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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OLKN

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
8. Full Survey After Complaint
9. Other

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/11/2017** (L34)

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	

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

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

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: **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 :
Kathryn Serie, Unit Supervisor — 06/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 07/25/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 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
05/16/2017
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245390 June 19, 2017

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 May 8, 2017 the above facility is certified for or recommended for:

69 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

An equal opportunity employer.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 19, 2017

Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: Project Number S5390026

Dear Ms. Pfeffer:

On April 26, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 13, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On May 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 20, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 13, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 13, 2017, effective May 8, 2017 and therefore remedies outlined in our letter to you dated April 26, 2017, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OLKN
Facility ID: 00036

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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 **04/13/2017** (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 :
Holly Kranz, HFE NE II 05/09/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/15/2017 (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
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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

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 26, 2017

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

RE: Project Number S5390026

Dear Ms. Pfeffer:

On April 13, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), 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

Informal Dispute Resolution - 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 a "F" 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
Marshall, Minnesota 56258-2529
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 May 23, 2017, 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 July 13, 2017 (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 October 13, 2017 (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 related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 ______	04/13/2017

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 The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money	F 278		5/8/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 05/05/2017

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 ______	04/13/2017

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 278	Continued From page 1 penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code the resident status on the Minimum Data Set (MDS) assessment for 1 of 2 residents (R7) reviewed related to urinary incontinence. Findings include: Review of the Minimum Data Set (MDS) dated 11/2/16, identified R7 was admitted to the facility 10/26/16, had a Brief Interview for Mental Status (BIMS) score of 15 (indicating intact cognition) and was always continent of bladder. Review of the care plan dated 11/17/16, identified R7 has bladder incontinence related to impaired mobility and function due to diagnosis of congestive heart failure, chronic obstructive pulmonary disease and chronic kidney disease. Review of the nursing assistant documentation related to urinary continence for 10/27/16 through 11/2/17, identified R7 had two incontinent episodes indicating occasional incontinence (during the 7-day look-back period the resident was incontinent less than 7 episodes. This	F 278	(F278) 1. Failure to accurately code an MDS was noted on one resident (R7). The MDS coded the resident has continent when the documentation and staff interviews noted the resident to be incontinent. Modification has been completed on R7□s admission MDS to change Always Continent to Occasionally Incontinent. 2. MDS Section H audits will be completed monthly on 10 residents for the next 3 months by the DON or designee to ensure that the MDS is accurately coded. Audit findings will be reported to QAPI Committee in July 2017. 3. The plan of correction will be completed by May 8, 2017.	

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 ______	04/13/2017

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 278	Continued From page 2 includes incontinence of any amount of urine sufficient to dampen undergarments, briefs, or pads during daytime or nighttime.) During interview with nursing assistant (NA) D on 4/12/17, at 7:27 a.m. she confirmed R7 was occasionally incontinent of urine. She stated it is only when he is out and about and can't make it back to his room in time to use the urinal. She stated his continence has not changed since admission. During interview with NA-B on 4/13/17, at 8:49 a.m., she stated R7 was occasionally incontinent of urine and had been since admission. She stated if he doesn't make it back to his room in time he will have some incontinence. During interview with registered nurse (RN)-B on 4/13/17, at 9:30 a.m. she verified the above findings and the admission MDS was inaccurately coded.	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to apply a palm protector as defined on the care plan for 1 of 1 resident	F 282	F282 1.Resident (R70) was observed to not	5/8/17

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 ______	04/13/2017

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 282	Continued From page 3 (R70) reviewed with skin integrity concerns related to a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the left hand and failed to ensure shaving needs were provided as defined on the plan of care for 1 of 1 resident (R10) reviewed for activities of daily living. Findings include: Review of the face sheet, dated 4/13/17 identified R70 was admitted to the facility on 5/26/16, with diagnoses including hemiplegia and hemiparesis affecting left non-dominant side. Review of the quarterly Minimum Data Set (MDS) dated 2/13/17, identified R70 had a functional limitation in range of motion (ROM) of the upper extremity which included the shoulder, elbow, wrist and hand. Review of R70's care plan, dated 11/20/16 identified R70 had potential/actual impairment to skin integrity related to impaired mobility a and function due to cerebral vascular accident with left sided weakness. Interventions included: (1) wear palm protector for one hour BID (twice daily), (2) keep hands from excessive moisture, (3) keep fingernails short, and (4) monitor skin weekly and daily with a.m. and h.s. (hour of sleep) cares. Review of R70's resident care sheet, updated 4/11/17 did not identify the use of a palm protector for R70. R70's OT progress and discharge summary, dated 10/10/16 identified discharge plan and	F 282	have palm protector during observations. Palm protector obtained and placed in resident□s palm upon notification of the omission. Education done with nurses working with resident outlining the expectation of placement palm protector and assessment of resident□s hand. NAR Care Sheets updated for staff to know that resident has a palm protector. 2.Audit for palm protector placement will be completed weekly for 2 months by the DON or designee to ensure that palm protector is being placed. Audit findings will be reported to QAPI Committee in July 2017. 3.Licensed staff and NARs will be educated on documentation policies at meeting on May 8, 2017. 4.The plan of correction will be completed by May 8, 2017. 1. Female resident (R10) was noted to have visible facial hair. Resident was shaven. Care plan was updated and follow-up monitoring by nurse was put in place. 2. All female residents of the facility will be assessed upon admission and routinely to determine if facial hair grooming needs to be completed. If the need is identified, care plan will be updated and nursing follow-up on TAR. 3. Licensed staff and NARs will be educated on personal care and shaving policies and procedures at meeting on May 8, 2017. This education includes expectations for proper grooming, which	

