Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 7, 2025

Administrator
Laurels Peak Care & Rehabilitation Center
700 JAMES AVENUE
MANKATO, MN 56001

RE: CCN: 245516
Cycle Start Date: May 16, 2025

Dear Administrator:

On June 23, 2025, we notified you a remedy was imposed. On July 15, 2025 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 9, 2025.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 16, 2025 did not go into effect. (42 CFR 488.417 (b))

In our letter of June 23, 2025, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2025 due to denial of payment for new admissions. Since your facility attained substantial compliance on July 9, 2025, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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August 7, 2025

Administrator
Laurels Peak Care & Rehabilitation Center

700 JAMES AVENUE
MANKATO, MN 56001

Re: Reinspection Results
Event ID: 15HW12 and J5KF-H2

Dear Administrator:

On June 17, 2025 and July 15, 2025 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 surveys completed on May 16, 2025 and June 11, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 29, 2025

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

RE: CCN: 245516
Cycle Start Date: May 16, 2020

Dear Administrator:

On May 16, 2025, 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 16, 2025 (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 16, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections

488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

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

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

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

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245516	A. BUILDING _____ B. WING _____	C 05/16/2025

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 5/15/25 and 5/16/25, 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 complaint was reviewed: H55164807C (MN00113041) with an incidental deficiency cited at F760. 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 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to clarify medication orders for 1 of 3 residents (R3) reviewed for medication errors. Findings include: R3's undated Face Sheet indicated diagnoses of	F 760	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other	6/12/25

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

Electronically Signed | 06/05/2025

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 760	Continued From page 1 malignant neoplasm of prostate (prostate cancer), permanent atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the heart), and diabetes. R3's Medicare Part A Discharge Minimum Data Set (MDS) dated 4/14/25, indicated R1 had intact cognition, and had diagnoses of cancer, end stage renal disease (ESRD), and diabetes. R1 received anticoagulants (blood thinners). R3's progress note dated 3/29/25 at 2:11 a.m., indicated R3 was sent to the emergency department (ED) via ambulance for gross hematuria. R3's progress note dated 3/29/25 at 11:36 a.m., indicated R3 returned to facility around 9:40 a.m. R3 was tired and if there was blood in his urine, to give it a few hours and push water to try to flush his bladder. If urine was to remain significantly bloody or if he developed large clots or had difficulty urinating, R3 was to return to the ED. There were no changes in his medication. R3's hospital After Visit Summary (AVS) dated 3/29/25, directed R3 to follow up with his primary care provider (PCP) and urologist. R3 was to stop taking his blood thinner as instructed, and if he developed further blood in his urine, to wait a few hours and drink lots of water to try to flush his bladder on his own. If his urine remained significantly bloody or he develop large clots or difficulty urinating, he was to return to the ED. R3's medication administration records (MAR) dated March and April 2025 indicated from March 29 through April 8, R1 received rivaroxaban (Xarelto, a blood thinner), daily for 11 days after it	F 760	individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. How corrective action will be accomplished for those residents found to have been affected by the deficient practice¿ R3 no longer resides at the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice will not recur¿ All residents who have returned from the ER have the potential to be affected. What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur¿	

