DEPARTMENT OF HEALT						EDICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 5DKH
	PART I	- TO BE COMP	LETED BY T	HE STA	TE SURVEY AGENCY	Facility ID: 00036
1. MEDICARE/MEDICAID PROVIDE (L1) 245390	ER NO.	3. NAME AND AL (L3) PATHSTON		LITY		4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID NO	Э.	(L4) 718 MOUNI	O AVENUE			1. Initial 2. Recertification 3. Termination 4. CHOW
(L2) 668722900		(L5) MANKATO	, MN		(L6) 56001	5. Validation 6. Complaint 7. On-Site Visit 9. Other
 EFFECTIVE DATE CHANGE OF C (L9) 	OWNERSHIP	7. PROVIDER/SU		RY 09 ESRD	(L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
	14 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF		
 6. DATE OF SURVEY 02/26/201 8. ACCREDITATION STATUS: 	(L10)	03 SNF/NF/Distinct	07 X-Ray	10 I.U 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30
2 AOA 3 Other						
11LTC PERIOD OF CERTIFICATION	Ň	10.THE FACILITY	IS CERTIFIED AS	:		
From (a):		A. In Complia			And/Or Approved Waivers Of Th	
To (b):			Requirements ice Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit 7. Medical Director
12.Total Facility Beds	69 (L18)	1	Acceptable POC		4. 7-Day RN (Rural SNF	—
					5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	69 (L17)		mpliance with Progr ents and/or Applied		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
69						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICABL	E SHOW LTC CANC	ELLATION DATE):		
Post Certification Revisit by	y review of the fa	cility's plan of co	prrection, to ve	rify that		maintained compliance with Federal for 69 skilled nursing facility beds.
17. SURVEYOR SIGNATURE	T lease refer to th	Date :		<u>uary 14.</u>	18. STATE SURVEY AGENCY A	
Kathryn M. Serie, Ui	nit Superviso		1			h, Program Specialist 04/24/2014
	int Superviso.		T	(L19)		0
	PART II - TO RE	COMPLETED	BV HCFA RE		L OFFICE OR SINGLE ST	(L20)
19. DETERMINATION OF ELIGIBIL	ITY		APLIANCE WITH GHTS ACT:	CIVIL		I Interest Disclosure Stmt (HCFA-1513)
X 1. Facility is Eligible to	-				3. Both of the Above	:
2. Facility is not Eligib	le (L21)					
22. ORIGINAL DATE	23. LTC AGREEM	ENT 2	4. LTC AGREEM	ENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING		ENDING DAT		VOLUNTARY _00	
12/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburseme	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
	B. Rescind Sus	pension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	37	. DETERMINATION	OF APPROVAL D	ATE		
5 NO RECENT OF CMB-1337	32	03/21/2014	or mino (ALD)			
	(L32)			(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5390

April 24, 2014

Ms. Jennifer Pfeffer, Administrator Pathstone Living 718 Mound Avenue Mankato, Minnesota 56001

Dear Ms. Pfeffer:

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

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

Effective February 14, 2014 the above facility is certified for:

69 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 69 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Jeach

Colleen B. Leach, Program Specialist Program Assurance Unit Licensing and Certification Program

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

March 7, 2014

Ms. Jennifer Pfeffer, Administrator Pathstone Living 718 Mound Avenue Mankato, Minnesota 56001

RE: Project Number S5390023

Dear Ms. Pfeffer:

On January 29, 2014 we informed you of the results of a standard survey completed by this Department on January 16, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for no more than minimal harm (Level C) whereby corrections were required.

