risperidone (antipsychotic medication) 2 milligram (mg) twice daily and 4 mg at bedtime.	F 278		

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F 278	Continued From page 8 Physician's orders dated 8/4/15, indicated order for Risperidone 2 mg twice daily and 4 mg at bedtime for schizophrenia. During interview on 9/10/15, at 10.00 a.m. the registered nurse (RN)-B (also MDS coordinator) reviewed R4's record and verified the Risperidone had been administered during the look back period, and was not coded accurately on the discharged/return anticipated MDS dated 8/24/15. RN-B stated she should have coded the antipsychotic mediation use. The policy titled, Mood Assessment Policy Patient Health Questionnaire (PHQ-9) dated 4/01 included: (2.) Social Services will complete the PHQ-9 assessment with each MDS 3.0 and as needed. (9.) If the ARD (Assessment Reference Date) is missed, staff will mark "not assessed" for the PHQ-9 and will complete the PHQ-9 (staff assessment). Staff will document in the residents chart why the ARD date was missed.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's	F 279		5/31/16

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F 279	Continued From page 9 highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive plan of care for 4 of 4 residents (R65, R12, R102, R24) related to urinary incontinence, pressure ulcers, nutrition and accidents. Findings include: The physician order summary dated 12/13/15, identified that R65 was admitted with diagnosis including end stage renal disease (ESRD). During record review the admission - medicare 5 day Minimum Data Set (MDS) dated 12/1/15, identified R65 as being continent of bladder. The quarterly MDS dated 3/2/16, identified R65 as being occasionally incontinent of bladder. Review of the facility bowel and bladder screening (3-day void) from 11/26/15 to 11/28/15, identified R65 as being incontinent 3 times during the assessment period. Review of the nursing assistant point of care documentation from 12/16/15 thru 3/31/16, identified R65 as being occasionally incontinent of bladder. The care plan dated 12/6/15, does not identify any bladder incontinence. During interview on 4/20/16, at 4:02 p.m. nursing assistant (NA)-A stated that R65 was occasionally	F 279	Affected R65 care plan was updated to reflect correct urinary status. Affected R102 discharged on 3/11/16. Affected R12 discharged on 1/14/16. Affected R 24 care plan was updated to reflect risk for falls. Random audit completed on other current residents to ensure care plans were up to date and reflect current plan of care. Nurse Managers were re-educated on importance of keeping care plan updated with current status information. DON or designee will conduct weekly audits of care plans to ensure accuracy. Audits will be reported at each QA meeting.	

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F 279	Continued From page 10	F 279		

incontinent, indicating staff take R65 to the bathroom when she calls but sometimes she is wet.

During interview on 4/21/16, at 10:38 a.m. nurse manager (NM)-A verified the care plan lacked any interventions related to R65's occasional incontinence.

R12 was admitted on 11/10/15, with diagnosis including atrial fibrillation. Review of the wound evaluation sheets dated 12/2/15, identified R12 as having a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed) to the right buttock and a stage 2 pressure ulcer to the right heel. Review of the care plan initiated 12/8/15, did not identify the presence of pressure ulcers.

During interview at 1:00 p.m. on 4/21/16, NM-B verified that the care plan did not identify the presence of pressure ulcers.

R102 was admitted to the facility on 12/31/15 following hospitalization for a right hip fracture. Review of the admission Minimum Data Set (MDS) assessment dated 1/6/16, indicated an admission weight (wt) of 219 pounds (lbs) with no known wt loss.

R102 was discharged to the hospital with return anticipated on 1/8/16 and returned to the facility on 1/11/16. The 14-day MDS dated 1/17/16 included a wt of 198 lbs (which is 21 lbs less than at admission or a 9.6% loss). The MDS indicated- no known wt loss. The 30-day MDS dated 2/10/16 included a wt of 191 lbs (which is 28 lbs less than at the time of admission or a 12.79% loss). Documentation on the MDS again

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indicated- no known wt loss.

The Nutrition Risk Evaluation dated 1/11/16, indicated an admission wt of 219.2 lbs and a current wt of 219.2 lbs. Review of 102's record revealed a wt of 206 lbs on 1/11/16 upon readmission to the facility (which is 13 lbs less than previous admission wt on 12/31/15 or a 5.9% loss). The evaluation further indicated: "Resident is at low nutritional risk. Appetite and intakes below baseline, though improving. No wt loss reported."

Further review of R102's medical record revealed a wt at 60 days after admission (02/26/2016) of 188 lbs (which is 31 lbs. less than at admission or a 14.2% loss).

Review of R102's care plan indicated R102 was independent with intake but did not identify the resident as a nutritional risk.

When interviewed on 2/21/16, at 12:26 p.m. the certified dietary manager (CDM) confirmed R102 had a significant wt loss which should have been included on the care plan.

Review of the quarterly Minimum data set (MDS) dated 2/10/16 identified R24 as independent with transfers, no staff supervision, and having no falls since admit. A falls assessment completed on 2/25/16 indicated that the resident fell 1-2x in the last 6 months, which classified her as being low risk. The MDS further identified R24 as requiring a walker for mobility. A plan of care related to falls was not developed to include interventions to prevent falls.

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Review the current care plan, identified R24 as independent with bed mobility and bilateral side rail use as needed. R24 uses a wheeled walker for ambulation, patient is safe ambulating in room using four wheeled walker and the care plan included to monitor and document and report MD as needed for signs and symptoms of immobility and fall related injury.

During observations on 4/19/16, at 1:53 p.m. of R24"s room environment, the room was noted to be cluttered. There were extra tables and a safe and a box of supplies for a dressing change laying on the floor, magazines, toy animals, and papers covering every surface.

During a interview, R24's reported that she does not get therapy. When I reviewed her falls with her she reported that she gets dizzy. "If I look up I get a little dizzy, and I go out." Staff will ask me to use the call light.

During interview on 4/19/16 at 3:43 p.m. she validated that several of her accidents happen early a.m. She reported that putting on her call light for assistance, "doesn't do any good.' "after one time when they didn't even come, I just get up and go out to the desk myself."

During record review was noted that R24 had falls documented at the following times: R24s documented falls in the last year include:
Falls documentation- incident reports
4/7/16 - 6:48 am found in room on her knees with arms on bed trying to get item out of her safe. -interventions, reminded to assist when reaching for objects, no injuries.
3/23/16- 3:46 a.m.- found on floor in bathroom,

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F 279	Continued From page 13 did not know what happened intervention- call for assist injury right anticubital- sent to emergency room and was admitted. for potassium level per progress note 3/22/16 - 5:40-am staff found resident on floor states she was rinsing out her ostomy bag and fell. Intervention - resident will be evaluated by physical therapy. sustained injury to LAU arm. 3/21/16 - 9:36 am-resident was found to be cleaning toilet, fell to floor. first said she was going into bathroom because she had diahrea. Intervention - resident was offered hospice and she declined. 12/3/15-8:45 pm - told staff she tripped fell to knees, hit her head, neuro checks done, residents room is cluttered per her preference, will encourage to declutter. 10/1/15 - 9:45 pm resident fell out of bed, bruise on Left arm did not know how it happened. then said she rolled out of bed. Interventions- independent with mobility continue to monitor. 8/14/15 -8:15 pm- found on floor at foot of bed, complained of wrist pain, called MD, X-ray of wrist. Intervention-Independent with mobility, sent to emergency room, sprain of right wrist, splinted. When interviewed on 4/21/16, at 1:00 p.m. R24's primary physician stated she was not aware of the falls history and agreed the medications administered at bedtime may be a contributing factor and should be reviewed. During review of the policy titled, Clinical Protocol, dated 10/10; Treatment and management (1.) Based on the proceeding assessment, the	F 279		

