Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

July 12, 2023

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

RE: CCN: 245516
Cycle Start Date: May 18, 2023

Dear Administrator:

On June 27, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 12, 2023

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

Re: Reinspection Results
Event ID: G04W12

Dear Administrator:

On June 27, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 18, 2023. At this time these correction orders were found corrected.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
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Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

DEPARTMENT OF HEALTH

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June 7, 2023

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

RE: CCN: 245516
Cycle Start Date: May 18, 2023

Dear Administrator:

On May 18, 2023, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by August 18, 2023, (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by November 18, 2023, (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Please contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245516	A. BUILDING _____ B. WING _____	C 05/18/2023

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 On 5/17/23 to 5/18/2023, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H55162127C (MN00093378), H55162244C (MN00091001 and MN00091009), H55162245C (MN00090156). The following complaint was reviewed. H55162239C (MN00093497), with a deficiency issued at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure	F 686		6/16/23

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

Electronically Signed | 06/12/2023

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 686	Continued From page 1 ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly inform the physician of a newly developing pressure ulcer (PU) resulting in a delay of treatment for 1 of 3 residents (R1) who had multiple pressure ulcers. Findings include: R1's electronic medical record (EMR) listed medical diagnoses, when admitted to the facility on 3/23/2023, included multiple sclerosis, paraplegia, a pressure ulcer of the right buttock classified as Unstageable, (defined as a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar), a pressure ulcer of the right hip classified as Stage 3, (defined as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed), cellulitis of the buttock. R1's Minimum Data Set (MDS) dated 3/28/2023, identified R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of	F 686	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿R1 is no longer a resident at Laurels Peak Rehabilitation How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All nurses have been educated on provider notification of new wound areas and securing orders. The facility completed a whole house pressure ulcer audit to insure appropriate interventions are in place. The facility is reviewing all pressure ulcers on a weekly basis Quality Assurance plans to monitor facility	

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F 686	Continued From page 2 13/15. The MDS also identified R1 had a history of urinary incontinence, pressure ulcers, malnutrition, and falling. R1's care plan dated 3/22/23, included the care focus "alteration in skin integrity; pressure injury R [right] buttock Date initiated 3/22/2023. Goals for this issue included skin breakdown will resolve by next review (target 6/22/23) and "resident will remain free from skin breakdown (dated 6/22/2023)." Corresponding interventions dated 3/22/23, included the following: -Reposition at least every 2 hours. R1 able to make major position changes on her own while in bed as well -Monitor skin integrity daily during cares -Monitor skin integrity daily during cares and weekly skin inspection by nurse -Treatment to open areas per order -Weekly measurements and assessment of wound -Monitor for skin breakdown for signs/symptoms of infection and report signs/symptoms to MD or physician assistant (PA)-C -Document on skin condition and keep MD or PA-C informed of changes -Followed by Wound Care There were no entries in the care plan related to an open area discovered over the coccyx on 4/19/2023. . On 4/13/2023, at 3:58 p.m., R1's medical record entry Wound Evaluation Form provided documentation for the two existing wounds. The right buttock wound was described as 2 cm length, 1.7 cm width, and 0.4 cm deep and had a wound bed that was pink with scant drainage and no odor. The second wound on the right hip (1.5 cm length, 1.0 cm width, and 0 depth) was	F 686	performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits 5 times per week for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/16/2023	

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F 686	Continued From page 3 characterized by pink skin without drainage or odor. No other wounds were noted. On 4/19/2023, at 5:03 p.m., R1's Wound Evaluation Form described the two existing wounds that showed improvement since the last assessment. A new third wound was located over the coccyx. The coccyx wound was described as Stage 1 (defined intact skin with a localized area of non-blanchable erythema (redness). The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue pressure injury), the measurements were 3.2 centimeters (cm) length, 2.0 cm width, and 1.5 cm depth and was described as follows, the wound is pink, no drainage or bleeding noted. The form indicated notification of the provider of a new wound was not applicable (NA). New interventions was also marked as NA. There were no additional notes or any indication the physician or wound nurse had been notified. On 4/26/2023, at 4:49 p.m., R1's Wound Evaluation Form described the two previous wounds that were stable. The wound located over the coccyx identified as a Stage 1, measurements were 0.9 cm length, 0.5 cm width, and 1.6 cm depth, wound pink, purulent drainage noted with no odor, tunneling, or signs of infection noted. Further, the form indicated a note was left for the provide, with new interventions planned. There was no indication that new orders or interventions entered into the medical record or care plan for the coccyx wound. A Physicians Communication Memo for Laurels Peak Rehabilitation Center dated 4/26/2023,	F 686		