On February 26, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 24, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 16, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 16, 2014.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

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

cc: Licensing and Certification File

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245390	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 2/26/2014
Name of Facility		Street Address, City, State, Zip Code	
PATHSTONE LIVING		718 MOUND AVENUE MANKATO, MN 56001	

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

(Y4) Item		(Y5)	Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix	F0465	C	orrection ompleted I/17/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
Reg. # LSC	483.70(h)			Reg. # LSC			Reg. # LSC		
Reg. #		C-	orrection ompleted	Bog #		Correction Completed			
Reg. #		C	orrection ompleted	Reg. #		Correction Completed	Reg. #		
Reg. #		C	orrection ompleted			Correction Completed	D "		
Reg. #		C	orrection ompleted	Reg. #			Dec. #		
Reviewed I	3y Revie	ewed B	y	Date:	Signature of Sur	veyor:		Date	
	-	KS/k ewed B		03/04/2014 Date:	Signature of Sur	03048 veyor:		Date	02/26/2014
CMS RO									
Followup t	o Survey Complete 1/16/2014				Check for any Uncor Uncorrected Defic				NO

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245390	(Y2) Multiple Construction A. Building B. Wing 01 - MAIN	BUILDING	(Y3) Date of Revisit 2/24/2014
Name of Facility	St	treet Address, City, State, Zip Code	
PATHSTONE LIVING		718 MOUND AVENUE MANKATO, MN 56001	

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

(Y4) Item	(Y	(5) Date	(Y4) Item	(Y5)	Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 02/14/2014	ID Prefix		Correction Completed	ID Prefix		Correction Completed
-	NFPA 101 K0018		Reg. # LSC			Reg. # LSC		
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. #		Correction Completed	ID Prefix		Correction Completed
Reg. #		Correction Completed	Reg. #		Correction Completed	Reg. #		Correction Completed
Reg. #		Correction Completed			Correction Completed			Correction Completed
Reviewed B	By Reviewe	ed By	Date:	Signature of Sur	veyor:		Date	:
State Agen	су	PS/KFD	03/04/2014			03049		02/24/2014
Reviewed E CMS RO	3y Reviewe	ed By	Date:	Signature of Sur	veyor:		Date	:
Followup t	o Survey Completed 1/15/2014	on:		Check for any Uncor Uncorrected Defic	rected Defic iencies (CM	iencies. Was a S S-2567) Sent to t	Summary of he Facility? YES	NO

DEPARTMENT OF HEALTI	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 5DKH
	PART I -	TO BE COMP	LETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00036
1. MEDICARE/MEDICAID PROVIDE (L1) 245390	R NO.	3. NAME AND AI (L3) PATHSTON	E LIVING	CILITY		4. TYPE OF ACTION: 2 (L8) 1. Initial 2. Recertification
2.STATE VENDOR OR MEDICAID N (L2) 668722900	0.	(L4) 718 MOUNI (L5) MANKATO			(L6) 56001	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF ((L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
6. DATE OF SURVEY 01/16 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/II 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION	ſ	10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		X A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements e Based On:		2. Technical Personnel	<u> </u>
12. Total Facility Beds	69 (L18)	1	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	 7. Medical Director IF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	69 (L17)		npliance with Pro- ents and/or Appli		: * Code: B	(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
69 (L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
See Attached Remarks						
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Joseph Garvey, HFE NE	II)2/14/2014	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 03/20/2014 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
 DETERMINATION OF ELIGIBIL 1. Facility is Eligible to P 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) ;
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING		ENDING DA		VOLUNTARY 00	
12/01/1986	DEGRATA		21.021.00.011		01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHER</u>
	of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change		
(L27)	B. Rescind S	spension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS	
		03001			Posted 03/21/20	014 CO. 5DKH
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAL	LDATE		
	(L32)			(L33)	DETERMINATION APPI	ROVAL

DEPARTMENT OF HEALTH AND HUMAN SERVICES	CENTERS FOR MEDICARE & MEDI	CAID SERVICES
MEDICARE/MEDICAID CERTIFICATION AN	D TRANSMITTAL	ID: 5DKH
PART I - TO BE COMPLETED BY THE STATE	SURVEY AGENCY	Facility ID: 00036

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN 24-5390

At the time of the Standard survey on January 16, 2014 the facility was in substantial compliance with Federal Certification Regulations This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C). Copies of the Statement of Deficiencies (CMS-2567) are enclosed. Post Certification Revisit to follow.



