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 Therefore, the NATCEP prohibition is rescinded.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

Electronically delivered

June 23, 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 May 29, 2025, we informed you that we may impose enforcement remedies.

On June 11, 2025, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 16, 2025

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective August 16, 2025. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 16, 2025.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by August 16, 2025, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Laurels Peak Care & Rehabilitation Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 16, 2025. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

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 November 16, 2025 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

tamika.brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

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 06/11/2025

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 6/10/25 through 6/11/25, 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 H55165987C(MN113454), H55166544C(MN113667). with a deficiency cited at F641 and F740. 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.	F 641		7/9/25

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

Electronically Signed | 07/02/2025

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 641	Continued From page 1 §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) 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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interviews and document review the facility failed to accurately document a resident's verbal and physical abuse towards staff, and rejection of cares for 1 of 3 residents (R2) reviewed when the Minimum Data Set (MDS) indicated the resident did not have any behaviors or rejection of cares during an evaluation period over seven days. The nursing progress notes for the same period documented daily rejections of care and yelling at staff when they tried to provide hygiene and incontinent care. Findings include: R2's nursing progress notes during the evaluation period dated from 2/27/25 through 3/6/25, indicated she refused the following: medication, walk, brush her hair, change soiled clothing, and bed linen, shower, and housekeeping services.	F 641	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 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	

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F 641	Continued From page 2 R2's annual MDS dated 3/6/25, indicated she had moderate impaired cognition and dementia. She was unable to move the right side of her body or communicate her thoughts and feelings after a stroke leading to worsening anxiety and depression. She required staff assistance to dress, shower, brush her hair, and provide incontinent care. There were no incidents of verbal or physical abuse towards staff or refusing care during the seven-day evaluation period. Her evaluation identified care areas of concern for cognitive impairment, communication, activities of daily living, psychosocial wellbeing, falls, nutrition, and psychotropic medication use. During an interview on 6/10/25 at 2:13 p.m., social worker (SW)-A stated anytime a patient shows behaviors such as rejecting care, verbally and physically abusive towards staff should be documented in the MDS to receive full reimbursement for the services provided. Requested policy how to complete an MDS, it was not provided.	F 641	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. R2's MDS has been corrected to appropriately reflect residents behaviors. All residents MDS' have been reviewed to ensure behaviors are appropriately documented. A full house audit was completed on all residents MDS' regarding behaviors. Education provided to Social Services and MDS Coordinator on appropriately documenting residents behaviors in an MDS. Administrator or designee will conduct random audits of residents MDS' two (2) times per week for three (3) weeks; one (1) time per week for (2) weeks; and monthly thereafter for one (1) month. 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 07/09/2025.	
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must	F 740		7/9/25

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F 740	Continued From page 3 provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: The facility failed to develop and revise a person centered behavior care plan, document the risk verse benefit associated with refusing care, identify root cause analysis, and determine what triggered her anxiety and agitation, and provide ordered psychiatric follow up care for 1 of 3 residents (R2) reviewed, when she was found to have maggots on her body because she refused to accept help to change soiled clothing and bed linen, and let housekeeping clean her room. Findings include: R2's initial admission care plan dated 2/10/23, indicated cognition deficit, unable to communicate her thoughts and needs, history of refusing care and becoming agitated when approached. She required the assistance from one person to dress, bath, incontinent care and brush her hair. Mood and behavior interventions included being alert to any changes in her mood, monitor and document her behaviors, and give medication as ordered by the doctor. The interventions were renewed during quarterly and annual assessments and no other interventions were developed. R2's care plan dated 9/8/23, indicated her inability to express her needs and her impaired cognition	F 740	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 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.	

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F 740	Continued From page 4 affected her behaviors. Interventions remained unchanged and no other interventions were developed. R2's psychiatric appointment dated 2/19/25, indicated her daughter reported in the fall of 2024 she was started on a low anti-anxiety medication to help with her frustration. She was started on sertraline for her irritability and anxiety. Staff instructed to monitor her response to the new medication over the next month. Schedule a follow up appointment in one month to assess the effectiveness of the medication and make any necessary adjustments. R2's care plan dated 2/26/25, developed after her appointment with the psychologist on 2/19/25, indicated interventions included monitoring for adverse drug reactions and update the medical provider as needed. The ordered one month follow up appointment to assess medication changes was not listed. R2's medical doctor (MD) dated 3/27/25, indicated her continued refusals to change urine soaked linen and clothing, refusing daily hygiene and showers is becoming a health hazard. Continue to work with psychologist to develop strategies and ideas to improve behavior and communication. R2's nurse practitioner (NP)-A dated 4/24/25, indicated her last virtual visit with the psychiatrist was 4/24/25 when Sertraline was started. Requested the psychiatrist's note but facility was unable to provide. NP-A documented there was a strong odor of urine during her visit. NP's plan of care included staff to provide incontinent care and keep her room clean.	F 740	R2's care plan has been updated to reflect residents mood and behavior, including refusal of cares and acting out towards staff. R2 or family representative have been offered psychologist services. Education will be provided to R2 or family representative regarding refusal of cares. All residents with behaviors care plans have been reviewed and updated. A full house audit was completed on all residents behavioral care plans. Education provided to the social services and nursing department on care planning residents behaviors. Director of Nursing or designee will conduct random audits of residents behavioral care plans one (1) times per week for three (3) 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 07/09/2025.	