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F 686	Continued From page 4 written by registered nurse (RN)-A was addressed to Physicians Assistant (PA)-A and dated 4/26/2023. The memo indicated R1 had requested her coccyx area to be checked. R1 was complaining of pain during repositioning. The form was signed by RN-A. Response written by PA-A included she will see R1 for wound care assessment Monday 5/1/2023 and asked R1 be added to her schedule for wound assessment in collaboration with Advanced Practice Registered Nurse (APRN)-A. This entry was signed on 4/27/2023 and countersigned as noted on 4/27/2023 by Nurse Manager (NM)-A. In review of R1's record between 4/26/23 to 4/30/23, there was no indication a physician had evaluated R1's coccyx wound and no treatment orders for the coccyx wound were transcribed in R1's electronic health record (EHR). R1's treatment administration record (TAR) identified no treatment orders for coccyx wound or any wound care or monitoring had been completed. On 5/1/23, a medical record entry from Mayo Health System, Nursing Home Rounding contained a wound assessment for the new wound over the coccyx. The wound assessment described, "coccyx with black eschar - 6.0 cm x 5.0 cm, depth undetermined. Needs debridement. Plan: contact wound care for direction regarding coccyx & buttock wounds." The note was signed by PA-A. The note did not identify treatment orders or dressing changes. In review of R1's record between 5/1/23 to 5/4/23, there was no indication R1's wound had been debrided nor evident R1's coccyx wound was treated and monitored. R1's care plan continued to lack interventions to improve and/or prevent	F 686		

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F 686	Continued From page 5 further deterioration. On 5/5/2023, at 19:45 a.m., the coccygeal wound was debrided by APRN-B after debridement, wound was described as unstageable and the size was described as 13, 18.9 square centimeters. Post debridement orders written by APRN-B for treatment of the coccygeal wound included, to cleanse/flush wound and surrounding skin with acetic acid 0.25%, pat dry. Apply skin prep to peri-wound skin and allow to dry. Apply triad cream or zinc-based barrier cream to pretreat wound edges if they appear macerated or irritated from adhesive. Cut to fit Hydrofera Blue Ready-Transfer. Loosely fill the wound cavity, undermining, sinus tract or tunnel with the dressing. Cover with 4 x 4 Optilock Super Absorbent dressing followed by a 6 x 6 border foam dressing. Change every other day and PRN. These orders were entered as into the physicians orders however, R1 was transported to the Emergency Department at Mankato Hospital for evaluation of respiratory condition before orders were implemented. Interview conducted on 5/17/2023, at 4:10 p.m. with nurse manager (NM)-A. NM-A stated she attended a treatment conference for R1 which was held in March, shortly after R1 was admitted to the facility. NM-A stated she did not know when the wound on the coccyx appeared. She did not recall the coccyx wound being discussed by staff and there were no entries pertaining to a coccygeal wound in the progress notes. NM-A stated she was not aware of the new coccygeal wound until after R1 was discharged and called to complain about care. NM-A described the process instituted when or if a new wound appeared on a resident. NM-A stated the "MHM	F 686		

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F 686	Continued From page 6 Wound Evaluation Form" is completed and entered as part of the resident's medical record. The wound should be measured and documented, and the provider updated. The provider is updated by placing a completed "Physicians Communication Memo for Laurels Peak Rehabilitation Center" in a folder specifically used to communicate with that specific provider. The provider would review, see the resident, and write new orders. These orders are entered into the medical record, new care orders would be instituted, and the resident's care plan is updated. NM-A stated she could not locate a completed "Physicians Communication Memo for Laurels Peak Rehabilitation Center" for 4/19/2023 but did offer the memo dated 4/26/2023. NM-A could not explain why there was no memo for 4/19/2023, and added she was not aware of this type of incident occurring prior to this incident. Interview conducted on 5/18/2023, at 9:13 a.m. with PA-A who stated she was notified of a new wound via the Physicians Communication Memo dated 4/26/2023. Stated she assessed the wound on 5/1/2023, and determined it needed debridement. PA-A described the wound as being covered in black eschar tissue and unstageable. PA-A stated she contacted APRN-A who agreed R1 needed to be seen earlier than R1's next appointment. R1 agreed to work with the in-house provider from Mankato Clinic, APRN-B. R1 was seen by APRN-B who assessed all three wounds and debrided the coccygeal wound on 5/4/2023. Interview on 5/18/2023, at 10:27 a.m. with RN-A stated on 4/19/2023, she recalls noticing a reddened area over R1's coccyx as she was doing wound care. Stated R1 complained of pain over the area. RN-A stated she completed the	F 686		