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8415

January 29, 2014

Ms. Jennifer Pfeffer, Administrator Pathstone Living 718 Mound Avenue Mankato, Minnesota 56001

RE: Project Number S5390023

Dear Ms. Pfeffer:

On January 16, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the attached CMS-2567 whereby corrections are required. Copies of the Statement of Deficiencies (CMS-2567) are enclosed.

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

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

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

Pathstone Living January 29, 2014 Page 2

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, MN 56258

Office: (507) 537-7158 Fax: (507) 537-7194

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

Pathstone Living January 29, 2014 Page 3

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable POC, a revisit of a facility may be conducted to verify that compliance with the regulations has been attained. If a revisit is conducted, it will occur after the date you identified that compliance was achieved in your plan of correction.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

Pathstone Living January 29, 2014 Page 4

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEŸ COMPLETED
		245390	B. WING		01/16/2014
	Provider or supplied DNE LIVING	τ	7	STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
F 000	your allegation of department 's act bottom of the first	NTS of correction (POC) will serve as compliance upon the ceptance. Your signature at the page of the CMS-2567 form will ation of compliance.	F 000		
F 465 SS=C	Upon receipt of an revisit of your faci validate that subs regulations has be your verification. 483.70(h)	n acceptable POC an on-site lity may be conducted to tantial compliance with the een attained in accordance with IAL/SANITARY/COMFORTABL	F 465	F465	
	sanitary, and com residents, staff an	provide a safe, functional, fortable environment for d the public.	pproved yout	 Corrective Action: A. All resident bathroom vents were inspected and cleaned or 01/16/14. 	1
	by: Based on observ failed to assure th housings were be maintain a sanitar	ation and interview the facility e exhaust vents and vent ing cleaned as scheduled to y bathroom environment in 7 or oms- 3106, 3111, 3208, 3201,		educated on vent cleaning protocol on 01/17/14 during a housekeeping meeting. 2. Date of Completion: 01/17/14	
	p.m. random resid were observed the both occupied and exhaust vents we	n on 1/15/14 starting at 2:00 lent bathroom air exhaust vents oughout the building, including d unoccupied rooms. The air re noted to have surface dust		 Reoccurrence will be Prevented b A. Bathroom vent cleaning was added to the "Bathroom Cleaning Procedure for the 30 Building" as well as to the "Monthly Resident Room checklist". 	
y deficience er safegua owing the	DIRECTOR'S OF PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG Data a sterisk () verjotes a deficiency whree rotection to the patients. (See instruction or not a plan of correction is provided.	NATURE MULLIE nich the institut ns.) Except fo For nursing ho	TITLE TITLE tion may be excused from correcting providing it is or nursing homes, the findings stated above are dis tions, the above findings and plans of correction and are cited, an approve the Correction for the state of the state	determined that closable 90 days re disclosable 14

		AND HUMAN SERVICES			RINTED: 01 FORMAPI VB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SL COMPLE	IRVEY
		245390	B. WING		01/16/2	2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE		
PATHSTO	ONE LIVING			MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE CC	(X5) MPLETION DATE
F 465	housings. During the environma.m. with the environ environmental coor random sample of s units were observed up on the ceiling ve 3106, 3111, 3208, 3 The ED and EC ver and stated the conor facility practice and indicated the currer	nental tour on 1/16/14 at 7:30 onmental director (ED) and the dinator (EC) the following seven (7) bathrooms from both d to have excessive dust build nts and their housings: rooms 3201, 3311, 3406 and 3609. ified the vents were dusty dition was not an acceptable that it was unsanitary. The EC the cleanly schedule included: cleaning and monthly cleaning	F 4	 4. The Correction will be Monitor by: A. Environmental Services Director or designee B. The monitoring of bathroon vent cleaning has been add the quarterly preventative maintenance "TELS" progr for additional oversight dur facility tours. 	n ed to ram	
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 5DKH11		Facility ID: 00036 If continu	ation sheet Pa	age 2 of 2

