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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OFDT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00036

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245390**
2.STATE VENDOR OR MEDICAID NO.
(L2) **668722900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PATHSTONE LIVING**
(L4) **718 MOUND AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **69** (L18)
13.Total Certified Beds **69** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	69			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Holly Kranz, HFE NE II — 03/28/2018 (L19)

18. SURVEYOR SIGNATURE — Date:
Kamala Fiske-Downing, Enforcement Specialist — 03/28/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245390

March 28, 2018

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

Dear Ms. Pfeffer:

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

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

Effective March 27, 2018 the above facility is certified for:

69 Skilled Nursing Facility/Nursing Facility Beds

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 28, 2018

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

RE: Project Number S5390027

Dear Ms. Pfeffer:

On March 14, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 1, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 15, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 1, 2018, effective March 27, 2018 and therefore remedies outlined in our letter to you dated March 14, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 28, 2018

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

Re: Reinspection Results - Project Number S5390027

Dear Ms. Pfeffer:

On March 27, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on, with orders received by you on March 22, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OFDT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00036

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245390**
2.STATE VENDOR OR MEDICAID NO.
(L2) **668722900**

3. NAME AND ADDRESS OF FACILITY
(L3) **PATHSTONE LIVING**
(L4) **718 MOUND AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/01/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **69** (L18)
13.Total Certified Beds **69** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	69			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Wendy Dobe, HFE NE II 03/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 03/26/2018 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 14, 2018

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

RE: Project Number S5390027

Dear Ms. Pfeffer:

On March 1, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 10, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 June 1, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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 _____	03/01/2018

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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 2/26/18 through 3/1/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		

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

Electronically Signed | 03/22/2018

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	03/01/2018

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
F 000	INITIAL COMMENTS On February 26th through March 1, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	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 record review, the facility failed to determine whether it was safe to self-administer medications for 1 of 7 residents (R19) observed during medication pass for the appropriateness of self-administration of medication. Findings include: On 2/28/18, at 8:15 a.m. registered nurse (RN)-A	F 554	1. Ordered obtained on 2/28/2018 for R19 to Resident to take pills independently unsupervised in room after Nurse/TMA set-up. 2. Immediate education provided to the nurse that did not follow the self-administration of medication policy with resident R19. 3. Education completed to the licensed nursing staff on 3/15/18 and TMAs on	3/15/18

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

Electronically Signed | 03/22/2018

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 _____	03/01/2018

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
F 554	Continued From page 1 was observed preparing oral medications for administration to R19; in addition, subcutaneous insulin was prepared. After medications were set up in the souffle cup, RN-A transported the medications to R19's room and placed them on the table located next to R19's chair. RN-A administered the insulin to R19 and proceeded to leave the room without ensuring the oral medications left on her table were taken. When interviewed following the observation on 2/28/18, at 8:20 a.m. RN-A indicated she was unsure whether R19 had a physician order to self-administer oral medications and/or whether an assessment had been conducted related to the ability to self-adminster. RN-A replied, "That's a good question. I'll look. She came from assisted living so I don't know." Review of R19's medical record identified an admission date of 1/21/17; a physician order to self-administer medications was lacking nor was an assessment related to self-administration evident. When interviewed on 3/1/18, at 1:30 p.m. the director of nursing (DON) indicated she had been informed by staff after the noted observation that an assessment and physician order was lacking for R19 related to self-administration of medications. The DON commented, "It's already been fixed and we are waiting for the doctor to send the order." The DON stated it was her expectation that nursing staff were to assess each resident for appropriateness of self-administration and obtain a physician's order prior to leaving medications with any resident. Review of the facility's February 2016 Self	F 554	3/8/18 regarding the appropriate self-administration of medications. Resident cannot self-administer medications without following the proper procedure which includes assessing resident□s abilities and obtaining a provider□s order. 4. Education and discussion will be completed at the monthly nurses meeting for three months regarding self-administration of medications. Monthly nurses meeting will allow for large group discussion regarding self-administration with the licensed nursing staff present to give their input. Discussion will include an audit (monthly for three months) of all residents to determine the need to have an assessment completed to pursue self-administration orders; if it hasn□t already been completed. Audit findings will be reported at the July 2018 QAPI Meeting.	