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F 740	Continued From page 5 R2's NP note dated 5/29/25, indicated she was seen by a psychiatrist in February and started on sertraline because the resident refused bathing and incontinent care. She was supposed to have a follow up appointment in one month, but staff held off scheduling it hoping to find a different placement for the resident. Alternative placement had been difficult and instructed staff to make an appointment to see the psychologist. R2's MD note dated 5/29/25, indicated she had an appointment on 2/19/25, and sertraline was started. She was supposed to have a follow up appointment in one month, but staff held off scheduling the appointment hoping to find alternative placement. Nurse manager will make a follow up appointment. R2's MD note dated 6/2/25, indicated she refused bathing and during wound care they found maggots in her folds. Staff questioned if they could premedicate her with anxiety medication to decrease anxiety levels. MD gave a new order for Ativan to be given 30 to 60 minutes before showering. R2's interdisciplinary team (IDT) note dated 6/9/25, indicated she continued to be incontinent of urine and refused staff assistance. Staff offered incontinent care and supplies every two hours without improvement in behaviors. During a medical record review on 6/10/25 at 2:35 p.m., requested risk verse benefit assessments but no records were provided. During an interview on 6/10/25 at 12:44 p.m., the receptionist at the Department of Psychiatric and	F 740		

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F 740	Continued From page 6	F 740		

Psychology confirmed R2 had appointment scheduled for next week. The appointment was initiated on 6/3/25.

During an interview on 6/10/25 at 1:40 p.m., family member (FM)-A stated the facility was unable to provide the neurological care her mother needed after her stroke. She stated a few months ago the facility started to look for a new placement to deal with her neurological conditions and behaviors. The facility would call her and her brother when R2 refused care. She said the facility had tried alternative approaches to resolve her behaviors including alternative communication devices. Their efforts have only escalated the behaviors and the reason they wanted her transfer to a different facility better suited for stroke patients. She denied telling the facility not to schedule the one month follow up psychologist and wanted her mother's medication reviewed. Her mother never wants the lights on in the room.

During an interview on 6/11/25 at 1:04 p.m., director of nursing (DON) stated R2 had resided at the facility for a while and had a history of refusing cares, brushing her hair, and bathing. Some staff has better luck getting her to agree to cares. They try to have consistent staffing for her. In the last few weeks if she refused to let the NA help her, the nurse would reapproach. She felt that they are moving in the right direction and the floor manager checks on her often. She stated they did not set up the initial follow up appointment with the psychologist because the family indicated they wanted to hold off until they found alternative placement.

Care Planning Policy dated 11/24, indicated each

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 06/11/2025

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 740	Continued From page 7 resident had a person-centered care plan developed by all team members to identify medical, physical, psychosocial, and functional needs. Nursing staff we will review patient rights, identify problem areas, and develop interventions specific and meaningful to the patient. Dementia Training not dated involved care for dementia patients, abuse and neglect topics associated with dementia. Interventions include identifying environmental factors and analyze the behaviors. Challenging behaviors involve identifying common triggers, develop strategies to minimize the behaviors associated with dementia including communication techniques, and recognize caregiver stress.	F 740		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2025

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

Re: State Nursing Home Licensing Orders
Event ID: J5KF11

Dear Administrator:

The above facility was surveyed on June 10, 2025 through June 11, 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
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 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 06/11/2025

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) COMPLETE DATE
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 6/10/25 through 6/11/25, 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		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed: H55165987C(MN113454), H55166544C(MN113667) with a licensing order issued at ST0550. 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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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		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interviews and document review the facility failed to accurately document a resident's verbal and physical abuse towards staff, and rejection of cares for 1 of 3 residents (R2) reviewed when the Minimum Data Set (MDS) indicated the resident did not have any behaviors or rejection of cares during an evaluation period over seven days. The nursing progress notes for the same period documented daily rejections of care and yelling at staff when they tried to provide hygiene and incontinent care. Findings include: R2's nursing progress notes during the evaluation period dated from 2/27/25 through 3/6/25, indicated she refused the following: medication, walk, brush her hair, change soiled clothing, and bed linen, shower, and housekeeping services.	2 550	Corrected	7/9/25

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2 550	Continued From page 3 R2's annual MDS dated 3/6/25, indicated she had moderate impaired cognition and dementia. She was unable to move the right side of her body or communicate her thoughts and feelings after a stroke leading to worsening anxiety and depression. She required staff assistance to dress, shower, brush her hair, and provide incontinent care. There were no incidents of verbal or physical abuse towards staff or refusing care during the seven-day evaluation period. Her evaluation identified care areas of concern for cognitive impairment, communication, activities of daily living, psychosocial wellbeing, falls, nutrition, and psychotropic medication use. During an interview on 6/10/25 at 2:13 p.m., social worker (SW)-A stated anytime a patient shows behaviors such as rejecting care, verbally and physically abusive towards staff should be documented in the MDS to receive full reimbursement for the services provided. Requested policy how to complete an MDS, it was not provided. 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.	2 550		