RECEIVED

FEB 0 5 2014

Minnestoa Department of Health Marskall

DEPARTMENT OF HEALTH AND HUMA CENTERS FOR MEDICARE & MEDICA	N SERVICES	-		EURW.	
CENTERSTOR MEDIOARE & MEDIOA			5390022		APPROVED 0938-0391
	ER/SUPPLIER/CLIA CATION NUMBER:	1 · ·	PLE CONSTRUCTION 3 02 - 2008 ADDITION	(X3) DATE SU COMPLE	
	245390	B. WING		01/15	5/2014
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
PATHSTONE LIVING		UND AVEN ATO, MN 5			
(X4) ID SUMMARY STATEMENT OF I		ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
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K 000 INITIAL COMMENTS		K 000			
FIRE SAFETY					
A Life Safety Code Survey was Minnesota Department of Publ Fire Marshal Division, on Janu the time of this survey, Building Living was found to be in subs with the requirements for partic Medicare/Medicaid at 42 CFR, 483.70(a), Life Safety from Fire edition of National Fire Protect (NFPA) 101 Life Safety Code (New Health Care Occupancies Pathstone Living was construct Building 01 was built in 1992, i basement, is fully fire sprinkler determined to be of Type II(11 ⁻ Building 02 consists of the 200 two-stories, has a partial base sprinkler protected, and was de	lic Safety, State ary 15, 2014. At g 02 of Pathstone tantial compliance cipation in Subpart e, and the 2000 ion Association LSC), Chapter 18 S. ted as follows: s one-story, has no protected and was 1) construction; 98 addition and is ment, is fully fire		€		
Type II(111) construction. The facility has a complete fire smoke detection in the corrido open to the corridors, which is automatic fire department notif Resident Room is also equippe single-station smoke detection capacity of 69 beds and had a time of the survey. Since the original building and	rs and spaces monitored for fication. Each ed with hard-wired, . The facility has a census of 67 at the new addition				
met the allowable construction was surveyed as one building CMS-2786R booklets were co 01 at Chapter 19 Existing Hea Occupancies and Building 02 a Healthcare Occupancies.	type, the facility and two (2) Form mpleted; Building Ith Care at Chapter 18 New	SNATURE	TITLE		(X6) DATE

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.

DEPART	MENT OF HEALTH	AND HUMAN SERV & MEDICAID SERV					0. 0938-0391
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		245390		B. WING		01/1	5/2014
NAME OF F	PROVIDER OR SUPPLIER				TATE, ZIP CODE		
PATHST	ONE LIVING			OUND AVEI ATO, MN 5			
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FORM CMS-2567(02-99) Previous Versions Obsolete