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 _____	03/01/2018

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
F 554	Continued From page 2 Administration of Medications policy indicated the RN manager will assess the resident's cognitive, physical, and visual ability to carry out the task. The nurse was to obtain an order from the physician for self-administration.	F 554		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess the safe use of an assist bar for 2 of 2 residents (R38, R50) reviewed for accidents and hazards related to a large gap in the center of the assist bar.	F 700	1. R50□s bedrail was immediately removed and replaced with a compliant transfer bar. Family educated on the change and the risks involved in the non-compliant bed rail. 2. R38□s bedrail was immediately	3/15/18

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F 700	Continued From page 3 Findings include: During an observation on 2/26/18, at 2:53 p.m. an assist bar was located on the exit side of R50's bed, at the head of the bed. On 2/26/18 at 3:13 p.m., registered nurse manager (RN)-B was observed to measure R50's assist bar. The opening of the assist bar measured 17 x 6.5 inches. RN-B confirmed the opening was larger than FDA recommendations for key body parts. R50's family member (FM)-A, present at the time, stated the assist bar had been brought in from home. FM-A stated a facility assist bar was utilized by R50, but R50 "had a fit" because she preferred the one she'd utilized previously while at home. R50's quarterly Minimum Data Set (MDS) assessment dated 2/12/18, indicated an admission date of 10/27/17, and further indicated R38 required extensive assist of 1 with bed mobility, transfers and ambulation. R50's care plan last reviewed 2/22/18, did not include the use of an assist bar. Further review of R50's medical record did not include an assessment for the safe use of the assist bar. During an observation on 2/26/18, at 6:55 p.m. R38's bed was noted to have an assist bar located on the exit side of the bed, near the head of the bed. At that time, RN-B was observed to measure the assist bar which was 9 1/2 x 7 3/4 inches. RN-B stated the assist bar was brought from home by R38 upon admission. R38's quarterly MDS dated 2/6/18, identified the admission date of 4/12/17, and further indicated R38 required extensive assist of 1 with bed	F 700	removed and replaced with a compliant transfer bar. Resident educated on the change and the risks involved in the non-compliant bed rail. 3. Education completed in the EVS department on 2/27/18. Education included the demonstration of the proper bed rails that can be used in the care center. If staff notice any other bed rails being used in the care center they are to immediately report it to their supervisor or nurse manager so it can be removed and the proper one installed. 4. The housekeeping staff will check for non-compliant bedrails monthly and document in TELS (electronic maintenance record). Staff will immediately report any non-complaint bedrails to their supervisor or the nurse manager. This will be completed on-going. 5. Education completed to the NAR staff on 3/8/18 regarding the appropriate transfer bars that are allowed in the care center. NAR staff are to inform supervisor, nurse manager, EVS department, or DON immediately if a non-compliant bed rail is found in resident□s room. 6. Education completed to the licensed nursing staff on 3/15/18 regarding the appropriate transfer bars that are allowed in the care center. NAR staff are to inform supervisor, nurse manager, EVS department, or DON immediately if a non-compliant bed rail is found in resident□s room.	

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PATHSTONE LIVING	**718 MOUND AVENUE MANKATO, MN 56001**

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F 700	Continued From page 4	F 700		

mobility, transfers and ambulation. R38's care plan last reviewed 11/15/17, did not include the use of an assist bar. Further review of R38's medical record did not include an assessment for the safe use of the assist bar.

When interviewed on 2/27/18, at 4:05 p.m. RN-B confirmed having previously been unaware R38 and R50's assist bar openings were outside FDA guidance. RN-B stated that upon admission, residents are assessed for whether an assist bar would be beneficial and subsequently a request for maintenance installation was submitted. RN-B said if a resident brought in their own assist bar it should be assessed for safety, and if the assist bar did not meet safety standards the resident would be offered the use of one of the facility's assist bars. RN-B further stated R50 had the assist bar prior to RN-B starting in her current position, and she didn't realize it hadn't been assessed. RN-B was unsure who had installed the assist bars on R38 and R50's beds.