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F 279	Continued From page 14 staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). (2.) If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment or the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).	F 279		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement interventions to	F 314	Affected R12 was discharged from facility on 1/14/16.	5/31/16

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F 314	Continued From page 15 prevent further skin breakdown for 1 of 3 residents (R12) reviewed during closed record and who had pressure ulcers. Findings include: R12 was admitted on 11/10/15. Review of the admission Minimum Data Set (MDS) assessment dated 11/16/15, identified R12 as being at risk for pressure ulcers. No pressure ulcer was identified at this time. Review of the admission initial nursing assessment dated 11/10/15, indicated R12 was transferred with a mechanical lift and needed extensive assistance of staff with bed mobility. No skin issues were identified on this assessment. The admission tissue tolerance observation identified that R12's coccyx area was reddened after sitting for 2 hours. The Braden Scale dated 11/10/15, identified R12 as a mild risk for pressure ulcers. A physical therapy daily treatment note dated 11/13/15, identified that R12 had complained of a sore bottom at which time therapy relieved pressure by standing for one minute. The Braden scale dated 11/18/15, identified R12 as a moderate risk for pressure ulcers. The treatment administration record (TAR) for November 2015, identified that R12's coccyx was to be monitored every evening due to being a high risk for pressure ulcer. The TAR also identified that staff were monitoring right foot scab/healing (unable to determine where on the foot this was) cellulitis until resolved. The nurses progress note dated 11/14/15, identified a nursing order for heel lift boots to be on when in bed due to limited mobility. R12 was admitted to the hospital on 11/19/15,	F 314	All residents will be accurately assessed on admission or readmission and ongoing for risk for skin breakdown. Staff nurses will continue to complete tissue tolerance assessments (lying and sitting). After tissue tolerance assessments completed, Nurse Managers will now be responsible for completing the tissue tolerance evaluation to ensure residents at risk are identified and appropriate interventions are in place. Interventions will be care planned and MDS coded appropriately. Staff Nurses and Nurse Managers will be re-educated on this process. Nurse Managers to complete weekly wound rounds on all residents with pressure ulcers and bring documentation to "Wounds on Wednesday" to review wound status and interventions in place to promote healing. Wound Book to be initiated by DON and ADON to keep weekly wound assessments in for all staff to view at nurses stations. "New Wound Packet" to be initiated as well, as a guide for floor nurses when a new wound is found to ensure appropriate interventions are in place. Audits will be conducted weekly by DON or designee and reported to QA quarterly.	

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and returned to the facility on 11/24/15. The patient care summary sent with P12 to the hospital from the facility, indicated, "no skin concerns." A hospital progress note dated 11/23/15, identified the presence of an unstagable ulcer to R12's right heel. A skin evaluation completed 11/24/15, identified R12's right heel as sore to touch, peeling and reddened. The Braden Scale completed on 12/2/15, identified a moderate risk for skin breakdown with an open area to the right buttock measuring 0.5 cm by 0.5 cm. and repositioning every 2 hours.

The weekly wound evaluation dated 11/25/15, identified right heel pressure ulcer 0.5 cm by 0.5 cm stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed). The treatment plan identified: paint wounds on left toe and right heel with betadine and air dry and elevate heels/boots.

Two weekly wound evaluation forms were dated 12/2/15. The form completed at 6:58 a.m. identified a stage 2 pressure ulcer to the right buttocks measuring 0.5 cm by 0.5 cm.. The treatment/plan was identified as Mepilex (a wound care dressing) changed every three days and as needed (PRN). A second weekly wound evaluation for dated 12/2/15, at 3:21 p.m. identified a stage 2 pressure ulcers to the right heel measuring 0.8 cm by 0.8 cm.; no treatment was identified.

Two weekly wound evaluations were noted for 12/9/15; (1) a stage 2 right buttock pressure ulcer measuring 0.8 by 0.8 cm with the treatment plan identified as Mepilex change every 3 days and prn and (2) unstageable right heel pressure ulcer measuring 0.5 cm by 0.5 cm. with the

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F 314	Continued From page 17 treatment/plan as clean and apply betadine daily. The weekly wound evaluation for 12/16/15, identified a stage 2 pressure ulcer to right buttock measuring 0.5 cm by 0.5 cm and an unstageable pressure ulcer to the right heel measuring 0.1 cm by 0.1 cm. The treatment/plan was: Mepilex changed every 3rd day and prn and betadine to heel daily. The weekly wound evaluation dated 12/27/15, identified a stage 2 pressure ulcer to the left buttock measuring 0.1 cm by 0.1 cm. Treatment plan identifed: barrier cream and reposition every 2 hours. No assessment of the heel was evident. The weekly wound evaluation from 12/30/15, identified left buttock pressure ulcer stage 2 0.1 cm by 0.1 cm. Treatment/plan was Mepilex change every 3 days and barrier cream. The weekly wound evaluation from 1/6/16, identified right buttock stage 2 pressure ulcer 0.1 cm by 0.1 cm. Treatment plan: change Mepilex every 3rd day and prn. The weekly wound evaluation from 1/13/16, identified right and left buttock stage 2 pressure ulcers measuring 0.1 cm by 0.1 cm. Treatment plan: Mepilex change every 3 days and prn and barrier cream. The weekly wound evaluations all indicated: continue current plan of care. The current plan of care did not address any skin issues, the risk for pressure ulcer development and/or the identification of the pressure ulcers. During interview on 4/21/16, at 1:00 p.m.	F 314		

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F 314	Continued From page 18 registered nurse (RN)-C stated that heel lift boots were initiated on 11/14/15, as a nursing order due to R12's heels being red and mushy. She stated there should have been documentation regarding the condition of the heels. She verified that the stage 2 ulcer to right buttock had started between 12/1/15 and 12/2/15. She confirmed a treatment of Mepilex was initiated but could not demonstrate in the documentation that any other interventions were implemented to prevent further skin breakdown. RN-C indicated "we put the Mepilex on that's it". She also verified a stage 2 pressure ulcer developed on R12's left buttock on 12/27/15. Mepilex was applied but no additional interventions were developed and/or implemented.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure causal risk factors related to falls were analyzed and interventions were implemented to minimize the risk of future falls for 1 of 3 residents (R24) reviewed with a history of falls. Findings include:	F 323	Affected R24 care plan was updated to reflect risk for falls and appropriate interventions. All residents assessed to be at risk for falls will have interventions documented on care plan. All falls will be reviewed daily by IDT to determine causal factors, possible contributing factors and proper	5/31/16

