



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 24, 2025

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: February 11, 2025

Dear Administrator:

On February 11, 2025, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 May 11, 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 August 11, 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>

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February 24, 2025
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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.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read "M. Poepping", with a stylized, cursive script.

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

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

PRINTED: 03/18/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/11/2025
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND 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
E 000	Initial Comments	E 000			
	On 2/10/25-2/11/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities was conducted during a standard recertification survey. The facility was IN compliance.				
	The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.				
F 000	INITIAL COMMENTS	F 000			
	On 2/10/25-2/11/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.				
	The following complaints were reviewed with NO deficiencies cited: H53907046C (MN00108162).				
	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 substantial compliance with the regulations has been attained.				
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii)	F 657			3/5/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2025

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 657	Continued From page 1 §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be-- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan included cultural aspects for 1 of 2 residents (R20) reviewed for food. Findings include: R20's facesheet printed on 2/11/25, included diagnoses of chronic kidney disease, heart failure			F 657	The identified deficiency for R20 was corrected as of 02/12/25, as care plan item to routinely discuss dietary preferences and offer options within religious and cultural preference was added. R20 has since discharged from facility. All residents have the potential to be		

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F 657	Continued From page 2 and diabetes. R20's admission Minimum Data Set (MDS) assessment dated 1/12/25, indicated he was moderately impaired cognition, clear speech, was understood and could understand. R20 had no problems eating and required partial assistance with most activities of daily living. R20's physician orders dated 1/6/25, included a low sodium diet; 1/11/25, oral supplement, and 1/16/25, daily weights. R20's care plan dated 1/10/25, indicated R20 had a potential nutritional problem related to risk for malnutrition and need for a therapeutic diet. The care plan did not include cultural aspects at all, including food and/or meal preferences for R20. R20's kardex (a brief overview summarizing a residents care plan and used by NA's (nursing assistants) did not include potential cultural preferences. A NA task sheet which was typically used by NA's and which included brief notes to identify specific care needs of residents did not include potential cultural preferences. A high-risk nutritional assessment completed by the dietician dated 1/18/25, indicated: --Visited with R20 on 1/24/25 at lunch. Reported not having a good appetite. Discussed food preferences and other supplement options; willing to try but when trialed, did not consume. --Reported a poor appetite. Culinary team offers options within religious and cultural preferences but R20 reported with his poor appetite, nothing sounded or looked good.			F 657	affected by the alleged deficient practice. The Director of Social Services, Life Enrichment Supervisor, and Dining Specialist have completed an audit of all current care center resident care plans, ensuring that cultural preferences are accurately documented. They have reviewed these preferences with each long-term and current short-term resident, updating care plans as needed to reflect individual cultural needs. Several Social Service Directors across Ecumen, in collaboration with the Director of Clinical Informatics and Analytics, developed a set of cultural preference questions and integrated them into the psychosocial, nutrition, and activities assessments, which automatically populates to the resident's care plan. This initiative ensures that cultural preferences related to food, religion/spirituality, social practices, and end-of-life traditions are consistently captured and incorporated into interdisciplinary care planning. The assessments are captured upon admission and then updated quarterly thereafter. The Director of Social Services, Life Enrichment Supervisor, and Dining Specialist will oversee the inclusion of cultural preferences in care plans upon admission and during quarterly reviews. Care plans will be reviewed with the resident and their family/caregiver at the admission care conference and subsequently at each quarterly and annual care conference. Administration will		

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F 657	Continued From page 3 --Weight dropped in the first few days but had remained stable since 1/10/25. During an interview on 2/10/25 at 1:51 p.m., while resting in bed, R20 stated he had been at the facility for a month. R20 stated "food was good for other residents, but not the kind we eat." R20 stated he was used to the same kinds of food but cooked in a different manner. R20 stated the "chef" was trying [to accommodate food preferences]. During an interview on 2/11/25 at 9:43 a.m., registered nurse (RN)-A who was also a nurse manager, stated she had developed R20's care plan and acknowledged nothing had been included to address R20's cultural preferences and needs, including food preferences. RN-A stated she had not thought to do that. During an observation and interview on 2/11/25 at 12:46 p.m., R20 was in the dining room seated at a table. On his plate were noodles with cut up chicken and vegetables on top, along with a brown sauce. R20 stated the food looked good, but didn't taste good, the chicken was tough. R20 stated, "I'll eat a few bites, but that is all." During an interview on 2/11/25 at 1:26 p.m., the director of nursing (DON) verified there was nothing on R20's care plan indicating his cultural preferences, including food. The DON stated she was new to the facility and wasn't sure who would be responsible for adding cultural aspects to a care plan but thought it would be the social worker. The DON acknowledged she would expect cultural preferences to be included on a care plan.	F 657	ensure compliance through the development, signing, and ongoing updates of care plans by the designated leadership team. To ensure ongoing compliance, results will be presented to the QAPI committee for the next three months. Audits will be completed for three months by the IDT, who will randomly select five admissions per month to review. The QAPI committee will review and provide recommendations regarding the frequency and content of further audits and new interventions as indicated. Pathstone Living will be in substantial compliance by March 5, 2025.		