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F 760	Continued From page 2 was instructed to be held. R3's ED Visit Record dated 3/29/25, indicated R3 was seen in the ED for blood in urine. R3 had history of bladder cancer. R3 was in the hospital for gross hematuria from 3/23/35 through 3/28/25, was treated with continuouss bladder irrigation (CBI) and received a blood transfusion. R3 returned to the ED for gross hematuria once again, and was passing clots. R3 was discontinued off of his anticoagulation upon discharge yesterday. R3's Physician Visit dated 4/2/25, indicated R3 was seen for post-hospital follow up. R3 occasionally had some blood in his urine, but it was not consistent. Per R3's physician's assessment and plan for atrial fibrillation, R3 was on Xarelto 15 milligrams (mg) daily by mouth. R3 was to follow with urology for his hematuria. Medications reviewed at this visit listed rivaroxaban 15 mg by mouth for atrial fibrillation as active. R3's AVS dated 4/9/25, indicated for R3 to hold/pause his rivaroxaban 15 mg until 4/11/25. R3's Provider Visit dated 4/23/25, indicated medications reviewed at this visit were rivaroxaban 15 mg daily, but not taking reported 4/22/25: however, the order remained active. Per physician's assessment and plan for hematuria, continue to follow urology related to metastatic prostate cancer. R3's treatment administration record (TAR) dated March and April 2025 indicated a treatment was entered to monitor R2's urine each shift for blood and clots. R3's March 2025 TAR reviewed from	F 760	A full house audit was completed on all residents who have returned from the ER since 05/01/25. Reviewed Monarch's Medication and Treatment Orders policy, facility process, and expectation for medication reconciliation and clarification of discrepancies. Nurses and Health Information Manager received education on Monarch's Medication and Treatment Orders policy, facility expectations for ensuring medication orders have been reconciled and that any discrepancies are appropriately clarified. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur Director of Nursing or designee will conduct random audits of residents who have returned from the ER to ensure medication orders have been reconciled and any discrepancies were appropriately clarified two (2) times per week for three (3) weeks; one (1) time per week for (2) weeks; and monthly thereafter for two (2) months. Audit results will be reviewed at QAPI. Any deficient practice will be identified and corrected at the time of occurrence. -Corrective action will be completed on or before 06/12/25.	

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F 760	Continued From page 3 March 29 evening shift through March 31, 2025, indicated 2 out of 8 shifts with blood in his urine. April 2025 TAR indicated from April 1, 2025 to April 9, 2025, R3 had 11 shift out of 25 shifts with blood in his urine. During an interview on 5/16/25 at 12:26 p.m., registered nurse (RN)-A stated she was the nurse working when R3 returned from the ED on 3/29/25. RN-A received a nurse-to-nurse call stating R3 was returning to facility with no medication changes. R3 returned to the facility with AVS indicating to not take blood thinners as he was instructed. RN-A stated because it was still listed as an active medication and she was told no medication changes, that meant no medication changes. She did not clarify the order because the hospital nurse said he had no medication changes and the blood thinner still listed as an active medication. During an interview on 5/16/25 at 10:19 a.m., the director of nursing (DON) stated as the AVS still contained an active order for rivaroxaban and RN-A received a nurse-to-nurse call indicating no medication changes, RN-A had put in an order to monitor R3's urine for blood and large blood clots, and to return to the ED if continued. During an interview on 5/16/25 at 1:54 p.m., medical doctor (MD)-A verified RN-A should have called back to ED to verify the rivaroxaban order. MD-A also stated the section for instructions had to be written in by the physician, and the medications are not always changed as then they are removed from the list and easily forgotten. Nursing staff are to put them on hold or pause. RN-A should have called for clarification of order, as the continued use of this medication could	F 760		

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

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F 760	Continued From page 4 have led to R3's continued hematuria. The facility policy Medication and Treatment Orders dated 2/2024, directed medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.	F 760		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 29, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: 15HW11

Dear Administrator:

The above facility was surveyed on May 15, 2025 through May 16, 2025 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:

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00035	A. BUILDING: _____ B. WING _____	C 05/16/2025

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: On5/15/25 and 5/16/25, 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 orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55164807C (MN00113041) with a licensing order issued at 1545. 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 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	2 000		

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	00035	A. BUILDING: _____ B. WING _____	C 05/16/2025

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	Continued From page 2 state form. 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.	2 000		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the	21545		6/5/25

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21545	Continued From page 3 physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to clarify medication orders for 1 of 3 residents (R3) reviewed for medication errors. Findings include: R3's undated Face Sheet indicated diagnoses of malignant neoplasm of prostate (prostate cancer), permanent atrial fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the heart), and diabetes. R3's Medicare Part A Discharge Minimum Data Set (MDS) dated 4/14/25, indicated R1 had intact cognition, and had diagnoses of cancer, end stage renal disease (ESRD), and diabetes. R1 received anticoagulants (blood thinners). R3's progress note dated 3/29/25 at 2:11 a.m., indicated R3 was sent to the emergency department (ED) via ambulance for gross hematuria.	21545	Corrected.	