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F 323	Continued From page 19 R24 was admitted on 2/18/15 and recently admitted to hospice on 3/28/16. Review of the Diagnosis Report located in the medical record indicated R24 has diagnoses including hypertension, anxiety disorder, major depressive disorder,osteoarthritis, Von Willebrands disease and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated 2/10/16, identified R24 as independent with transfers, no staff supervision, and having no falls since admit. A falls assessment completed on 2/25/16, indicated R24 fell 1-2 times in the last 6 months, which classified her as being low risk. The MDS further identified R24 as requiring a walker for mobility. Review the current care plan dated 3/10/16, identified R24 as independent with bed mobility and bilateral side rail use as needed. R24 uses a wheeled walker for ambulation and is safe ambulating in room using four wheeled walker. The care plan included to monitor and document and report MD as needed for signs and symptoms of immobility and fall related injury. In addition, the care plan identified that R24 was at risk for psychoactive medications and related side effects. During observations of R24's room on 4/19/16, at 1:53 p.m. it was noted to be cluttered. There were extra tables, a safe and a box of supplies for a dressing change, with magazines, toy animals, and papers covering every surface. When interviewed on 4/19/16, at 1:54 p.m. R24 reported she does not received therapy and reported she gets dizzy; "If I look up I get a little dizzy and I go out." R24 further indicated that staff	F 323	interventions will be implemented and care planned. Nurse Manager will be responsible for documentation of new intervention. Resident care sheets will be adjusted with new interventions with goal to prevent further incidents. Education provided to IDT team members related to the process of reviewing falls. Weekly audits will be conducted by DON or designee to ensure compliance and reviewed at the next QA meeting.	

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request she uses the call light.

During further interview on 4/19/16, at 3:43 p.m. R24 validated that several of her accidents occur early in the morning. She reported that activating the call light for staff assistance "doesn't do any good.". R24 indicated that after one time when staff didn't even come to help, she went to the desk without help.

Documented falls as noted during incident report review included the following in the past year for R24:
(1) 4/7/16 - 6:48 am found in room on her knees with arms on bed trying to get item out of her safe. -interventions, reminded to assist when reaching for objects, no injuries;
(2) 3/23/16- 3:46 a.m.- found on floor in bathroom, did not know what happened intervention- call for assist; injury right antecubital- sent to emergency room and was admitted. for potassium level per progress note;
(3) 3/22/16 - 5:40-am staff found resident on floor states she was rinsing out her ostomy bag and fell. Intervention - resident will be evaluated by physical therapy. sustained injury to LAU arm;
(4) 3/21/16 - 9:36 am-resident was found to be cleaning toilet, fell to floor;
first said she was going into bathroom because she had diarrhea. Intervention - resident was offered hospice and she declined;
(5) 12/3/15-8:45 pm - told staff she tripped fell to knees, hit her head, neuro checks done, residents room is cluttered per her preference, will encourage to de-clutter;
(6) 10/1/15 - 9:45 pm resident fell out of bed, bruise on Left arm did not know how it happened. then said she rolled out of bed. Interventions- independent with mobility continue to monitor;

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F 323	Continued From page 21 and (7) 8/14/15 -8:15 pm- found on floor at foot of bed, complained of wrist pain, called MD, X-ray of wrist. Intervention-Independent with mobility, sent to emergency room, sprain of right wrist, splinted. No further documentation in the medical record was found nor provided by staff related to the above documented falls. Documentation was lacking to indicate a comprehensive fall assessment had been conducted at the time of each incident related to the fall and therefore no interventions were identified to prevent and/or to minimize the future risk of fall and injury. Interventions were not evaluated to determine their effectiveness and/or the need for revision An interview was conducted with R24's primary physician on 4/21/16 at 1:00 p.m. The Dr. stated that she was not aware of the falls history, and agreed that the medications given at bedtime may be a causal factor and will be subject for further review. During review of the policy titled, Clinical Protocol, dated 10/10; subtitle: Cause Identification. (1.) For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall: a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b. Often, multiple factors in varying degrees contribute to a falling problem. (2.) If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the	F 323		

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F 323	Continued From page 22 individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. a. After more than on fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. b. Many categories of medications, and especially combinations of medications in several of those categories,increase the risk of falling. (3.) The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Treatment and management (1.) Based on the proceeding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). (2.) If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment or the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance).	F 323		

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F 412	Continued From page 23	F 412		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dental services were scheduled with the on-site dental provider for 1 of 3 residents (R9) reviewed for dental services and who requested routine dental services. Findings include: On 4/18/16, at 11:05 a.m. R9 was observed to be missing several upper and lower teeth. The annual Minimum Data Set (MDS) assessment dated 12/3/16, for R9 indicated obvious or likely cavity or broken natural teeth. The Oral/Dental Evaluation dated 12/4/15, indicated several missing teeth, teeth broken or appears to have caries (cavities), and plaque or debris in localized areas (between teeth). R9's IDT (Interdisciplinary team) Care Conference and Quarterly Review dated	F 412	A consent for On-Site dental services was signed on 4/22/16 and affected R9 will be seen by on-site dentist on 6/7/16. Upon admission all residents will be offered on-site services by social worker or designee and ongoing at care conferences which will be documented at care conferences. Social workers will bring consents for all on-site services to all care conferences for smoother process for residents wanting on-site care. A new care conference summary form will be initiated by DON for all IDT members to complete. This form will include dates of last visit for dental, vision, hearing and podiatry and residents will be offered these services at care conference. An audit will be completed on all current residents to ensure all residents who want dental services have consents signed and are provided to on-site dental to be seen. Audits will be conducted quarterly and	5/31/16

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	245516	A. BUILDING _____ B. WING _____	04/21/2016

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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F 412	Continued From page 24 12/28/15, indicated the resident would like to see the on-site dentist. When interviewed on 4/21/16, at 9:11 a.m. the director of nursing (DON) stated the process related to on-site dental services was as follows: When a resident reports an interest in dental services the licensed social worker (LSW) is responsible for obtaining a consent. The LSW then would forward the consent to the DON who would fax to the on-site dental provider so the resident could be added to the list for the next on-site dental appointment. DON confirmed the next on-site dental visit was scheduled for 5/11/16. DON provided the Daily Appointments list for 5/11/16 which had been sent by the dental provider. The list also included residents the DON had hand-written onto the sheet received from the provider. The DON stated the residents she had written on the list were residents who had expressed interest and signed a consent but had not shown up on the dental appointment list. The DON would verify with the dental provider to ensure all consents had been completed and thus the residents could be added unto the appointment list. The DON reviewed the Daily Appointments list and confirmed R9 was not on the list. In addition, the DON confirmed there was no evidence a consent for dental services had been signed by R9. She clarified that without a written consent, R9 would not be added to the list of residents to be seen on 5/11/16. The DON then reviewed R9's medical record and confirmed R9 had requested to see the on-site dentist when she attended the 12/28/15 care conference. The DON further confirmed that LSW-A had been present at R9's care conference. When interviewed on 4/21/16, at 9:24 a.m.	F 412	reported to QA.	

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F 412	Continued From page 25 LSW-A confirmed responsibility for obtaining a consent from residents (or responsible party) when they express interest in on-site routine dental services. LSW-A further confirmed a consent for on-site dental services had not been obtained for R9. LSW-A stated it must have gotten missed.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		5/31/16

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F 441	Continued From page 26 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement infection control policies and procedures for 2 of 2 residents (R5 & R21) who required transmission based precautions. Findings include: R121 was admitted on 4/4/16. R121's admission diagnosis report dated 4/21/16, included sepsis and methicillin resistant staphylococcus aureus (MRSA-a multi-drug resistant organism that can be spread through contact with infectious body fluids or via airborne droplets) infection in the sputum; onset date 4/4/16. During the initial tour on 4/18/16, at 8:36 a.m. R21 was observed to wear a face mask. No signage was evident in R21's room and/or on the door alerting staff of any special precautions. R5 was admitted to the facility on 4/7/15. R5's current diagnosis report dated 4/21/16, identified the bacteria MRSA in the urine; onset date of 4/7/16. During the initial tour on 4/18/16, at 8:36 a.m. no signage was noted on the door and/or in the room	F 441	Immediately upon observation during survey signs were placed on doors of affected residents R5 and R21. These residents are no longer on precautions. All residents that are identified as needing special precautions will have signs placed on doors as soon as identified. The precaution signs were placed in the nurses stations rather than the OHL office. All nurses educated on location of precaution signs. A QAPI project will be conducted by nursing department and reported to QA quarterly.	

