DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 21, 2023

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: February 2, 2023

Dear Administrator:

On March 21, 2023, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 22, 2023

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: February 2, 2023

Dear Administrator:

On February 2, 2023, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
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 2, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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

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

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

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

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

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

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

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

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHSTONE LIVING	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 On 1/30/23 - 2/2/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 1/30/23 - 2/2/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H53907975C (MN85951) and H53907951C (MN86432), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H53907952C (86117), H53907950C (MN86444), H53905603C (MN88119), and H53908029C (MN89969). 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	F 000		

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

Electronically Signed | 03/02/2023

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

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F 000	Continued From page 1 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 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R33 and R34), who were observed to have medications in their room, had been appropriately assessed and deemed safe to self-administer medications. Findings include: R33's facesheet printed on 1/31/23, included diagnoses seborrheic dermatitis (skin condition that causes scaly patches and red skin, mainly on the scalp), impacted cerumen (ear wax) in both ears, and osteoarthritis of a knee. R33's annual Minimum Data Set (MDS) assessment dated 9/15/22, indicated R33 had intact cognition, clear speech, could understand and be understood. R33 did not walk, required extensive assistance of one or two staff for most activities of daily living (ADL's).	F 554	Audit of all rooms for medications for any over the counter or prescription medications that do not have valid orders and removal from resident□s room. Completed week of 2/13/23. Reeducation of Nursing Staff to ensure that residents are not storing medications in their rooms unless they have physician orders and self-administration assessment completed. Just in Time Training on 2/9/23 and at Nurse/NAR Meeting on 2/15/23. Letter to residents and families indicating that no at home medications should be brought to the facility without Nursing being notified so they can obtain a proper order for them. 2/7/23 Letters also to be placed in Admission Packets starting 2/7/23	3/1/23

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F 554	Continued From page 2 R33's physician orders included carbamide peroxide solution 6.5%, instill four drops in left ear and right ear at bedtime for impacted cerumen. R33's care plan had no indication of self-administration of medication. During an interview and observation on 1/30/23, at 3:45 p.m., the following medications were observed in a plastic three-drawer cart in front of R33's room window: --Lotrimin cream (antifungal medication) --Ear wax removal system (used to loosen ear wax) --Neosporoin ointment (antibiotic ointment) --Campho-Phenique (used to treat cold sores) --Aspercreme (pain relief cream) R33 stated the medications were from when she lived in an assisted living unit about two years ago. The director of nursing (DON) was asked for in writing, a self- administration of medication assessment for R33 and replied one had not been completed. R34 R34's facesheet printed on 1/31/23, included diagnoses of diabetes and COPD (congestive heart failure - when the heart does not pump blood as well as it should). R34's significant change Minimum Data Set (MDS) assessment dated 9/7/22, indicated R34 was cognitively intact, had clear speech, could understand and be understood. R34 required assistance of one staff for ADL's.	F 554	Audit of All Residents currently with Self Administration Orders to ensure they are still capable of Self Administration. Audit completed 2/7/23. Residents to be assessed annually or with significant changes or decline in status to ensure they are still capable of self-administration of medication. R33 had All Personal Medications removed from her room. R34 Self Administration Assessment completed on 1/30/23 and 2/20/23 and orders obtained for all bedside medications was obtained on 1/30/23, 2/1/23 and 2/10/23. A new form was created for staff to document any non-prescribed medications found in resident rooms to ensure follow-up is completed. This form will be reviewed by Nurse Managers each morning M-F to determine if any medication was found and collected and they will follow up with a). necessary required assessment, b). obtain orders if medication is appropriate for the resident and c). update care plan. Director of Nursing will Review with Nurse Managers each week at our weekly meeting and perform an audit to ensure all steps are being followed. If medication is not appropriate or nursing is unable to obtain an order, this medication will be sent home with family	