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F 657	Continued From page 4 During an interview on 2/11/25 at 1:40 p.m., licensed social worker (LSW)-A who was new to the facility stated she had not added anything to resident care plans. The facility Comprehensive Person-Centered Care Plans policy with revised date of March 2022, indicated the comprehensive, person-centered care plan described the services that were to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Services provided for or arranged by the facility and outlined in the comprehensive care plan were culturally competent. Care plan interventions were chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. The Facility Assessment with revised date of 8/7/24, indicated: --The facility provided person-centered, competent care that helped each person served to live their lives as they wish. --The facility assessment collected information about the facility's resident population to identify...staff competencies, the ethnic, cultural and religious aspects of the unique resident population. --Each department identified the relevant information to identify the resident population and the resources available within their departments to meet the residents' needs. --The facility supported a culture of person-centered care with respect to personal preferences. The facility supported this through their admission process as well as day-to-day operations. For example: a variety of meal			F 657			

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F 657	Continued From page 5 choices and times were offered...and resident-driven individualized plans of care were created. --The dining specialist completed an assessment with all new residents. When this information was shared and identified, it was added to the appropriate list and was followed in the kitchen when plating occurred and as tickets were brought in from the dining assistants. These preferences may be updated through the charting schedule, direct communication with dietary or nursing staff.	F 657			
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards;	F 880			3/21/25

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F 880	Continued From page 6 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880			

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F 880	Continued From page 7 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections, and failed to ensure enhanced barrier precautions (EBP) were implemented for 1 of 1 residents (R38) reviewed for nephrostomy tube. This had potential to affect all 64 residents who resided in the facility. Finding include: On 2/11/25 at 1:23 p.m., during an interview the assistant director of nursing (ADON)-B who also identified as infection preventionist, stated he tracked and documented infections and antibiotics use on a software program but was having difficulty accessing reports. ADON-B showed a separate spread sheet used for Influenza and Covid-19 outbreaks they recently had in December 2024 and January 2025, which did not include signs and symptoms, treatment, or if transmission based precautions were implemented. On 2/11/25 at 2:45 p.m., the ADON-B was able to print out infection/antibiotic use lists. The form included headers on flow sheet for resident, unit/room number, infection date, infection, diagnosis, medication, provider, outcome, date infection resolved and bacteria data. There was also a space for signs and symptoms and other information located underneath the headings. Review of the facility's monthly resident infection statistics 5/1/24 through February 11, 2025,	F 880	The alleged deficiency for [R38] has been corrected as of 02/11/25. The team member was provided immediate education on Enhanced Barrier Precautions. The Director of Nursing was responsible for implementing the corrections. All 18 residents currently on EBP have the potential to be affected by the alleged deficient practice. Facility Nurse Managers have completed initial audits of PPE for EBP residents as of 02/21/25 to ensure no other residents were affected by the alleged deficient practice. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: All staff education Feb 24-March 4th, 2025 EBP to be tracked in Peerlytics for ease of reporting and monitoring which residents are required, the reason they are required, and removal of EBP as soon as it is no longer deemed necessary. All residents on EBP added to Peerlytics on 02/27/25. Updated (3/11/2025) information in Peerlytics shows 26 current residents on EBP. All have appropriate signage and		