Printed: 01/28/2014

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

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A. BUILDING 01 - MAIN BUILDING 245390 B. WING	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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MARKEN EACH DEPROCENCY MUST BE PRECEDED BY FULL TAG PRECULATORY OR LSC DENTIFYING INFORMATION) PREFX CROSS-REFERENCED TO THE APPROPRIATE COMPLIANCE K 000 INITIAL COMMENTS K 000 FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR K 000 ALLEGATION OF COMPLIANCE: UPON THE DEFICIENCY DEPARTMENT'S ACCEPTANCE: YOUR SIGNATURE AT THE BOTTOM OF THE FIRST Y SIGNATURE AT THE BOTTOM OF THE FIRST Y UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION, A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on January 15, 2014. At Heditare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLEAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections					718	MOUND AVENUE			
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	5X17. 1-1614	A Life Safety Code Minnesota Departn Fire Marshal Division the time of this sum Living was found no compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National (NFPA) 101 Life Safe Existing Health Car PLEASE RETURN CORRECTION FC DEFICIENCIES (K Health Care Fire In	Survey was conducted by the nent of Public Safety, State on, on January 15, 2014. At vey, Building 01 of Pathstone ot to be in substantial e requirements for participation aid at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association afety Code (LSC), Chapter 19 re Occupancies. THE PLAN OF PR THE FIRE SAFETY -TAGS) TO:			MN DEPT. OF PUBLIC SAFETY			
ABORATORY DIRECTOR'S OF/PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		XUMAN	10m	t		may be excused from correcting providin	2/1	0/14	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI IDENTIFICATION N	uuunen I				(X3) DATE SURVEY COMPLETED	
		245390		B. WING			01/1	5/2014
	Provider or supplier DNE LIVING				71	TREET ADDRESS, CITY, STATE, ZIP CODE 18 MOUND AVENUE ANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENC Y MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa By eMail to: Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/or responsible for corr prevent a reoccurre Pathstone Living w Building 01 was bu basement, is fully fi determined to be o Building 02 consist two-stories, has a p sprinkler protected Type II(111) constru- The facility has a c smoke detection in open to the corrido automatic fire depa Resident Room is a single-station smol capacity of 69 beds time of the survey. Since the original to was surveyed as o CMS-2786R bookle	tate.mn.us RRECTION FOR B T INCLUDE ALL C DRMATION: what has been, or v iency. oposed, completio or title of the person rection and monito ence of the deficier ras constructed as ilt in 1992, is one-s ire sprinkler protec f Type II(111) cons s of the 2008 addit partial basement, is , and was determinuction. omplete fire alarm the corridors and rs, which is monito artment notification also equipped with ke detection. The file and had a census puilding and the ner construction type, t	OF THE will be, done n date. n date. n ring to ncy. follows: story, has no ted and was truction; tion and is s fully fire hed to be of system with spaces ored for . Each hard-wired, facility has a s of 67 at w addition he facility o (2) Form	KO	000			
FORM CMS-2	01 at Chapter 19 E 567(02-99) Previous Versions	xisting Health Car		1	Fac	cility ID: 00036 If contin	uation she	et Page 2 of 4

We have a concern war

PRINTED: 02/04/2014 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

PRINTED: 02/04/2014 FORM APPROVED OMB NO. 0938-0391

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

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	tiple Ing 0	E CONSTRUCTION 11 - MAIN BUILDING	(X3) DATE COMP	
		245390	B. WING			01/1	5/2014
	ROVIDER OR SUPPLIER		ID PBEF	71 M	REET ADDRESS, CITY, STATE, ZIP CODE 18 MOUND AVENUE ANKATO, MN 56001 PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG K 000 K 018 SS=C	(EACH DEFICIENC' REGULATORY OR L Continued From pa Occupancies and I Healthcare Occupa The requirement a NOT MET as evide NFPA 101 LIFE SA Doors protecting of required enclosure hazardous areas a those constructed wood, or capable of minutes. Doors in required to resist to no impediment to are provided with the door closed. If are permitted. Roller latches are in all health care for This STANDARD Based on observed to positively latch emergency, this of	Age 2 Building 02 at Chapter 18 New ancies. t 42 CFR, Subpart 483.70(a) is enced by: AFETY CODE STANDARD corridor openings in other than as of vertical openings, exits, or are substantial doors, such as of 1¾ inch solid-bonded core of resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors a means suitable for keeping Dutch doors meeting 19.3.6.3.6 19.3.6.3 prohibited by CMS regulations acilities.	PREF TAG	000	 (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY) K 018 Manual flush bolts on closets in 3100, 3200 wings will be replace automatic flush bolts Completion date will The Environmental S Director or his desig responsible for corred deficiency. The ope the automatic flush h monitored monthly p schedule for fire doce 	n linen and 3300 ad with be 2/14/14 Services nee will be cting the eration of polts will b per the PM	COMPLETION DATE