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F 282	Continued From page 4	F 282		

instructions to recommend patient wear palm protector overnight and part time during the day as tolerated to protect skin in left hand.

Review of the current treatment administration record dated (TAR) identified R70 was to wear a palm protector for one hour twice daily (BID) every day and evening shift. Documentation revealed the treatment was implemented twice daily.

During observations on 4/10/17, at 5:35 p.m. and 7:00 p.m.; on 4/11/17, at 9:00 a.m., 11:15 a.m., 1:25 p.m.; on 4/12/17, at 7:11 a.m. and 11:00 a.m.; and on 4/13/17, at 8:37 a.m. R70 did not have a palm protector applied at any time. During these observations, R70's nails were observed to be long and his fingers pressed into his left hand. An indentation was noted, but no skin breakdown was observed.

During observation on 4/12/17, at 7:11 a.m. R70's cares were being completed by nursing assistant (NA)-D. R70 was in bed and did not have a palm protector nor any kind of soft rolled device in his left hand. NA-D stated R70 used to have a splint, but hadn't seen it for quite some time. NA-D searched R70's drawers but did not find any device for R70's hand.

When interviewed on 4/13/2017, at 8:52 a.m. NA-B stated R70 doesn't use anything in his hand during the day. NA-B stated, "I think it used to be a carrot type thing but just at night; I think now they put a wash cloth in but just at night".

During interview on 4/13/17, at 9:00 a.m. registered nurse (RN)-C verified R70 should

includes facial shaving.
4. Care plan, NAR charting, Nurse Charting, and resident visual audits will be completed bi-weekly for the next 3 months by the DON or designee to ensure that residents are appropriately groomed or there is documentation of refusal. Audit findings will be reported to QAPI Committee in July 2017.
5. The plan of correction will be completed by May 8, 2017.

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F 282	Continued From page 5 have a palm protector on the left hand. RN-C stated the NA's should apply the protector and then licensed staff sign off on the TAR. RN-C also verified that R70's nails were too long and should be cut. During interview on 4/13/17, at 8:37 a.m. RN-B verified R70 should have a palm protector in the left hand. During observation with the surveyor, RN-B verified R70 currently did not have the palm protector applied. RN-B searched R70's room and was unable to find the palm protector. During interview on 4/13/17, at 10:00 a.m. the occupational therapist inspected R70's hand and verified that R70 should be using the palm protector as defined in the plan of care. R10's admission MDS assessment dated 2/28/17, identified R10 with severe cognitive impairment. The MDS further identified R10 as requiring limited assistance of one staff for personal hygiene (which included shaving) and no behaviors or rejection of care. R10's care area assessment (CAA) for activities of daily living (ADLs) dated 3/3/17, indicated R10 required assistance of staff with all aspects of ADLs except eating. It further identified R10 as being alert and oriented to place and person with some periods of forgetfulness and confusion. R10's current care plan last revised 3/23/17, and resident care sheet dated 4/11/17, indicated R10 required assistance of one staff member to assist in grooming. The care plan further identified R10 with impaired cognitive function/dementia and to keep R10's routine consistent to decrease confusion.	F 282		

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F 282	Continued From page 6 During initial observation on 4/10/17, at 2:11 p.m. R10 was seated in a recliner located in her room. Gray/white whiskers were observed on R10's upper lip and chin area. The facial hair was visible from a typical conversational distance. During observation on 4/11/17, at 8:12 a.m. R10 was dressed and eating breakfast in the dining room. R10 continued to have thick gray/white facial hair approximately 0.5 centimeters (cm) in length that was visible on upper lip and chin area. During interview on 4/11/17, at 11:14 a.m. R10 stated she tries to look nice everyday and would "want that off" if facial hair was present. During observation on 4/12/17, at 7:31 a.m. NA-A was shaving R10's facial hair. R10 was calm and cooperative during process. NA-A stated R10 needed assistance to shave but wasn't always cooperative. NA-A indicated she had not shaved R10 the previous day because R10 had refused. NA-A further stated residents should be shaved when they need it, and refusals should be documented. Review of NA and nurse charting for the previous 14 days did not include any care refusal from R10. This was confirmed with RN-A on 4/12/17, at 8:28 a.m. During interview at this time, RN-A stated she was not aware of R10 ever refusing to be shaved. RN-A indicated R10 needs re-approaching and/or coaxing for cares at times but would expect staff to shave R10 for grooming needs daily or to report and document refusals so that the care plan could be revised.	F 282		