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F 686	Continued From page 7 wound evaluation form and placed in the medical record. Stated the Physicians Communication Memo was also completed and placed in the communication book for PA-A. RN-A stated she did not recall passing the information on to anyone else. RN-A stated she did not follow up as she was not scheduled to work on the unit again for a while. Interview on 5/18/2023, at 11:40 a.m., the Director of Nursing (DON) stated if a resident was discovered to have a new lesion or pressure sore, the facility policy would be followed. One of the steps would be to notify provider by completing the Physicians Communication Memo and placing it in the providers communication book where they will see it. Depending on circumstances, if the wound was serious, the provider was expected to be notified sooner. The provider evaluates the wound and writes orders. Staff would be expected to call the provider if emergent, otherwise, the Physicians Communication Memo form is used. DON stated she has no idea what could have happened to the form from 4/19/2023, that was supposedly placed in the communication book. Providers have their own binders allowing direct communication with them. PA-A comes to the facility twice a week, this has been an efficient means of communication. Asked when the care plan would be updated, DON stated if it was a new area, the nurse manager should enter the assessment and ordered care into the care plan. DON expected the interventions to be entered into the care plan after the provider writes orders. Policy: "Skin Assessment and Wound Management, revised on 2/10/2023." The section entitled Pressure Wounds indicated: "When a	F 686		

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F 686	Continued From page 8 pressure ulcer is identified, the following actions will be taken: 1. notify MD/Treatment ordered, 2. notify resident representative, 3. complete education with resident/resident representative including risks & benefits, 4. initiate weekly wound evaluation, 5. notify nurse manager/wound nurse, 6. referral to dietary, if appropriate, 7. referral to therapies, appropriate, 8. update care plan, 9. update resident care lists, 10. update care plan to identify risks for skin breakdown.	F 686		

Electronically delivered

June 7, 2023

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

Re: State Nursing Home Licensing Orders
Event ID: G04W11

Dear Administrator:

The above facility was surveyed on May 17, 2023, through May 18, 2023, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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 immediately contact:

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 contact me with any questions regarding this letter.

Sincerely,

Lori Hagen, Compliance Analyst
Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4306
E-Mail: Lori.Hagen@state.mn.us

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 _____	C 05/18/2023

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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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: On 5/1723 to 5/18/2023, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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

Electronically Signed | 06/12/23

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed with no deficiency issued. H55162127C (MN00093378), H55162244C (MN00091001 and MN00091009), H55162245C (MN00090156). The following complaint was reviewed. H55162239C (MN00093497) with a licensing order issued at ST0900 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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 <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
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 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 to complete a comprehensive pressure ulcer (PU) assessment and implement interventions to prevent additional PU from developing for 1 of 3 residents (R1) who had multiple pressure ulcers. This resulted in actual harm when R1's developed a new PU on their coccyx that required surgical debridement. Findings include:	2 900	Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿R1 is no longer a resident at Laurels Peak Rehabilitation	6/16/23

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2 900	Continued From page 3 R1's electronic medical record (EMR) listed medical diagnoses, when admitted to the facility on 3/23/2023, included multiple sclerosis, paraplegia, a pressure ulcer of the right buttock classified as Unstageable, (defined as a full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar), a pressure ulcer of the right hip classified as Stage 3, (defined as full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible but does not obscure the depth of tissue loss. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed), cellulitis of the buttock. R1's Minimum Data Set (MDS) dated 3/28/2023, identified R1 was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13/15. The MDS also identified R1 had a history of urinary incontinence, pressure ulcers, malnutrition, and falling. R1's care plan dated 3/22/23, included the care focus "alteration in skin integrity; pressure injury R [right] buttock Date initiated 3/22/2023. Goals for this issue included skin breakdown will resolve by next review (target 6/22/23) and "resident will remain free from skin breakdown (dated 6/22/2023)." Corresponding interventions dated 3/22/23, included the following: -Reposition at least every 2 hours. R1 able to make major position changes on her own while in bed as well -Monitor skin integrity daily during cares -Monitor skin integrity daily during cares and weekly skin inspection by nurse	2 900	How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: All nurses have been educated on provider notification of new wound areas and securing orders. The facility completed a whole house pressure ulcer audit to insure appropriate interventions are in place. The facility is reviewing all pressure ulcers on a weekly basis Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits 5 times per week for 2 weeks as needed to monitor f¿r compliance. Completion date: 6/16/2023	