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F 441	Continued From page 27 of R5 alerting staff and visitors of any precautions. When interviewed on 4/20/16, at 12:52 p.m. the director of nursing (DON) confirmed R5 and R21 were still infectious and precaution signs should have been posted on the outside of their doors per facility policy to alert staff of the need for additional precautions to prevent the spread of illness. The DON confirmed these signs were not posted until after survey staff completed the initial tour. The DON further indicated the Occupational Health and Learning coordinator was responsible for posting the appropriate signage. The facility policy, entitled Contact Precautions, last revised 1/08 indicated contact precautions will be used in the care of all residents known to be infected with organisms that are transmitted by contact with the patient or contaminated surfaces. An additional policy, entitled Droplet precautions, last revised 1/08 indicated droplet precautions will be used in addition to standard precautions during the care of all residents known or suspected to be infected with organisms that are transmitted by the droplet route when in contact with potentially contaminated surfaces or when working greater than three feet around resident.	F 441		

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	245516	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/19/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY 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. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2016

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 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Laurel's Peak Rehabilitation Center was constructed as follows: The original building was constructed in 1962, it is one-story, has a partial basement, is fully fire sprinkler protected and is of Type I(332) construction; The 1992 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 1998 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction. The nursing home is separated from an assisted living facility by a two-hour fire-rated wall assembly, with opening protectives appropriate to the rating. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire	K 000		

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K 000	Continued From page 2 department notification. The facility has a capacity of 65 beds and had a census of 48 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 FINDINGS INCLUDE: On 04/19/2016 between 9:00 AM and 1:30 PM, during the inspection a penetration was observed around cables above the ceiling tiles in the 2 hour fire separation between Laurels Peak and the Assisted Living Building. This deficient practice was verfied by the Maintenance Supervisor.	K 011	Penetration in ceiling above the ceiling tiles were patched and fire caulking around wires was completed. Ongoing environmental audits to be completed and will be reviewed at QA.	5/31/16

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K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. This STANDARD is not met as evidenced by: Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: (a) The required manual fire alarm system and (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an	K 021	The magnetic holder was replaced on the main kitchen door. Ongoing environmental audits to be completed and will be reviewed at QA.	5/31/16

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K 021	Continued From page 4 approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed. FINDINGS INCLUDE: On 04/19/2016, between 9:00 AM and 1:30 PM, observation revealed the magnetic hold open device was observed broken off of the Main Kitchen Door. This door would not close upon activation of the fire alarm system. This deficient practice was verfied by the Maintenance Supervisor.	K 021		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029	The bricks were removed immediately from all doors in the laundry room. Staff was educated on the importance of not keeping doors propped open. Ongoing environmental audits to be completed and will be reviewed at QA.	5/31/16

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K 029	Continued From page 5 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on April 16, 2016 between 9:00 AM and 1:30 PM, observation during the inspection revealed the door in the Lower Laundry Area was observed propped open with bricks. This deficient practice was verfied by the Maintenance Supervisor.	K 029		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 FINDINGS INCLUDE: During Facility Inspection on April 16, 2016 between 9:00 AM and 1:30 PM, observation during the inspection revealed items(boxes) being stored within the egress stairway to the Lower Laundry Area. This deficient practice was verfied by the Maintenance Supervisor.	K 038	All boxes were removed from the egress area and signs were posted to ensure all staff members are aware of the regulation. Staff members educated. Ongoing environmental audits to be completed and will be reviewed at QA..	5/31/16
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration	K 046		5/31/16

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K 046	Continued From page 6 is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Findings include: On facility tour between 9:00 AM and 1:30 PM, review of the Battery Emergency Light Testing documentation could not be provided that showed that the wall mounted emergency lights were receiving an annual 90 minute test. This deficient practice was confirmed with the Maintenance Supervisor at the time of discovery.	K 046	The annual emergency light test was performed on May 3rd, 2016 and documented properly. Ongoing audits to be conducted.	
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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	K 050	Fire drills will be conducted on each shift quarterly and at least 90 minutes apart from the last fire drill conducted of that shift. Ongoing audits to be completed and reviewed at QA.	5/31/16

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LAURELS PEAK CARE & REHABILITATION CENTER	**700 JAMES AVENUE** **MANKATO, MN 56001**

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K 050	Continued From page 7 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Findings include: During documentatation review between 09:00AM and 1:30 PM on 4/19/2016, documentation reviewed revealed that fire drills were not conducted at unexpected times and under varying conditions on shifts throughout the year: Day Shift: 1st Quarter-1:00PM on 03-09-16 and 3rd Quarter-1:00PM on 07-20-15 Evening Shift: 3rd Quarter- 4:00PM on 08-17-15 and 4th Quarter-11/24/15 on 11-24-15 Night Shift: 1st Quarter-06:00AM on 03-26-16, 2nd Quarter- 06:00AM on 06-11-15 and 4th Quarter- 06:00AM on 12-18-15. This deficient practice was confirmed with the Maintenance Supervisor at the time of discovery.	K 050		
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept	K 052	Paperwork will be properly filled out at the time of fire drills indicating DACT was tested. Staff educated on how to fill out paperwork properly.	5/31/16

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** B. WING _____	**04/19/2016**

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
K 052	Continued From page 8 readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. FINDINGS INCLUDE: On facility tour between 9:00 AM and 1:30 PM on 04/19/2016, documentation could not be provided indicating that the DACT was tested during the fire drills. This deficient practice was confirmed by the Maintenance Supervisor upon discovery.	K 052		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During Facility Inspection on April 19, 2016 between 9:00 AM and 1:30 PM, it was observed during documentation review that the transfer time and cool down time was not noted during the monthly load test of the emergency generator. This deficient practice was verfied by the Maintenance Supervisor.	K 144	Proper documentation will be completed in regards to generator testing and will include transfer time and cool down periods.	5/31/16

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** B. WING _____	**04/19/2016**

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
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 FINDINGS INCLUDE: During Facility Inspection on April 19, 2016, between the hours of 09:00 AM and 1:30 PM, it was observed that a floor fan in the laundry had exposed wires on the power cord and a ceiling mounted junction box, also in the laundry, was missing a cover. This deficient practice was confirmed by the Maintenance Supervisor upon discovery.	K 147	The junction box was replaced and the fan cord was fixed. Ongoing environmental audits to be completed.	5/31/16

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** B. WING _____	**04/19/2016**

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
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 19, 2016. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2016

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.