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F 554	Continued From page 3 R34's physician orders indicated: --Azithromycin 250 mg, one tablet daily related to COPD. --Yogurt with live cultures daily, every day shift for long-term antibiotic use. R34's care plan revised on 1/30/23, indicated R34 could safely self-administer a nebulizer treatment after set-up by a nurse. No other medications were identified for self-administration. During record review, a self-administration of medication assessment was completed on 1/30/23, for R34 to self-administer after set-up by a nurse, a medication via nebulizer. No self-administration assessment had been completed for a probiotic medication. During an observation and interview on 1/30/23, at 5:25 p.m., observed a box of Walgreen's brand probiotic pills on the dresser next to R34's bed. R34 stated they helped his stomach because he was taking an antibiotic. During an interview on 1/31/23, at 9:33 a.m., licensed practical nurse (LPN)-A stated residents could not have any medications in their room unless there was a physician order for it. LPN-A did not know if a resident needed to undergo an assessment to determine safe self-administration of medications. During an interview on 1/31/23, at 1:50 p.m., registered nurse (RN)-A stated a physician order was required for residents who wanted to keep medications in their room. In addition, RN-A stated a self-administration assessment for a medication was required initially and then	F 554	or locked away in Nurses Station Med Room. Nurse Managers or Designee to Maintain this ongoing.	

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F 554	Continued From page 4	F 554		

quarterly thereafter to make sure a resident understood how to take the medication and why they were taking it.

During an interview on 1/31/23, at 1:58 p.m., RN-B who looked in R34's EMR (electronic medical record) stated there was no physician order for the probiotic medication, nor had there been an assessment for self-administration of this medication.

During an interview on 1/31/23, at 5:24 p.m., the DON was informed of observations of medications in resident rooms. The DON stated sometimes residents bought medication from home or family members brought in medications without staff being aware. The DON stated residents were informed they may be able to keep medication in their room, but physicians and staff needed to ensure it was safe for a resident to do so. The DON stated it appeared staff overlooked the medications that were in plain sight, adding it was her expectation staff made these observation in order to ensure the medication was appropriate for the resident and a self administration of medication assessment had been conducted.

Facility policy titled Self-Administration of Medications, with revised dated 2/2021, indicated residents had the right to self-administer medications if the interdisciplinary team had determined it was clinically appropriate and safe for the resident to do so. A resident would be assessed for cognitive and physical abilities to determine whether self-administering medications were safe and appropriate for the resident. If deemed safe and appropriate, it was documented in the medical record and care plan. Any

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F 554	Continued From page 5 medication found at the bedside that are not authorized for self-administration would be turned over to the nurse in charge for return to the family or responsible party.	F 554		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review the facility failed to ensure the dialysis access site was appropriately monitored and assessed for 1 of 1 residents (R30) receiving hemodialysis Findings include: R30's, quarterly Minimum Data Set (MDS) dated 12/27/22 identified R30 had intact cognition, and no behaviors. R30 required limited assistance with personal cares and walking. R30's care plan last revised 1/23/23, identified R30 was at risk for complications related to dialysis secondary to renal failure. Interventions included to observe shunt (a connection that shifts blood from an artery to a vein, bypassing the microscopic network in the tissues that normally connect them) for signs and symptoms of complications such as redness, swelling, bleeding, temperature and to check and change dressing daily at access site.	F 698	Audit for bandage removal- Audit of bandage removal will occur each Tuesday, Thursday, and Saturday of Dialysis days for one month and then once weekly for one month and then monthly thereafter, beginning 2/14/23, then continuing for 3 months. R30-An Additional sign off in PCC in place for HS Nurse to verify that bandage has been removed. Any Newly Admitted Residents on Dialysis will also have this additional sign off at HS in place. Nurse Manager or Designee to complete Re-education provided to Nurses to ensure they are following policy and protocol with dialysis patient’s orders via Just in Time Training 2/7/23 and	3/1/23