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F 880	Continued From page 8 indicated: signs and symptoms of infection were documented for 13 of 128 infections listed; the bacteria column was completed on 27 of 128 infections listed; the outcome column was completed on 61 of 128 infections listed. The surveillance flow sheet also lacked information regarding transmission based precautions implementation and if infection was healthcare associated (HAI) in the facility. ADON-B confirmed the tracking log did not include signs and symptoms, transmission based precaution use, if HAI, date of resolution and culture/x-ray results. ADON-B indicated had a difficult time accessing culture and x-ray reports and not all physicians follow McGeer's criteria (consensus definition of infection in long term care) for ordering testing prior to treating infections. ADON-B stated he does not print out monthly or quarterly reports for infection analysis, was unable to state what the facilities current infection are or have been and he does not report on this information at infection control meetings and quality assurance and performance improvement meetings. On 2/11/25 at at 3:59 p.m., the director of nursing (DON) stated ADON-B was responsible for collection, analysis and surveillance of facility infections. The DON indicated it has been a difficult process to access culture results. The DON confirmed infection surveillance was not complete and the facility could improve the process. The facility Surveillance for Infections policy dated 11/2017, with review date of 10/24, included: That infection preventionist will conduct ongoing surveillance for healthcare associated infections			F 880	supplies. Ongoing audits for EBP show staff compliance with posted EBP guidance. Enhanced Barrier Precaution policy has been reviewed by facility clinical leadership team on 03/04/25. Education will be provided for nurses and nursing assistants regarding policies and processes noted above; this education will be completed by the compliance date noted below. PRN and casual staff not working during this period will be required to receive this training prior to their scheduled workday. Ecumen Pathstone will monitor its performance to make sure corrections noted above are sustained. Director of Nursing or designee will audit PPE compliance, two times weekly for a period of no less than three months. To ensure ongoing compliance, results will be presented to the QAPI committee. The committee will review and provide recommendations regarding the frequency and content of further audits and new interventions as indicated. Ecumen Pathstone Living will be in substantial Compliance by 03/21/2025. The alleged deficiencies for F880 ☐ Infection Prevention and Control have		

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F 880	Continued From page 9 (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions. 1. The purpose of this surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and health care associated infections to guide appropriate interventions and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment b. available processes and procedures that prevent or reduce the spread of infection c. clinically significant morbidity or mortality associated with infection (e.g. pneumonia, UTIs, C. difficile); d. pathogens associated with serious outbreaks 4. Infections that may be considered in surveillance include those with limited transmissibility and health care environment and/or limited prevention strategies Gathering Surveillance Data 1. Infection preventionist are designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and or QAPI committee may be involved in interpretation of data 2. If surveillance should include a review of any or all of the following information to help identify possible indicators of infection: a. laboratory records			F 880	been resolved. Infection and antibiotic tracking have been shifted fully to the software program Peerlytics for centralized tracking and transparency among licensed staff. The DON and/or designee was responsible for implementing the correction. The deficiency identified a group of residents that have the potential to be affected by the alleged deficient practices versus a single resident. The DON and/or designee will track all signs/symptoms of infections in residents in Peerlytics to aid in the identification of trends and prevention of spread of infectious conditions. The following measures and systemic changes have been made to ensure the alleged deficient practice will not reoccur:¿ DON received basic training on 02/21/25 in the use of Peerlytics to ensure ongoing surveillance, tracking, trending and analysis of resident infections while the facility Infection Preventionist role is being filled. Facility will review current reports of symptoms at daily morning Standup meeting for monitoring or precautions needed □ urinary symptoms, respiratory symptoms, GI symptoms, any communicable disease symptoms, etc. Data cleanup from last year in Peerlytics was completed on 02/26/25 to ensure		

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F 880	Continued From page 10 b. skin care sheets c. infection control rounds or interviews d. verbal reports from staff infection documentation records e. temperature logs f. pharmacy records g. antibiotic review h. transfer log/summaries 3. Laboratory reports are used to identify relevant information the following findings merit further evaluation: a. positive blood cultures b. positive cultures that do not just represent surface colonization c. positive urine cultures with corresponding signs and symptoms that suggest infection d. positive sputum culture e. other positive cultures f. all cultures positive for Group A streptococcus 4. In addition to collecting data on the incidence of infections the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted for example focus surveillance data may be gathered for residents with high risk for infection or those with their recent hospital stay. Data Collection and Recording 1. For residents with infections that meet the criteria for definition of infection for surveillance collect the following data as appropriate: identifying information, diagnosis, admission date date of onset of infection, infection site, pathogens invasive procedures are risk factors, pertinent remarks, treatment measures and precautions. Calculating infection rates: to determine the			F 880	accuracy of current data. Open cases that were resolved were cleared to ensure accuracy of infection cases and trend tracking. Enhanced Barrier Precaution tracking added to Peerlytics under Watch and Wait on 2/27/25 for all applicable residents. Infection and antibiotic tracking will be delegated to each nurse manager for their respective resident assignments will take place on 3/4/25 when a training is scheduled with Peerlytics. Additional training sessions to be scheduled as needed. Ongoing audits will be conducted by DON and/or designee for 3 residents per week through the week of 5/5/2025. For any difficulties in obtaining culture and sensitivities for lab specimens, the Medical Director will be consulted for assistance in obtaining said results. Ecumen Pathstone Living will monitor its performance to ensure corrections noted above are sustained. DON and/or designee to present quarterly/yearly infection trends and any outbreaks to the QAPI committee. Current antibiotic use to also be reviewed at QAPI meetings. The QAPI committee will review and provide recommendations regarding the frequency and content of further follow-up as needed. Substantial compliance to be achieved 3/5/25 following Peerlytics training for facility Nurse Managers on 03/04/2025.		