When interviewed on 2/28/18, at 2:10 p.m. the director of nursing (DON) stated typically the process related to assist bars was to have therapy evaluate the resident for the type of assist bar that would best benefit the resident. Then one of the facility's assist bars would be implemented. The DON said she was unaware R38 and R50 had brought in their own assist bars. The DON further stated she had spoke with the maintenance director and also checked the TELS system (an electronic system utilized for maintenance work orders) and confirmed there had been no work orders to install assist bars for R38 or R50. DON stated FM-A had confirmed placing the assist bar from home on R50's bed; R38 had indicated bringing the assist bar with

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F 700	Continued From page 5 from her last placement though it was unknown who had installed it on the bed. DON stated she had checked all rooms at the facility following the surveyors identification of R38 an R50's assist bars that did not meet safety regulations. DON also contacted the maintenance director who re-educated his staff related to only installing assist bars provided by the facility. The facility's policy Bed Rails revised February 2016 included: The person applying the bed rails to a bed (including air therapy beds) checks to assure there are no gaps between the rail and the mattress or within the rail that is large enough to cause increased risk of injury (refer to manufacturer's instructions and other bed rail use guidelines such as Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment available through the Food and Drug Administration). The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches, representing head breadth.	F 700		

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	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 28, 2018. At the time of this survey, Pathstone Living was found to be 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 Occupancies. 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 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. The facility has a capacity of 69 beds and had a census of 69 at time of the survey. 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.	K 000		

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

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

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	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/28/2018**

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K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

Electronically delivered
March 14, 2018

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

Re: State Nursing Home Licensing Orders - Project Number S5390027

Dear Ms. Pfeffer:

The above facility was surveyed on February 26, 2018 through March 1, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 476-4233 or kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PATHSTONE LIVING	718 MOUND AVENUE MANKATO, MN 56001

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/26/18 through 3/1/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to determine whether it was safe to self-administer medications for 1 of 7 residents (R19) observed during medication pass for the appropriateness of self-administration of medication. Findings include: On 2/28/18, at 8:15 a.m. registered nurse (RN)-A was observed preparing oral medications for administration to R19; in addition, subcutaneous insulin was prepared. After medications were set up in the souffle cup, RN-A transported the medications to R19's room and placed them on the table located next to R19's chair. RN-A administered the insulin to R19 and proceeded to leave the room without ensuring the oral medications left on her table were taken. When interviewed following the observation on 2/28/18, at 8:20 a.m. RN-A indicated she was	21565	Corrected.	3/15/18

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21565	Continued From page 3	21565		

unsure whether R19 had a physician order to self-administer oral medications and/or whether an assessment had been conducted related to the ability to self-adminster. RN-A replied, "That's a good question. I'll look. She came from assisted living so I don't know."

Review of R19's medical record identified an admission date of 1/21/17; a physician order to self-administer medications was lacking nor was an assessment related to self-administration evident.

When interviewed on 3/1/18, at 1:30 p.m. the director of nursing (DON) indicated she had been informed by staff after the noted observation that an assessment and physician order was lacking for R19 related to self-administration of medications. The DON commented, "It's already been fixed and we are waiting for the doctor to send the order." The DON stated it was her expectation that nursing staff were to assess each resident for appropriateness of self-administration and obtain a physician's order prior to leaving medications with any resident.

Review of the facility's February 2016 Self Administration of Medications policy indicated the RN manager will assess the resident's cognitive, physical, and visual ability to carry out the task. The nurse was to obtain an order from the physician for self-administration.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies for self administration of medication according to evidence based practices/procedures. Nursing staff could be educated as necessary to the importance of ensuring the resident is capable of

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21565	Continued From page 4 administering their own medications initially, quarterly, annually, or with a change to a resident's physical or mental ability to do so. Nursing staff could also ensure there is a physician's order in place, prior to a nurse/medication aide administering medication. The DON or designee, could audit any/all resident's medical records, to ensure compliance with appropriate medication administration. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21565		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess the safe use of an assist bar in accordance with manufacturer's recommendations for 2 of 2 residents (R38, R50) reviewed for accidents and hazards related the large gap in the center of the assist bar. Findings include: During an observation on 2/26/18, at 2:53 p.m. an assist bar was located on the exit side of R50's bed, at the head of the bed.	21665	Corrected.	3/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	03/01/2018