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F 698	Continued From page 6 R30's physician orders dated 11/5/22, included remove access dressings/bandages eight hours after dialysis every evening shift every Tuesday, Thursday and Saturday. R30's treatment record and progress note dated 1/31/23, at 7:15 p.m. indicated R30's dressing to remain in place for 24 hours to reduce chance of bleeding. During observation and interview on 1/31/23, at 12:40 p.m., R30 stated he leaves for dialysis at 5:15 a.m. and generally returns 4 hours later. R30 was sitting in his wheelchair watching television. A 2x2 gauze with paper tape was present on 2 areas and dry and intact on upper right arm from morning dialysis. R30 indicated staff sometimes take off the dressing and sometimes he takes it off if they forget. During observation and interview on 2/1/23, at 8:41 a.m., R30 was sitting in his wheelchair in his room watching television. R30 showed surveyor the two 2x2 gauze and tape remained on the fistula site. R30 indicated they generally take the dressing off after 24 hours and if they forget the dialysis staff will remove the dressing before dialysis. During interview on 2/1/23, at 9:21 a.m. LPN-C indicated R30 does what he wants to and refuses cares quite a bit. LPN-A indicated the dialysis dressing should remain on for 24 hours, but upon reviewing the electronic medical record (EMR), indicated it should come off after 8 hours, adding she wasn't aware of that. During interview and observation on 2/1/23, at	F 698	Nurse/CNA Meeting on 2/15/23.	

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F 698	Continued From page 7 12:04 p.m., R30 was in the dining room and indicated he still had the same dressing on his fistula from the previous day's dialysis treatment. R30 indicated sometimes staff don't remove the dressing at all and other times they take it off before they should. Dressing remained dry and intact on his left upper arm. R30 added, I don't think they (dialysis center) want it on this long. During interview on 2/1/23, registered nurse from dialysis center (RN)-D indicated staff are to leave the dressing on for 4-6 hours after dialysis treatment. RN-D indicated some staff like to leave it on overnight, but it shouldn't be left on any longer than that. RN-D indicated there could be a higher rate of infection and injury to the surrounding tissue. During interview on 2/1/23, at 1:17 p.m., LPN-A was unaware R30's dialysis dressing was still in place adding he usually asks to have it taken off. LPN-A indicated evening staff should have taken it off last night. During interview on 2/1/23, at 1:28 p.m., registered nurse (RN)-A indicated the dressing generally comes off after supper the day of dialysis adding R30 generally lets us know when he wants it off. RN-A reviewed the plan of care and indicated the care plan should address when the dressing is to come off but currently does not. RN-A confirmed the dialysis dressing should be removed before the next morning. During interview on 2/1/23 at 2:02 p.m., the director of nursing (DON) indicated the treatment record indicates the dressing is to be removed 8 hours after R30 returns from dialysis. The DON confirmed it should be taken off by the evening	F 698		

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F 698	Continued From page 8 shift on the evening of dialysis. Facility policy and procedure titled Hemodialysis Access Care, dated 9/10, included: - Care involves the primary goals of preventing infection and maintaining patency of the catheter - Check for signs of infection at the access site when performing routine care and at regular intervals	F 698		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate	F 755		3/1/23

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 9 reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the removal and destruction of a controlled narcotic medication was accounted for in order to prevent potential narcotic diversion, for 1 of 1 residents (R25) who received a controlled narcotic medication, specifically fentanyl patch. Findings include: R25's facesheet printed on 1/31/23, included diagnoses of encounter for palliative care, chronic kidney disease and heart failure. R25's quarterly Minimum Data Set (MDS) assessment dated 1/3/23, indicated R25 experienced frequent pain, had severe cognitive impairment, clear speech, was able to understand and be understood. R25 required extensive assistance of one or two staff for most all activities of daily living. R25's physician order dated 1/4/23, indicated fentanyl patch 72-hour, 12 mcg/hr (microgram per hour). Apply one patch transdermally (via the skin) one time a day every three days for pain. R25's care plan with multiple revision dates from 2020 and 2021, indicated R25 had acute and chronic back pain related to repair of right hip fracture, chronic back pain and lumbar degenerative disc disease; would report	F 755	Edit of order entry process to include Application/Removal/Disposal-Reeducation with Nurses and HUCs regarding order entry for Fentanyl to indicate the application, removal, and disposal of the used patches appropriately- Just In Time Training 2/7/23. Documentation Destruction Log- A new destruction log in the Narcotic Book to be signed by staff member disposing of the used Patch. Completed 1/31/23 Review with Nurses/TMA's of Disposition of Controlled Substances and Pharmacy guidelines for disposal of Duragesic Patches Via JIT Training on 2/7/23 and Nurse/CNA Meeting on 2/15/23. Audit of Destruction Log weekly for 4 weeks and then monthly, beginning week of 2/13/23, continuing for 3 months. ADON or designee to complete R25- This Resident Expired on 2/4/23.	