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F 880	Continued From page 11 incidence of infection per 1000 residents days, divide the number of new healthcare associated infections for the month by the total resident days for the month. Interpreting Surveillance Data 1. Analyze the data to identify trends a. compare the rates to previous months in the current year and to the same month in previous years to identify trends. b. consider how increases or decreases might relate to recent process changes, events, or activities in the facility. Trends should be monitored c. if the infection rates rise each month over a period of six months additional advice is warranted. 2. Surveillance data will be provided to the Infection Control Committee regularly. 3. The Infection Control Committee will determine how important surveillance data will be communicated to the Physicians and other providers, the Administrator, nursing units and the local and State Health Departments. EBP R38's facesheet printed on 2/11/24, included diagnosis of hydronephrosis (when one or both kidneys swell and urine does not fully empty from body). R38's admission Minimum Data Set (MDS) assessment dated 2/3/25, indicated R38 had a nephrostomy tube, and required substantial assistance with toileting. R38's physician order dated 1/31/25, indicated enhanced barrier precautions were required due to risk factors, every shift for infection prevention.			F 880			

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F 880	Continued From page 12 R38's care plan dated 1/31/25, indicated R38 had moderately impaired cognition, required substantial assistance with toileting, had a nephrostomy tube and risk factors that required EBP. During observation and interview on 2/10/25 at 3:21 p.m., observed nursing assistant (NA)-A enter R38's room. R38's light had been on and R38 informed NA-A she needed to use the bathroom. Observed a PPE (personal protective equipment) cart outside of R38's room, and a sign next to R38's door indicating R38 was in EBP's, and staff were to wear gloves and gown when assisting with toileting. NA-A entered the room without donning gloves and gown. During observation and interview on 2/10/25 at 3:29 p.m., NA-A exited R38's room. NA-A stated she had assisted R38 to the bathroom. NA-A stated she was aware R38 was in EBP because she had a tube going into her kidney, but didn't think she needed to wear PPE if she wasn't dealing with the tube directly. Together looked at the EBP sign and NA-A stated she should have worn PPE, but didn't think of it. NA-A stated she had education on EBP. During an interview on 2/11/25 at 9:41 a.m., registered nurse (RN)-A who was also a nurse manager stated R38 was in EBP because she had a nephrostomy tube and expected staff to wear PPE when they toileted her. RN-A provided a pocket guide the facility recently created to remind staff when to wear PPE for EBP's as staff were not always clear on it.			F 880			

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F 880	Continued From page 13 During an interview on 2/11/25 at 12:29 p.m., ADON-B stated he expected staff to wear PPE when a resident was in EBP and that toileting was a direct care activity that required PPE for the protection of that resident and other residents. ADON-B stated they had done multiple trainings on EBP and created a pocket guide to assist staff because not all were compliant with the policy. During an interview on 2/11/25 at 1:23 p.m., the DON was informed of the findings and stated she expected staff to adhere to the EBP sign on the door. A sign-in sheet for a NA meeting dated 3/28/24, where EBP was discussed indicated NA-A was in attendance. The facility Enhanced Barrier Precautions policy with revised date of 8/2022, indicated EBP's were used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. Gloves and gown were applied prior to performing the high contact resident care activity. Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's included transferring and assisting with toileting. EBP's were indicated.... for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. Staff were trained prior to caring for residents on EBP's. Signs were posted on the door or wall outside the resident room indicating the type of precautions and PPE required. PPE was available outside of the resident rooms.	F 880			
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3)	F 881			3/5/25