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21545	Continued From page 4 R3's progress note dated 3/29/25 at 11:36 a.m., indicated R3 returned to facility around 9:40 a.m. R3 was tired and if there was blood in his urine, to give it a few hours and push water to try to flush his bladder. If urine was to remain significantly bloody or if he developed large clots or had difficulty urinating, R3 was to return to the ED. There were no changes in his medication. R3's hospital After Visit Summary (AVS) dated 3/29/25, directed R3 to follow up with his primary care provider (PCP) and urologist. R3 was to stop taking his blood thinner as instructed, and if he developed further blood in his urine, to wait a few hours and drink lots of water to try to flush his bladder on his own. If his urine remained significantly bloody or he develop large clots or difficulty urinating, he was to return to the ED. R3's medication administration records (MAR) dated March and April 2025 indicated from March 29 through April 8, R1 received rivaroxaban (Xarelto, a blood thinner), daily for 11 days after it was instructed to be held. R3's ED Visit Record dated 3/29/25, indicated R3 was seen in the ED for blood in urine. R3 had history of bladder cancer. R3 was in the hospital for gross hematuria from 3/23/35 through 3/28/25, was treated with continuouss bladder irrigation (CBI) and received a blood transfusion. R3 returned to the ED for gross hematuria once again, and was passing clots. R3 was discontinued off of his anticoagulation upon discharge yesterday. R3's Physician Visit dated 4/2/25, indicated R3 was seen for post-hospital follow up. R3 occasionally had some blood in his urine, but it	21545		

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21545	Continued From page 5 was not consistent. Per R3's physician's assessment and plan for atrial fibrillation, R3 was on Xarelto 15 milligrams (mg) daily by mouth. R3 was to follow with urology for his hematuria. Medications reviewed at this visit listed rivaroxaban 15 mg by mouth for atrial fibrillation as active. R3's AVS dated 4/9/25, indicated for R3 to hold/pause his rivaroxaban 15 mg until 4/11/25. R3's Provider Visit dated 4/23/25, indicated medications reviewed at this visit were rivaroxaban 15 mg daily, but not taking reported 4/22/25: however, the order remained active. Per physician's assessment and plan for hematuria, continue to follow urology related to metastatic prostate cancer. R3's treatment administration record (TAR) dated March and April 2025 indicated a treatment was entered to monitor R2's urine each shift for blood and clots. R3's March 2025 TAR reviewed from March 29 evening shift through March 31, 2025, indicated 2 out of 8 shifts with blood in his urine. April 2025 TAR indicated from April 1, 2025 to April 9, 2025, R3 had 11 shift out of 25 shifts with blood in his urine. During an interview on 5/16/25 at 12:26 p.m., registered nurse (RN)-A stated she was the nurse working when R3 returned from the ED on 3/29/25. RN-A received a nurse-to-nurse call stating R3 was returning to facility with no medication changes. R3 returned to the facility with AVS indicating to not take blood thinners as he was instructed. RN-A stated because it was still listed as an active medication and she was told no medication changes, that meant no medication changes. She did not clarify the order	21545		

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21545	Continued From page 6 because the hospital nurse said he had no medication changes and the blood thinner still listed as an active medication. During an interview on 5/16/25 at 10:19 a.m., the director of nursing (DON) stated as the AVS still contained an active order for rivaroxaban and RN-A received a nurse-to-nurse call indicating no medication changes, RN-A had put in an order to monitor R3's urine for blood and large blood clots, and to return to the ED if continued. During an interview on 5/16/25 at 1:54 p.m., medical doctor (MD)-A verified RN-A should have called back to ED to verify the rivaroxaban order. MD-A also stated the section for instructions had to be written in by the physician, and the medications are not always changed as then they are removed from the list and easily forgotten. Nursing staff are to put them on hold or pause. RN-A should have called for clarification of order, as the continued use of this medication could have led to R3's continued hematuria. The facility policy Medication and Treatment Orders dated 2/2024, directed medication shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to medication errors. The DON or designee could educate staff to ensure medications are correctly administered, which may include, but is not limited to, the need for verifying orders and accurately transcribing. The DON or designee should review processes to ensure the	21545		

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21545	Continued From page 7 pharmacist begins or maintains appropriate oversight of the medication administration process. The DON or designee could develop a system to verify compliance, such as auditing medication administration and or medical records for specific amount of days x14, then weekly x 4, then monthly x 6, to gather appropriate data to ensure staff have corrected the concern or if further education would be required. Results of any actions and/or audits should be taken to the QAPI committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21545		