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2 900	Continued From page 4 -Treatment to open areas per order -Weekly measurements and assessment of wound -Monitor for skin breakdown for signs/symptoms of infection and report signs/symptoms to MD or physician assistant (PA)-C -Document on skin condition and keep MD or PA-C informed of changes -Followed by Wound Care There were no entries in the care plan related to an open area discovered over the coccyx on 4/19/2023. . On 4/13/2023, at 3:58 p.m., R1's medical record entry Wound Evaluation Form provided documentation for the two existing wounds. The right buttock wound was described as 2 cm length, 1.7 cm width, and 0.4 cm deep and had a wound bed that was pink with scant drainage and no odor. The second wound on the right hip (1.5 cm length, 1.0 cm width, and 0 depth) was characterized by pink skin without drainage or odor. No other wounds were noted. On 4/19/2023, at 5:03 p.m., R1's Wound Evaluation Form described the two existing wounds that showed improvement since the last assessment. A new third wound was located over the coccyx. The coccyx wound was described as Stage 1 (defined intact skin with a localized area of non-blanchable erythema (redness). The presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes of intact skin may also indicate a deep tissue pressure injury), the measurements were 3.2 centimeters (cm) length, 2.0 cm width, and 1.5 cm depth and was described as follows, the wound is pink, no drainage or bleeding noted. The form indicated notification of the provider of a new wound was	2 900		

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2 900	Continued From page 5 not applicable (NA). New interventions was also marked as NA. There were no additional notes or any indication the physician or wound nurse had been notified. On 4/26/2023, at 4:49 p.m., R1's Wound Evaluation Form described the two previous wounds that were stable. The wound located over the coccyx identified as a Stage 1, measurements were 0.9 cm length, 0.5 cm width, and 1.6 cm depth, wound pink, purulent drainage noted with no odor, tunneling, or signs of infection noted. Further, the form indicated a note was left for the provide, with new interventions planned. There was no indication that new orders or interventions entered into the medical record or care plan for the coccyx wound. A Physicians Communication Memo for Laurels Peak Rehabilitation Center dated 4/26/2023, written by registered nurse (RN)-A was addressed to Physicians Assistant (PA)-A and dated 4/26/2023. The memo indicated R1 had requested her coccyx area to be checked. R1 was complaining of pain during repositioning. The form was signed by RN-A. Response written by PA-A included she will see R1 for wound care assessment Monday 5/1/2023 and asked R1 be added to her schedule for wound assessment in collaboration with Advanced Practice Registered Nurse (APRN)-A. This entry was signed on 4/27/2023 and countersigned as noted on 4/27/2023 by Nurse Manager (NM)-A. In review of R1's record between 4/26/23 to 4/30/23, there was no indication a physician had evaluated R1's coccyx wound and no treatment orders for the coccyx wound were transcribed in R1's electronic health record (EHR). R1's treatment administration record (TAR) identified	2 900		

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2 900	Continued From page 6 no treatment orders for coccyx wound or any wound care or monitoring had been completed. On 5/1/23, a medical record entry from Mayo Health System, Nursing Home Rounding contained a wound assessment for the new wound over the coccyx. The wound assessment described, "coccyx with black eschar - 6.0 cm x 5.0 cm, depth undetermined. Needs debridement. Plan: contact wound care for direction regarding coccyx & buttock wounds." The note was signed by PA-A. The note did not identify treatment orders or dressing changes. In review of R1's record between 5/1/23 to 5/4/23, there was no indication R1's wound had been debrided nor evident R1's coccyx wound was treated and monitored. R1's care plan continued to lack interventions to improve and/or prevent further deterioration. On 5/5/2023, at 19:45 a.m., the coccygeal wound was debrided by APRN-B after debridement, wound was described as unstageable and the size was described as 13, 18.9 square centimeters. Post debridement orders written by APRN-B for treatment of the coccygeal wound included, to cleanse/flush wound and surrounding skin with acetic acid 0.25%, pat dry. Apply skin prep to peri-wound skin and allow to dry. Apply triad cream or zinc-based barrier cream to pretreat wound edges if they appear macerated or irritated from adhesive. Cut to fit Hydrofera Blue Ready-Transfer. Loosely fill the wound cavity, undermining, sinus tract or tunnel with the dressing. Cover with 4 x 4 Optilock Super Absorbent dressing followed by a 6 x 6 border foam dressing. Change every other day and PRN. These orders were entered as into the physicians orders however, R1 was transported to the	2 900		