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

PRINTED: 02/04/2014 FORM APPROVED OMB NO 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			0	IVID INO.	0936-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			(X3) DATE SURVEY COMPLETED		
		245390	B. WING	2		01/1	15/2014
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE		
PATHST	ONE LIVING				MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
K 018	On 01/15/2014 bet observation reveal Linen Closets in th positively latch into flush bolts on the in activated: A). Linen closet or B). Linen closet or C). Linen closet or These findings we	age 3 ween 10:00 AM and 1:00 PM, ed double doors leading into e following areas did not o their frames, as the manual nactive door leafs had not been in the 3100 wing corridor; in the 3200 wing corridor. re verified with the chief at the times of discovery.	ĸ	018			

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FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00036



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 8415

January 29, 2014

Ms. Jennifer Pfeffer, Administrator Pathstone Living 718 Mound Avenue Mankato, Minnesota 56001

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5390023

Dear Ms. Pfeffer:

The above facility was surveyed on January 13, 2014 through January 16, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by."

Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health:

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, MN 56258 Office: (507) 537-7158 Fax: (507) 537-7194

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kumalu Fiske Downing

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

Enclosure(s) cc: Original - Facility Licensing and Certification File

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 01/16/2014 00036 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **718 MOUND AVENUE** PATHSTONE LIVING MANKATO, MN 56001 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 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:** Minnesota Department of Health is On January 13,14,15 and 16th, 2014, surveyors documenting the State Licensing of this Department's staff, visited the above provider and the following correction orders are Correction Orders using federal software. Tag numbers have been assigned to issued. When corrections are completed, please Minnesota state statutes/rules for Nursing sign and date, make a copy of these orders and Homes. return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Minnesota Department of Health (X6) DATE TITI F LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM FOR A CONTRACT STATE STATE FORM FOR A CONTRACT STATE STATE STATE FOR A CONTRACT STATE STAT

Manestoa Department of Health Marshall

FEB 0 5 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00036	B. WING		01/1	01/16/2014	
NAME OF PF	ROVIDER OR SUPPLIER			STATE, ZIP CODE			
PATHSTO	NE LIVING		ND AVENUE O, MN 5600				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE	
2 000	Continued From pa	ge 1	2 000				
	Continued From page 1 Licensing and Certification Program, 1400 E. Lyon Street, Marshall, Minnesota 56258.			 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 surveyors findings are the Suggested Method of Correction and 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. 			
	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685				
i : : : : :	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00036			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		B. WING	01/	01/16/2014		
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST		01/	10/2014
	ONE LIVING		IND AVENUE			
FAIIIST	1		O, MN 56001			
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21685	Continued From pa	ige 2	21685			
	Based on observati failed to assure the housings were bein maintain a sanitary 35 bathrooms (roor 3311, 3406 & 3609 Findings include: During observation p.m. random reside were observed thro both occupied and exhaust vents were buildup and excess housings. During the environ ra.m. with the environ environmental coor random sample of s units were observed up on the ceiling ver 3106, 3111, 3208, 3 The ED and EC ver and stated the correr weekly ceiling vent of the vent housing SUGGESTED MET The facility adminis review and revise p relation to the faciliti maintanence and h	on and interview the facility exhaust vents and vent ing cleaned as scheduled to bathroom environment in 7 of ns- 3106, 3111, 3208, 3201, a). on 1/15/14 starting at 2:00 ent bathroom air exhaust vents bughout the building, including unoccupied rooms. The air e noted to have surface dust sive dust hanging from the vent inve dust hanging from the vent mental tour on 1/16/14 at 7:30 onmental director (ED) and the dinator (EC) the following seven (7) bathrooms from both d to have excessive dust build ents and their housings: rooms 3201, 3311, 3406 and 3609. rified the vents were dusty dition was not an acceptable that it was unsanitary. The EC nt cleanly schedule included: cleaning and monthly cleaning				

5DKH11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00036	B. WING		01/	16/2014
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
PATHSTO	ONE LIVING		ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ACTION SHOULD BE COMPLE TO THE APPROPRIATE DATE	
21685	Continued From pa	ge 3	21685			
	TIME PERIOD FOF (21) Days	R CORRECTION: Twenty-one				

5DKH11