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** B. WING _____	**04/19/2016**

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
K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Chapter 18 New Health Care Occupancies. Building 02 of Laurel's Peak Rehabilitation Center consists of two (2) building additions to the original nursing home, and were constructed as follows: The 2008 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction; The 2010 addition is one-story, has no basement, is fully fire sprinkler protected and is of Type V(000) construction. 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. Building 02 has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

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** B. WING _____	**04/19/2016**

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
K 000	Continued From page 2 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 48 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 11/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 11/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2. FINDINGS INCLUDE: On 04/19/2016 between 9:00 AM and 1:30 PM, during the inspection a penetration was observed around cables above the ceiling tiles in the 2 hour fire separation between Laurels Peak and the Assisted Living Building.	K 011	Corrected	5/31/16

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	245516	A. BUILDING **02 - 2008 NEW WING** B. WING _____	**04/19/2016**

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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K 011	Continued From page 3 This deficient practice was verfied by the Maintenance Supervisor.	K 011		
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. This STANDARD is not met as evidenced by: Emergency lighting of at least 1 1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1. Findings include: On facility tour on April 19, 2016, between 9:00 AM and 1:30 PM, review of the Battery Emergency Light Testing documentation could not be provided that showed that the wall mounted emergency lights were receiving an annual 90 minute test. This deficient practice was confirmed with the Maintenance Supervisor at the time of discovery.	K 046	Corrected	5/31/16
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by:	K 050		5/31/16

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** B. WING _____	**04/19/2016**

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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K 050	Continued From page 4 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 Findings include: During documentatation review between 09:00AM and 1:30 PM on 4/19/2016, documentation reviewed revealed that fire drills were not conducted at unexpected times and under varying conditions on shifts throughout the year: Day Shift: 1st Quarter-1:00PM on 03-09-16 and 3rd Quarter-1:00PM on 07-20-15 Evening Shift: 3rd Quarter- 4:00PM on 08-17-15 and 4th Quarter-11/24/15 on 11-24-15 Night Shift: 1st Quarter-06:00AM on 03-26-16, 2nd Quarter- 06:00AM on 06-11-15 and 4th Quarter- 06:00AM on 12-18-15. This deficient practice was confirmed with the Maintenance Supervisor at the time of discovery.	K 050	Corrected	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with	K 052		5/31/16

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** B. WING _____	**04/19/2016**

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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K 052	Continued From page 5 applicable requirement of NFPA70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7. FINDINGS INCLUDE: On facility tour between 9:00 AM and 1:30 PM on 04/19/2016, documentation could not be provided indicating that the DACT was tested during the fire drills. This deficient practice was confirmed by the Maintenance Supervisor upon discovery.	K 052	Corrected	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) FINDINGS INCLUDE: During Facility Inspection on April 19, 2016	K 144	Corrected	5/31/16

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** B. WING _____	**04/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 6 between 9:00 AM and 1:30 PM, it was observed during documentation review that the transfer time and cool down time was not noted during the monthly load test of the emergency generator. This deficient practice was verfied by the Maintenance Supervisor.	K 144		

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
May 6, 2016

Ms. Erin Aanenson, Administrator
Laurels Peak Care & Rehabilitation Center
700 James Avenue
Mankato, MN 56001

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5516024

Dear Ms. Aanenson:

The above facility was surveyed on April 18, 2016 through April 21, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the

correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at 507-476-4233.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00035	A. BUILDING: _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELS PEAK CARE & REHABILITATION CE	700 JAMES AVENUE MANKATO, MN 56001

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00035	A. BUILDING: _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 04/18/16 through 04/21/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		
2 485	MN Rule 4658.0265 Deposit of Personal Funds A nursing home, except for veterans homes under Minnesota Statutes, section 198.265, must deposit a resident's personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the nursing home's operating accounts, and that credits all interest earned on the resident's account to the resident's account. Pooled accounts must separately account for each resident's share. This MN Requirement is not met as evidenced by: Based on interview and documentation review the facility failed to ensure residents' personal funds in excess of $50.00 were maintained in an interest bearing account for 23 of 28 residents (R4, R57, R24, R28, R51, R71, R49, R56, R8, R15, R9, R95, R41, R43, R14, R10, R3, R31, R68, R23, R69, R53, and R18) whose personal funds were managed by the facility.	2 485	Corrected	5/31/16

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2 485	Continued From page 2 Findings include: On 4/21/16, at 1:25 p.m. R57's personal funds account transaction history was reviewed. No interest had been deposited into R57's account and it was noted the balance on the account dated 12/31/15 was $54.00, 1/31/16-$81.00, 2/29/16-$87.00 and 4/21/16- $87.00. When interviewed on 4/21/16, at 1:25 p.m. the human resource director (HRD) stated that as of 1/1/16, the facility no longer had interest bearing accounts for resident personal fund accounts. These resident accounts had signed permission forms, allowing the facility to manage their fund. During review of resident personal fund accounts on 4/21/16, the following balances were identified on the document: R4=$1,654.87; R57= $87.00; R24- $69.75; R28= $3,475.73; R51=$2,305.53; R71= $261.55; R49= $113.17; R56=$74.29; R8= $203.07; R15= $252.73; R9= $99.36; R95= $243.85; R41= $123.47; R43= $115.66; R14= $50.00; R10= $5,844.96; R3= $114.70; R31= $142.00; R68= $90.97; R23= $1,381.81; R69= $300.00; R53= $725.57 and R18= $377.94. Although residents had personal fund managed by the facility and the balances ranged from $50.00 to $5,844.96, none of the identified residents had been receiving interest on their individual accounts. SUGGESTED METHOD OF CORRECTION: The human resource director could educate accounting staff that interest on personal funds is a requirement. A system could be developed to audit the financial records to ensure interest is	2 485		

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2 485	Continued From page 3 earned for personal fund accounts. The result of this could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 485		
2 495	MN Rule 4658.0275 Subp. 1 Return of Funds After Discharge or Death Subpart 1. Discharge of a resident. Upon discharge of a resident, the resident's funds must be returned to the resident or resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident, with a written accounting in exchange for a signed receipt. If a resident's bed is being held for anticipated readmission, the resident's funds need not be returned. Funds which are maintained outside of the nursing home must be returned within five business days. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to convey a final accounting of personal funds within 30 days of death for 2 of 2 residents (R122, R123) reviewed who had personal funds deposited with the facility. Findings include: R122 expired on 10/6/15 and at the time her personal fund account balance with the facility was $276.00. Review of R122's transaction statement indicated the funds were given to the R122's family on 2/25/16 (142 days later). R123 expired on 11/6/15. At the time of death,	2 495	Corrected	5/31/16

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2 495	Continued From page 4 R123 had an account balance of $75.00 in the personal fund account deposited with the facility. Review of R123's trust transaction statement indicated the remaining funds in the account were conveyed to the individual responsible for R123's estate on 2/18/16 (104 days later). During interview on 4/21/16, at 8:43 a.m. the human resource director (HRD) stated she was responsible for overseeing the resident's personal funds accounts. HRD stated once a death affidavit was received, she would receive an email from the corporate office with approval to convey the remaining personal funds to the appropriate entity. Facility policy Resident Trust Account, dated 11/06, reads; "Upon the death of a resident, the center will release the personal trust account funds to an individual or county human services. This is determined by information received by county human services." SUGGESTED METHOD OF CORRECTION: The financial staff could be educated that personal fund disbursement should be disbursed to the appropriate estate/individual within 30 days after death. An audit tool could be developed and reported to the quarterly quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 495		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable	2 560		5/31/16