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) COMPLETE DATE
21665	Continued From page 5 On 2/26/18 at 3:13 p.m., registered nurse manager (RN)-B was observed to measure R50's assist bar. The opening of the assist bar measured 17 x 6.5 inches. RN-B confirmed the opening was larger than FDA recommendations for key body parts. R50's family member (FM)-A, present at the time, stated the assist bar had been brought in from home. FM-A stated a facility assist bar was utilized by R50, but R50 "had a fit" because she preferred the one she'd utilized previously while at home. R50's quarterly Minimum Data Set (MDS) assessment dated 2/12/18, indicated an admission date of 10/27/17, and further indicated R38 required extensive assist of 1 with bed mobility, transfers and ambulation. R50's care plan last reviewed 2/22/18, did not include the use of an assist bar. Further review of R50's medical record did not include an assessment for the safe use of the assist bar. During an observation on 2/26/18, at 6:55 p.m. R38's bed was noted to have an assist bar located on the exit side of the bed, near the head of the bed. At that time, RN-B was observed to measure the assist bar which was 9 1/2 x 7 3/4 inches. RN-B stated the assist bar was brought from home by R38 upon admission. R38's quarterly MDS dated 2/6/18, identified the admission date of 4/12/17, and further indicated R38 required extensive assist of 1 with bed mobility, transfers and ambulation. R38's care plan last reviewed 11/15/17, did not include the use of an assist bar. Further review of R38's medical record did not include an assessment for the safe use of the assist bar. When interviewed on 2/27/18, at 4:05 p.m. RN-B	21665		

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21665	Continued From page 6 confirmed having previously been unaware R38 and R50's assist bar openings were outside FDA guidance. RN-B stated that upon admission, residents are assessed for whether an assist bar would be beneficial and subsequently a request for maintenance installation was submitted. RN-B said if a resident brought in their own assist bar it should be assessed for safety, and if the assist bar did not meet safety standards the resident would be offered the use of one of the facility's assist bars. RN-B further stated R50 had the assist bar prior to RN-B starting in her current position, and she didn't realize it hadn't been assessed. RN-B was unsure who had installed the assist bars on R38 and R50's beds. When interviewed on 2/28/18, at 2:10 p.m. the director of nursing (DON) stated typically the process related to assist bars was to have therapy evaluate the resident for the type of assist bar that would best benefit the resident. Then one of the facility's assist bars would be implemented. The DON said she was unaware R38 and R50 had brought in their own assist bars. The DON further stated she had spoke with the maintenance director and also checked the TELS system (an electronic system utilized for maintenance work orders) and confirmed there had been no work orders to install assist bars for R38 or R50. DON stated FM-A had confirmed placing the assist bar from home on R50's bed; R38 had indicated bringing the assist bar with from her last placement though it was unknown who had installed it on the bed. DON stated she had checked all rooms at the facility following the surveyors identification of R38 an R50's assist bars that did not meet safety regulations. DON also contacted the maintenance director who re-educated his staff related to only installing assist bars provided by the facility.	21665		

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21665	Continued From page 7 The facility's policy Bed Rails revised February 2016 included: The person applying the bed rails to a bed (including air therapy beds) checks to assure there are no gaps between the rail and the mattress or within the rail that is large enough to cause increased risk of injury (refer to manufacturer's instructions and other bed rail use guidelines such as Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment available through the Food and Drug Administration). The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 1 as the area, "any open space within the perimeter of the rail". It also noted HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend the space be less than 4 3/4 inches, representing head breadth. SUGGESTED METHOD OF CORRECTION: The administrator, DON, maintenance supervisor, or designee could ensure bed rail safety entrapment assessments were performed on all residents with bed rails and included in the preventative maintenance program. Those assessments should occur upon admission, quarterly, yearly, with a significant change and periodically thereafter as needed to accurately reflect bed rails in-use by residents. The facility could create policies and procedures, educate staff on these changes, and perform environmental rounds/audits periodically to ensure resident safety from entrapment is appropriately monitored. The facility could report those findings to the quality assurance	21665		

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21665	Continued From page 8 performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21665		