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F 881	Continued From page 14 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any residents who had infections requiring antibiotic use. Finding include: On 2/11/25 at 1:23 p.m., during an interview, the assistance director of nursing (ADON)-B, also identified as infection preventionist, stated he tracked and documented infections and antibiotics use on a software program but was not able to print out any reports. On 2/11/25 at 2:45 p.m., ADON-B was able to print out infection/antibiotic use lists. Review of the facility's monthly antibiotic use from 5/1/24 through February 11, 2025, included: resident, unit/room number, infection date, infection, diagnosis, medication, provider, outcome, date infection resolved and bacteria. There was also a space for signs and symptoms and other information located underneath the headings. Review of the data indicated 34 urinary tract			F 881	The alleged deficiencies for F881 Antibiotic Stewardship have been resolved. Infection and antibiotic tracking have been shifted to the software program Peerlytics for centralized tracking and transparency among licensed staff. The DON and/or designee was responsible for implementing the correction. The deficiency identified a group of residents have the potential to be affected by the alleged deficient practices versus a single resident. The DON and/or designee will track all resident antibiotics in Peerlytics to aid in the monitoring of antibiotic usage, the completion of 72 hour timeouts, and provide tracking for reduction of use. The following measures and systemic changes have been made to ensure the alleged deficient practice will not reoccur: DON received basic training on 02/21/25		

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F 881	Continued From page 15 infections (UTI) treated with antibiotics out of 37 total infections did not include culture results and analysis of antibiotic treatment. Six of the 37 UTI's had documented diagnosis of suspected UTI on the flow sheet. Five residents were on prophylactic antibiotics with 126 residents receiving antibiotics. ADON-B indicated he has a difficult time accessing culture results and not all physicians follow the McGeer criteria (set of consensus definitions for infections) and complete testing for suspected infections. ADON-B stated he doesn't report on MDRO, prophylactic use or antibiotic use at infection control meetings or quality assurance performance improvement meetings (QAPI). On 2/11/25 at 3:59 p.m., the director of nursing (DON) stated ADON-B was responsible for collection, analysis and surveillance of antibiotic use. DON indicated it has been a difficult process to access culture results. DON confirmed the antibiotic stewardship program lacks analysis and monitoring. The facility Antibiotic Stewardship policy dated 12/2016, with review date of 10/24, included: -Antibiotics will be prescribed and administered to residents under the guidance of the facility's Antibiotic Stewardship Program. - The purpose of our Antibiotic Stewardship Program is to monitor the use of antibiotics in our residents. - When a culture and sensitivity is ordered lab results and the current clinical situation will be communicated to the prescriber as soon as available to determine if antibiotic therapy should be started, continued, modified or discontinued.			F 881	in the use of Peerlytics to ensure ongoing surveillance, tracking, trending and analysis of resident antibiotic use while the facility Infection Preventionist role is being filled. Facility will review current antibiotic usage at daily morning Standup meeting for need for additional follow up on 72 hour timeouts. Data cleanup from last year in Peerlytics was completed on 02/26/25 to ensure accuracy of current data. The majority of open cases were ones had been previously resolved/discontinued, so were cleared. Additions were made to Peerlytics data - which included antibiotic use, prophylactic antibiotics, and current antibiotic usage. Infection and antibiotic tracking will be delegated to each nurse manager for their respective resident assignments will take place on 3/4/25 when a training is scheduled with Peerlytics. Additional training sessions to be scheduled as needed for those unable to attend the session on 3/4/25. Ongoing audits will be conducted by DON and/or designee for 3 residents per week through the week of 5/5/2025. For any difficulties in obtaining culture and sensitivities for lab specimens, the Medical Director will be consulted for assistance in obtaining said results. Ecumen Pathstone Living will monitor its		

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F 881	Continued From page 16 The facility Prevention and Control Program policy dated 10/18, indicated Infection prevent control program is established and maintained to provide safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. 8. Antibiotics stewardship a. Culture reports sensitivity data and antibiotic usage reviews are included in surveillance activities. b. Medical criteria and standard definitions are of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews			F 881	performance to ensure corrections noted above are sustained. DON and/or designee to present quarterly/yearly infection trends and any outbreaks to the QAPI committee. Current antibiotic use/trends to also be reviewed at QAPI meetings. The QAPI committee will review and provide recommendations regarding the frequency and content of further follow-up as needed. Substantial compliance to be achieved 3/5/25 following Peerlytics training for facility Nurse Managers on 03/04/2025.		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure 3 of 7 (R16, R54, R226) resident ceiling vents in the 3400 wing were clean when they had a black substance present on the vents. This deficient practice had the potential to affect all residents, staff, and visitors on the 3400 wings. Findings include: R16's admission Minimum Data Set (MDS) assessment dated 1/29/25, indicated R16 was admitted on 1/23/25.			F 921			3/21/25