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2 560	Continued From page 5 objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a comprehensive plan of care for 4 of 4 residents (R65, R12, R102, R24) related to urinary incontinence, pressure ulcers, nutrition and accidents. Findings include: The physician order summary dated 12/13/15, identified that R65 was admitted with diagnosis including end stage renal disease (ESRD). During record review the admission - medicare 5 day Minimum Data Set (MDS) dated 12/1/15, identified R65 as being continent of bladder. The quarterly MDS dated 3/2/16, identified R65 as being occasionally incontinent of bladder. Review of the facility bowel and bladder screening (3-day void) from 11/26/15 to 11/28/15, identified R65 as being incontinent 3 times during the assessment period. Review of the nursing assistant point of care documentation from 12/16/15 thru 3/31/16, identified R65 as being occasionally incontinent of bladder. The care plan dated 12/6/15, does not identify any bladder incontinence. During interview on 4/20/16, at 4:02 p.m. nursing assistant (NA)-A stated that R65 was occasionally incontinent, indicating staff take R65 to the	2 560	Corrected	

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2 560	Continued From page 6 bathroom when she calls but sometimes she is wet. During interview on 4/21/16, at 10:38 a.m. nurse manager (NM)-A verified the care plan lacked any interventions related to R65's occasional incontinence. R12 was admitted on 11/10/15, with diagnosis including atrial fibrillation. Review of the wound evaluation sheets dated 12/2/15, identified R12 as having a stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed) to the right buttock and a stage 2 pressure ulcer to the right heel. Review of the care plan initiated 12/8/15, did not identify the presence of pressure ulcers. During interview at 1:00 p.m. on 4/21/16, NM-B verified that the care plan did not identify the presence of pressure ulcers. R102 was admitted to the facility on 12/31/15 following hospitalization for a right hip fracture. Review of the admission Minimum Data Set (MDS) assessment dated 1/6/16, indicated an admission weight (wt) of 219 pounds (lbs) with no known wt loss. R102 was discharged to the hospital with return anticipated on 1/8/16 and returned to the facility on 1/11/16. The 14-day MDS dated 1/17/16 included a wt of 198 lbs (which is 21 lbs less than at admission or a 9.6% loss). The MDS indicated- no known wt loss. The 30-day MDS dated 2/10/16 included a wt of 191 lbs (which is 28 lbs less than at the time of admission or a 12.79% loss). Documentation on the MDS again indicated- no known wt loss.	2 560		

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2 560	Continued From page 7 The Nutrition Risk Evaluation dated 1/11/16, indicated an admission wt of 219.2 lbs and a current wt of 219.2 lbs. Review of 102's record revealed a wt of 206 lbs on 1/11/16 upon readmission to the facility (which is 13 lbs less than previous admission wt on 12/31/15 or a 5.9% loss). The evaluation further indicated: "Resident is at low nutritional risk. Appetite and intakes below baseline, though improving. No wt loss reported." Further review of R102's medical record revealed a wt at 60 days after admission (02/26/2016) of 188 lbs (which is 31 lbs. less than at admission or a 14.2% loss). Review of R102's care plan indicated R102 was independent with intake but did not identify the resident as a nutritional risk. When interviewed on 2/21/16, at 12:26 p.m. the certified dietary manager (CDM) confirmed R102 had a significant wt loss which should have been included on the care plan. Review of the quarterly Minimum data set (MDS) dated 2/10/16 identified R24 as independent with transfers, no staff supervision, and having no falls since admit. A falls assessment completed on 2/25/16 indicated that the resident fell 1-2x in the last 6 months, which classified her as being low risk. The MDS further identified R24 as requiring a walker for mobility. A plan of care related to falls was not developed to include interventions to prevent falls. Review the current care plan, identified R24 as independent with bed mobility and bilateral side rail use as needed. R24 uses a wheeled walker for ambulation, patient is safe ambulating in room	2 560		

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2 560	Continued From page 8 using four wheeled walker and the care plan included to monitor and document and report MD as needed for signs and symptoms of immobility and fall related injury. During observations on 4/19/16, at 1:53 p.m. of R24"s room environment, the room was noted to be cluttered. There were extra tables and a safe and a box of supplies for a dressing change laying on the floor, magazines, toy animals, and papers covering every surface. During a interview, R24's reported that she does not get therapy. When I reviewed her falls with her she reported that she gets dizzy. "If I look up I get a little dizzy, and I go out." Staff will ask me to use the call light. During interview on 4/19/16 at 3:43 p.m. she validated that several of her accidents happen early a.m. She reported that putting on her call light for assistance, "doesn't do any good.' "after one time when they didn't even come, I just get up and go out to the desk myself." During record review was noted that R24 had falls documented at the following times: R24s documented falls in the last year include: Falls documentation- incident reports 4/7/16 - 6:48 am found in room on her knees with arms on bed trying to get item out of her safe. -interventions, reminded to assist when reaching for objects, no injuries. 3/23/16- 3:46 a.m.- found on floor in bathroom, did not know what happened intervention- call for assist injury right anticubital- sent to emergency room and was admitted. for potassium level per progress note 3/22/16 - 5:40-am staff found resident on floor	2 560		

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2 560	Continued From page 9 states she was rinsing out her ostomy bag and fell. Intervention - resident will be evaluated by physical therapy. sustained injury to LAU arm. 3/21/16 - 9:36 am-resident was found to be cleaning toilet, fell to floor. first said she was going into bathroom because she had diahrea. Intervention - resident was offered hospice and she declined. 12/3/15-8:45 pm - told staff she tripped fell to knees, hit her head, neuro checks done, residents room is cluttered per her preference, will encourage to declutter. 10/1/15 - 9:45 pm resident fell out of bed, bruise on Left arm did not know how it happened. then said she rolled out of bed. Interventions- independent with mobility continue to monitor. 8/14/15 -8:15 pm- found on floor at foot of bed, complained of wrist pain, called MD, X-ray of wrist. Intervention-Independent with mobility, sent to emergency room, sprain of right wrist, splinted. When interviewed on 4/21/16, at 1:00 p.m. R24's primary physician stated she was not aware of the falls history and agreed the medications administered at bedtime may be a contributing factor and should be reviewed. During review of the policy titled, Clinical Protocol, dated 10/10; Treatment and management (1.) Based on the proceeding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors,	2 560		

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2 560	Continued From page 10 addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). (2.) If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment or the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to developing a comprehensive care plan. The DON or designee, could provide training for all nursing staff related to the care plan process. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	2 830		5/31/16

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2 830	Continued From page 11 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure causal risk factors related to falls were analyzed and interventions were implemented to minimize the risk of future falls for 1 of 3 residents (R24) reviewed with a history of falls. Findings include: R24 was admitted on 2/18/15 and recently admitted to hospice on 3/28/16. Review of the Diagnosis Report located in the medical record indicated R24 has diagnoses including hypertension, anxiety disorder, major depressive disorder,osteoarthritis, Von Willebrands disease and chronic pain. Review of the quarterly Minimum Data Set (MDS) assessment dated 2/10/16, identified R24 as independent with transfers, no staff supervision, and having no falls since admit. A falls assessment completed on 2/25/16, indicated R24 fell 1-2 times in the last 6 months, which classified her as being low risk. The MDS further identified R24 as requiring a walker for mobility. Review the current care plan dated 3/10/16, identified R24 as independent with bed mobility and bilateral side rail use as needed. R24 uses a wheeled walker for ambulation and is safe ambulating in room using four wheeled walker. The care plan included to monitor and document	2 830	Corrected	