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2 900	Continued From page 7 Emergency Department at Mankato Hospital for evaluation of respiratory condition before orders were implemented. Interview conducted on 5/17/2023, at 4:10 p.m. with nurse manager (NM)-A. NM-A stated she attended a treatment conference for R1 which was held in March, shortly after R1 was admitted to the facility. NM-A stated she did not know when the wound on the coccyx appeared. She did not recall the coccyx wound being discussed by staff and there were no entries pertaining to a coccygeal wound in the progress notes. NM-A stated she was not aware of the new coccygeal wound until after R1 was discharged and called to complain about care. NM-A described the process instituted when or if a new wound appeared on a resident. NM-A stated the "MHM Wound Evaluation Form" is completed and entered as part of the resident's medical record. The wound should be measured and documented, and the provider updated. The provider is updated by placing a completed "Physicians Communication Memo for Laurels Peak Rehabilitation Center" in a folder specifically used to communicate with that specific provider. The provider would review, see the resident, and write new orders. These orders are entered into the medical record, new care orders would be instituted, and the resident's care plan is updated. NM-A stated she could not locate a completed "Physicians Communication Memo for Laurels Peak Rehabilitation Center" for 4/19/2023 but did offer the memo dated 4/26/2023. NM-A could not explain why there was no memo for 4/19/2023, and added she was not aware of this type of incident occurring prior to this incident. Interview conducted on 5/18/2023, at 9:13 a.m. with PA-A who stated she was notified of a new	2 900		

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2 900	Continued From page 8 wound via the Physicians Communication Memo dated 4/26/2023. Stated she assessed the wound on 5/1/2023, and determined it needed debridement. PA-A described the wound as being covered in black eschar tissue and unstageable. PA-A stated she contacted APRN-A who agreed R1 needed to be seen earlier than R1's next appointment. R1 agreed to work with the in-house provider from Mankato Clinic, APRN-B. R1 was seen by APRN-B who assessed all three wounds and debrided the coccygeal wound on 5/4/2023. Interview on 5/18/2023, at 10:27 a.m. with RN-A stated on 4/19/2023, she recalls noticing a reddened area over R1's coccyx as she was doing wound care. Stated R1 complained of pain over the area. RN-A stated she completed the wound evaluation form and placed in the medical record. Stated the Physicians Communication Memo was also completed and placed in the communication book for PA-A. RN-A stated she did not recall passing the information on to anyone else. RN-A stated she did not follow up as she was not scheduled to work on the unit again for a while. Interview on 5/18/2023, at 11:40 a.m., the Director of Nursing (DON) stated if a resident was discovered to have a new lesion or pressure sore, the facility policy would be followed. One of the steps would be to notify provider by completing the Physicians Communication Memo and placing it in the providers communication book where they will see it. Depending on circumstances, if the wound was serious, the provider was expected to be notified sooner. The provider evaluates the wound and writes orders. Staff would be expected to call the provider if emergent, otherwise, the Physicians Communication Memo form is used. DON stated	2 900		

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2 900	Continued From page 9 she has no idea what could have happened to the form from 4/19/2023, that was supposedly placed in the communication book. Providers have their own binders allowing direct communication with them. PA-A comes to the facility twice a week, this has been an efficient means of communication. Asked when the care plan would be updated, DON stated if it was a new area, the nurse manager should enter the assessment and ordered care into the care plan. DON expected the interventions to be entered into the care plan after the provider writes orders. Policy: "Skin Assessment and Wound Management, revised on 2/10/2023." The section entitled Pressure Wounds indicated: "When a pressure ulcer is identified, the following actions will be taken: 1. notify MD/Treatment ordered, 2. notify resident representative, 3. complete education with resident/resident representative including risks & benefits, 4. initiate weekly wound evaluation, 5. notify nurse manager/wound nurse, 6. referral to dietary, if appropriate, 7. referral to therapies, appropriate, 8. update care plan, 9. update resident care lists, 10. update care plan to identify risks for skin breakdown. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designated person to determine how the deficiency occurred, review policies and procedures, revise as necessary, educated staff on revisions, and monitor to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 900		