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	245390	A. BUILDING _____ B. WING _____	C 02/02/2023

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F 755	Continued From page 10	F 755		

satisfactory comfort level of 4/10, and analgesia would be administered per orders. R25's care plan dated 1/20/23, indicated R25 was admitted to hospice care due to a decline in status and heart failure.

R25's medication administration record (MAR) indicated R25 received a fentanyl patch for pain on 1/4, 1/7, 1/10, 1/13, 1/16, 1/19, 1/22, 1/25, and 1/28/23.

During record review and interviews, there was no documentation in R25's EMR regarding removal and disposal of fentanyl patches, nor was there a facility process to document the removal and subsequent disposal of fentanyl patches. Progress notes and/or other documention of fentanyl patch removal were requested and none were received.

During an interview on 1/31/23, at 3:08 p.m., licensed practical nurse (LPN)-B described the process used when a fentanyl patch was removed from a resident: the patch was removed, folded in half and walked to the locked medication room on the short-term rehab (rehabilitation) wing and placed in the MedSafe (a stainless steel collection receptacle for disposal of medications). A nurse observed the other nurse placing the fentanyl patch in the MedSafe. LPN-B admitted there was no logging, tracking, signing or co-signing of the fentanyl patch being placed into the MedSafe to ensure no diversion of the fentanyl patch. During an interview on 1/31/23, at 3:16 p.m., registered nurse (RN)-C in the medication room on the short term rehab unit verified the process outlined by LPN-B and confirmed there was no logging, tracking, signing or co-signing of the fentanyl patch being placed

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F 755	Continued From page 11 into the MedSafe. During an interview on 1/31/23, at 4:19 p.m., together with the director of nursing (DON), looked at the policy on disposal of fentanyl patches. The DON admitted there was no logging, tracking, signing or co-signing of the patch being placed in the MedSafe to ensure no diversion of the fentanyl patch, adding she would be addressing the process right away. Facility policy titled Disposal of Fentanyl Patches by Thrifty White Pharmacy dated 8/2019, indicated disposal and witness of disposal must be documented on the MAR or other appropriate documentation record in order to provide the facility with appropriate tracking of patch disposal in patient records.	F 755		

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	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/01/2023**

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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 02/01/2023. 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		03/02/2023

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

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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. Pathstone Living was constructed as follows: 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; Building 02 consists of the 2008 addition and 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 complete fire alarm system with smoke detection in the corridors and spaces	K 000		

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K 000	Continued From page 2 open to the corridors, which is monitored for automatic fire department notification. Each Resident Room is also equipped with hard-wired, single-station smoke detection. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 69 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed	K 920		3/3/23

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K 920	Continued From page 3 immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect patient-care-related electrical equipment per NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6 and UL 1363A. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/01/2023 at 10:00 AM, it was revealed by observation that a medical device (CPAP) was plugged into a power strip that did not meet the requirements of UL 1363A. This medical device and power strip was located in Resident Room 3309. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	1. Education provided to all staff on the use of power strips in resident care areas. 2. Initial room audits completed in all resident areas to monitor compliance. Audits have been added into TELS system for monthly audit to be completed by housekeeping department. 3. The Environmental Services Director will be responsible for the correction and monitoring.	