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F 921	Continued From page 17 R54's quarterly MDS dated 1/3/25, indicated R54 was admitted 9/6/24. R226'S entry MDS 1/30/25, indicated R226 was admitted 1/30/25. On 2/10/25 at 2:14 p.m., R226 stated the vent on his ceiling was "dirty", and stated he didn't know if it was just dirt or mold. R226's ceiling vent was observed and the vent slates were covered with black substance. On 2/11/25 at 7:52 a.m., R226's ceiling vent was observed with the maintenance director (MD)-A and MD-A stated the vent had dust and dirt buildup and the vents need to be taken down and cleaned. MD-A added it was likely due to moisture causing the dirt to stick. MD-A stated maintenance was responsible to clean the vents and the vent cleaning was on a monthly checklist. MD-A further stated the checklist was a monthly checklist, but done only done quarterly. MD-A stated, the vents were expected cleaned prior to new residents moving into the rooms, at resident discharge, and when visibly dirty. MD-A confirmed the vents were dirty and needed cleaning. On 2/11/25 at 8:45 a.m., R16's and R54's ceiling vents were observed with MD-A, and MD-A confirmed the ceiling vents slates were black and dirty. On 2/11/25 1:51 p.m., the administrator stated the ceiling vents were expected cleaned and expected maintenance and housekeeping to keep vents and fans clean as often as necessary. The facility policy titled Departmental (Maintenance) - Plumbing, HVAC and Related			F 921	residents were affected by the alleged deficient practice; vents that were identified to be dirty were marked for cleaning and painting. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recur: Facility all staff education occurred from Feb 24-March 4th, 2025. The cleaning of ceiling vents has also been added to the quarterly room checklist and task has been added into TELS work order system. Vent audit has been scheduled in TELS. Facility Maintenance team has reviewed the facility's Plumbing, HVAC and Related Systems policy. Facility Housekeeping team has reviewed the facility's Cleaning and Disinfecting Residents' Rooms policy. Facility's Quarterly Room Checklist has been updated to include Vents as a list item. Ecumen Pathstone will monitor its performance to make sure corrections noted above are sustained. Environmental Services Director or designee will audit five rooms for vent compliance, once a month for a period of no less than three months. To ensure ongoing compliance, results will be presented to the QAPI committee. The committee will review and provide recommendations regarding the		

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F 921	Continued From page 18 Systems undated, indicated: The purpose of this procedure is to guide the sanitary handling of the plumbing, heating, ventilation, air conditioning, and related systems within the facility. Items to be repaired should be free of visible soil.	F 921	frequency and content of further audits and new interventions as indicated. Pathstone Living Will be in substantial Compliance by 3/21/25.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245390	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING B. WING _____	DATE SURVEY COMPLETE: 2/12/2025
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 133	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide properly firestopped fire barriers in accordance with LSC Sections 8.2 and 19.1.3.1. This deficient practice could have a isolated impact on residents within the facility. Findings include: On 02/12/2025 between 9:15 A.M. and 12:30 PM, it was revealed by observation that there were unsealed penetrations in the fire wall located between the nursing home and the assisted living. Maintenance corrected the deficiencies at the time of discovery. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.			

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

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

PRINTED: 03/10/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025	
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING				STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/12/2025. At the time of this survey, Pathstone Living was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/05/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001		
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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. BUILDING 01 Building 01 was built in 1992, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2008 addition is two-stories, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a capacity of 69 beds and had a census of 64 at the time of the survey.	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 02/12/2025
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K 000	Continued From page 2	K 000			
K 211 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain emergency egress doors per NFPA 101 (2012 edition), Life Safety Code, section 7.2.1.4.5.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: 1. On 02/12/2025 between 9:15 A.M. and 12:30 PM, it was revealed by observation that emergency exit door #31 was difficult to open. An interview with the Environmental Service Director verified this deficient finding at the time of discovery.	K 211	The Director of Environmental Services is responsible for implementing the corrections for the alleged deficiency for facility emergency exit door #31. All residents have the potential to be affected by the alleged deficient practice. The Environmental Services Director has received a quote for service from an outside vendor for a replacement for the identified emergency exit door and frame. On 03/05/25, the facility approved the quote from the vendor; the vendor has notified the facility that lead times are currently approximately 3-5 weeks on necessary materials for the exit door and frame replacement. The vendor reports that labor can be done as soon as the materials become available, and the facility will be notified when materials are received.	5/9/25	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 16, 2025

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: February 11, 2025

Dear Administrator:

On April 14, 2025, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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