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2 830	Continued From page 12 and report MD as needed for signs and symptoms of immobility and fall related injury. In addition, the care plan identified that R24 was at risk for psychoactive medications and related side effects. During observations of R24's room on 4/19/16, at 1:53 p.m. it was noted to be cluttered. There were extra tables, a safe and a box of supplies for a dressing change, with magazines, toy animals, and papers covering every surface. When interviewed on 4/19/16, at 1:54 p.m. R24 reported she does not received therapy and reported she gets dizzy; "If I look up I get a little dizzy and I go out." R24 further indicated that staff request she uses the call light. During further interview on 4/19/16, at 3:43 p.m. R24 validated that several of her accidents occur early in the morning. She reported that activating the call light for staff assistance "doesn't do any good.". R24 indicated that after one time when staff didn't even come to help, she went to the desk without help. Documented falls as noted during incident report review included the following in the past year for R24: (1) 4/7/16 - 6:48 am found in room on her knees with arms on bed trying to get item out of her safe. -interventions, reminded to assist when reaching for objects, no injuries; (2) 3/23/16- 3:46 a.m.- found on floor in bathroom, did not know what happened intervention- call for assist; injury right antecubital- sent to emergency room and was admitted. for potassium level per progress note; (3) 3/22/16 - 5:40-am staff found resident on floor states she was rinsing out her ostomy bag and fell. Intervention - resident will be evaluated by	2 830		

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2 830	Continued From page 13 physical therapy. sustained injury to LAU arm; (4) 3/21/16 - 9:36 am-resident was found to be cleaning toilet, fell to floor; first said she was going into bathroom because she had diarrhea. Intervention - resident was offered hospice and she declined; (5) 12/3/15-8:45 pm - told staff she tripped fell to knees, hit her head, neuro checks done, residents room is cluttered per her preference, will encourage to de-clutter; (6) 10/1/15 - 9:45 pm resident fell out of bed, bruise on Left arm did not know how it happened. then said she rolled out of bed. Interventions-independent with mobility continue to monitor; and (7) 8/14/15 -8:15 pm- found on floor at foot of bed, complained of wrist pain, called MD, X-ray of wrist. Intervention-Independent with mobility, sent to emergency room, sprain of right wrist, splinted. No further documentation in the medical record was found nor provided by staff related to the above documented falls. Documentation was lacking to indicate a comprehensive fall assessment had been conducted at the time of each incident related to the fall and therefore no interventions were identified to prevent and/or to minimize the future risk of fall and injury. Interventions were not evaluated to determine their effectiveness and/or the need for revision An interview was conducted with R24's primary physician on 4/21/16 at 1:00 p.m. The Dr. stated that she was not aware of the falls history, and agreed that the medications given at bedtime may be a causal factor and will be subject for further review. During review of the policy titled, Clinical Protocol, dated 10/10;	2 830		

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2 830	Continued From page 14 subtitle: Cause Identification. (1.) For an individual who has fallen, staff will attempt to define possible causes within 24 hours of the fall: a. Causes refer to factors that are associated with or that directly result in a fall; for example, a balance problem caused by an old or recent stroke. b. Often, multiple factors in varying degrees contribute to a falling problem. (2.) If the cause of a fall is unclear, if the fall may have a significant medical cause such as a stroke or an adverse drug reaction (ADR), or if the individual continues to fall despite attempted interventions, a physician will review the situation and help identify contributing causes. a. After more than on fall, the physician should review the resident's gait, balance, and current medications that may be associated with dizziness or falling. b. Many categories of medications, and especially combinations of medications in several of those categories,increase the risk of falling. (3.) The staff and physician will continue to collect and evaluate information until either the cause of the falling is identified or it is determined that the cause cannot be found or that finding a cause would not change the outcome or the management of falling and fall risk. Treatment and management (1.) Based on the proceeding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. a. Examples of such interventions may include calcium and vitamin D supplementation to address osteoporosis, use of hip protectors, addressing medical issues such as hypotension and dizziness, and tapering, discontinuing, or	2 830		

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2 830	Continued From page 15 changing problematic medications (for example, those that could make the resident dizzy or cause blood pressure to drop significantly on standing). (2.) If underlying causes cannot be readily identified or corrected, staff will try various relevant interventions, based on assessment or the nature or category of falling, until falling reduces or stops or until a reason is identified for its continuation (for example, if the individual continues to try to get up and walk without waiting for assistance). SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the assessment process for resident's who experience falls. An audit could be developed to ensure the proper assessment and interventions have been implemented after each resident fall. The results of the audit could be reported to the quality assurance committee during the quarterly meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and	2 900		5/31/16

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2 900	Continued From page 16 B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement interventions to prevent further skin breakdown for 1 of 3 residents (R12) reviewed during closed record and who had pressure ulcers. Findings include: R12 was admitted on 11/10/15. Review of the admission Minimum Data Set (MDS) assessment dated 11/16/15, identified R12 as being at risk for pressure ulcers. No pressure ulcer was identified at this time. Review of the admission initial nursing assessment dated 11/10/15, indicated R12 was transferred with a mechanical lift and needed extensive assistance of staff with bed mobility. No skin issues were identified on this assessment. The admission tissue tolerance observation identified that R12's coccyx area was reddened after sitting for 2 hours. The Braden Scale dated 11/10/15, identified R12 as a mild risk for pressure ulcers. A physical therapy daily treatment note dated 11/13/15, identified that R12 had complained of a sore bottom at which time therapy relieved pressure by standing for one minute. The Braden scale dated 11/18/15, identified R12 as a moderate risk for pressure ulcers. The treatment administration record (TAR) for November 2015, identified that R12's	2 900	Corrected	

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2 900	Continued From page 17 coccyx was to be monitored every evening due to being a high risk for pressure ulcer. The TAR also identified that staff were monitoring right foot scab/healing (unable to determine where on the foot this was) cellulitis until resolved. The nurses progress note dated 11/14/15, identified a nursing order for heel lift boots to be on when in bed due to limited mobility. R12 was admitted to the hospital on 11/19/15, and returned to the facility on 11/24/15. The patient care summary sent with P12 to the hospital from the facility, indicated, "no skin concerns." A hospital progress note dated 11/23/15, identified the presence of an unstagable ulcer to R12's right heel. A skin evaluation completed 11/24/15, identified R12's right heel as sore to touch, peeling and reddened. The Braden Scale completed on 12/2/15, identified a moderate risk for skin breakdown with an open area to the right buttock measuring 0.5 cm by 0.5 cm. and repositioning every 2 hours. The weekly wound evaluation dated 11/25/15, identified right heel pressure ulcer 0.5 cm by 0.5 cm stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed). The treatment plan identified: paint wounds on left toe and right heel with betadine and air dry and elevate heels/boots. Two weekly wound evaluation forms were dated 12/2/15. The form completed at 6:58 a.m. identified a stage 2 pressure ulcer to the right buttocks measuring 0.5 cm by 0.5 cm.. The treatment/plan was identified as Mepilex (a wound care dressing) changed every three days and as needed (PRN). A second weekly wound evaluation for dated 12/2/15, at 3:21 p.m. identified a stage 2 pressure ulcers to the right	2 900		

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2 900	Continued From page 18 heel measuring 0.8 cm by 0.8 cm.; no treatment was identified. Two weekly wound evaluations were noted for 12/9/15; (1) a stage 2 right buttock pressure ulcer measuring 0.8 by 0.8 cm with the treatment plan identified as Mepilex change every 3 days and prn and (2) unstageable right heel pressure ulcer measuring 0.5 cm by 0.5 cm. with the treatment/plan as clean and apply betadine daily. The weekly wound evaluation for 12/16/15, identified a stage 2 pressure ulcer to right buttock measuring 0.5 cm by 0.5 cm and an unstageable pressure ulcer to the right heel measuring 0.1 cm by 0.1 cm. The treatment/plan was: Mepilex changed every 3rd day and prn and betadine to heel daily. The weekly wound evaluation dated 12/27/15, identified a stage 2 pressure ulcer to the left buttock measuring 0.1 cm by 0.1 cm. Treatment plan identifed: barrier cream and reposition every 2 hours. No evaluation of the right heel was evident. The weekly wound evaluation from 12/30/15, identified left buttock pressure ulcer stage 2 0.1 cm by 0.1 cm. Treatment/plan was Mepilex change every 3 days and barrier cream. No assessment related to the heel condition was evident. The weekly wound evaluation from 1/6/16, identified right buttock stage 2 pressure ulcer 0.1 cm by 0.1 cm. Treatment plan: change Mepilex every 3rd day and prn. The weekly wound evaluation from 1/13/16, identified right and left buttock stage 2 pressure	2 900		

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2 900	Continued From page 19 ulcers measuring 0.1 cm by 0.1 cm. Treatment plan: Mepilex change every 3 days and prn and barrier cream. The weekly wound evaluations all indicated: continue current plan of care. The current plan of care did not address any skin issues, the risk for pressure ulcer development and/or the identification of the pressure ulcers. During interview on 4/21/16, at 1:00 p.m. registered nurse (RN)-C stated that heel lift boots were initiated on 11/14/15, as a nursing order due to R12's heels being red and mushy. She stated there should have been documentation regarding the condition of the heels. She verified that the stage 2 ulcer to right buttock had started between 12/1/15 and 12/2/15. She confirmed a treatment of Mepilex was initiated but could not demonstrate in the documentation that any other interventions were implemented to prevent further skin breakdown. RN-C indicated "we put the Mepilex on that's it". She also verified a stage 2 pressure ulcer developed on R12's left buttock on 12/27/15. Mepilex was applied but no additional interventions were developed and/or implemented. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development.	2 900		

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2 900	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure dental services were scheduled with the on-site dental provider for 1 of 3 residents (R9) reviewed for dental services and who requested routine dental services. Findings include: On 4/18/16, at 11:05 a.m. R9 was observed to be missing several upper and lower teeth. The annual Minimum Data Set (MDS) assessment dated 12/3/16, for R9 indicated obvious or likely cavity or broken natural teeth. The Oral/Dental Evaluation dated 12/4/15, indicated several missing teeth, teeth broken or appears to have caries (cavities), and plaque or debris in localized areas (between teeth).	21325	Corrected	5/31/16

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21325	Continued From page 21 R9's IDT (Interdisciplinary team) Care Conference and Quarterly Review dated 12/28/15, indicated the resident would like to see the on-site dentist. When interviewed on 4/21/16, at 9:11 a.m. the director of nursing (DON) stated the process related to on-site dental services was as follows: When a resident reports an interest in dental services the licensed social worker (LSW) is responsible for obtaining a consent. The LSW then would forward the consent to the DON who would fax to the on-site dental provider so the resident could be added to the list for the next on-site dental appointment. DON confirmed the next on-site dental visit was scheduled for 5/11/16. DON provided the Daily Appointments list for 5/11/16 which had been sent by the dental provider. The list also included residents the DON had hand-written onto the sheet received from the provider. The DON stated the residents she had written on the list were residents who had expressed interest and signed a consent but had not shown up on the dental appointment list. The DON would verify with the dental provider to ensure all consents had been completed and thus the residents could be added unto the appointment list. The DON reviewed the Daily Appointments list and confirmed R9 was not on the list. In addition, the DON confirmed there was no evidence a consent for dental services had been signed by R9. She clarified that without a written consent, R9 would not be added to the list of residents to be seen on 5/11/16. The DON then reviewed R9's medical record and confirmed R9 had requested to see the on-site dentist when she attended the 12/28/15 care conference. The DON further confirmed that LSW-A had been present at R9's care conference.	21325		

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21325	Continued From page 22 When interviewed on 4/21/16, at 9:24 a.m. LSW-A confirmed responsibility for obtaining a consent from residents (or responsible party) when they express interest in on-site routine dental services. LSW-A further confirmed a consent for on-site dental services had not been obtained for R9. LSW-A stated it must have gotten missed. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop a system to ensure that routine dental services are provided and/or scheduled upon resident request. Staff could be inservices on the system to ensure proper communication with the on-site dental provider. An audit could be conducted and reported at the quarterly quality assurance committee meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as	21390		5/31/16

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21390	Continued From page 23 defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement infection control policies and procedures for 2 of 2 residents (R5 & R21) who required transmission based precautions. Findings include: R121 was admitted on 4/4/16. R121's admission diagnosis report dated 4/21/16, included sepsis and methicillin resistant staphylococcus aureus (MRSA-a multi-drug resistant organism that can be spread through contact with infectious body fluids or via airborne droplets) infection in the sputum (onset dates 4/4/16). During the initial tour on 4/18/16, at 8:36 a.m. R21 was observed to wear a face mask. No signage was evident in R21's room and/or on the door alerting staff of any special precautions. R5 was admitted to the facility on 4/7/15. R5's	21390	Corrected	

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21390	Continued From page 24 current diagnosis report dated 4/21/16, identified the bacteria methicillin resistant staphylococcus aureus in the urine, with an onset date of 4/7/16. During the initial tour on 4/18/16, at 8:36 a.m. no signage was noted on the door and/or in the room of R5 alerting staff and visitors of any precautions. When interviewed on 4/20/16, at 12:52 p.m. the director of nursing (DON) confirmed R5 and R21 were still infectious and precaution signs should have been posted on the outside of their doors per facility policy to alert staff of the need for additional precautions to prevent the spread of illness. The DON confirmed these signs were not posted until after survey staff completed the initial tour. The DON further indicated the Occupational Health and Learning coordinator was responsible for posting the appropriate signage. The facility policy, entitled Contact Precautions, last revised 1/08 indicated contact precautions will be used in the care of all residents known to be infected with organisms that are transmitted by contact with the patient or contaminated surfaces. An additional policy, entitled Droplet precautions, last revised 1/08 indicated droplet precautions will be used in addition to standard precautions during the care of all residents known or suspected to be infected with organisms that are transmitted by the droplet route when in contact with potentially contaminated surfaces or when working greater than three feet around resident. SUGGESTED METHOD OF CORRECTION: The director of nursing could inservice staff on the importance of posting the appropriate signage to alert staff and visitors of proper precautions. A	21390		

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21390	Continued From page 25 tool could be developed as part of the medical record to alert the appropriate staff of the need to post the appropriate signage. An audit could be developed and the results reported to the quality assurance committee at the quarterly meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		