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F 282	Continued From page 7 During interview on 4/12/17, at 9:45 a.m. trained medication aide (TMA)-A stated R10 needs staff assistance with grooming and shaving and was unaware of any refusals by R10. During interview on 4/12/17, at 9:54 a.m. NA-A stated R10's whiskers were "too long" and confirmed the gray/white thick whiskers covered her upper lip and chin area. NA-A indicated the whisker growth was more than a couple days of growth for R10. When interviewed on 4/13/17, at 9:06 a.m. the director of nursing (DON) verified shaving is part of a residents personal hygiene/grooming task to be done daily or as needed. The DON further stated it was her expectation staff would follow the care plan for residents. The facilities Personal Care Policy dated 10/09, indicated criteria for determining adequate and proper care includes assistance with or supervision of shaving of all residents as necessary to keep them clean and well groomed.	F 282		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care	F 309		5/8/17

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F 309	Continued From page 8 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (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 observation, interview and document review the facility failed to provide care related to the application of a palm protector as recommended by occupational therapy (OT) for 1 of 1 resident (R70) reviewed with skin integrity concerns related to a contracture (a condition of shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints) of the left hand. Findings include:	F 309	F 309 1.Resident (R70) was observed to not have palm protector during observations. Palm protector obtained and placed in resident□s palm upon notification of the omission. Education done with nurses working with resident outlining the expectation of placement palm protector and assessment of resident□s hand. NAR Care Sheets updated for staff to know that resident has a palm protector.	

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F 309	Continued From page 9 Review of the face sheet, dated 4/13/17 identified R70 was admitted to the facility on 5/26/17, with diagnoses including hemiplegia and hemiparesis affecting left non-dominant side. Review of the quarterly Minimum Data Set (MDS) assessment dated 2/13/17, identified R70 had a functional limitation in range of motion (ROM) of the upper extremity which included the shoulder, elbow, wrist and hand. Review of R70's care plan dated 11/20/16, identified R70 had potential/actual impairment to skin integrity related to impaired mobility and function due to cerebral vascular accident (CVA) with left sided weakness. Interventions included: (1) wear palm protector for one hour BID (twice daily), (2) keep hands from excessive moisture, (3) keep fingernails short, (4) monitor skin weekly and daily with a.m. and h.s. (hour of sleep) cares. Review of R70's resident care sheet, updated 4/11/17 did not identify the use of a palm protector for R70. Review of the OT plan of care for R70 dated 9/16/16, identified the reason for referral was to fit with an appropriate hand orthotic in order to maintain range of motion (ROM) in left hand for proper hand hygiene and prevent skin breakdown. R70's OT progress and discharge summary dated 10/10/16, identified discharge plan and instructions to recommend patient wear palm protector overnight and part time during the day as tolerated to protect skin in left hand.	F 309	2.Audit for palm protector placement will be completed weekly for 2 months by the DON or designee to ensure that palm protector is being placed. Audit findings will be reported to QAPI Committee in July 2017. 3.Licensed staff and NARs will be educated on documentation policies at meeting on May 8, 2017. 4.The plan of correction will be completed by May 8, 2017.	

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F 309	Continued From page 10	F 309		

Review of the current treatment administration record (TAR) dated April 2017, identified R70 to wear palm protector for one hour twice daily (BID) every day and evening shift. Documentation revealed the treatment was implemented twice daily.

During observations on 4/10/17, at 5:35 p.m. and 7:00 p.m.; on 4/11/17, at 9:00 a.m., 11:15 a.m., 1:25 p.m.; on 4/12/17, at 7:11 a.m. and 11:00 a.m.; and on 4/13/17, at 8:37 a.m. R70 did not have a palm protector applied at any time. During these observations, R70's nails were observed to be long and his fingers pressed into his left hand. An indentation was noted, but no skin breakdown was observed.

During observation on 4/12/17, at 7:11 a.m. R70's cares were being completed by nursing assistant (NA)-D. R70 was in bed and did not have a palm protector nor any kind of soft rolled device in his left hand. NA-D stated R70 used to have a splint, but hadn't seen it for quite some time. NA-D searched R70's drawers but did not find any device for R70's hand.

When interviewed on 4/13/2017, at 8:52 a.m. NA-B stated R70 doesn't use anything in his hand during the day. NA-B stated, "I think it used to be a carrot type thing but just at night; I think now they put a wash cloth in but just at night".

During interview on 4/13/17, at 9:00 a.m. registered nurse (RN)-C verified R70 should have a palm protector on the left hand. RN-C stated the NA's should apply the protector and then licensed staff sign off on the TAR. RN-C also verified that R70's nails were too long and should

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F 309	Continued From page 11 be cut. During interview on 4/13/17, at 8:37 a.m. RN-B verified R70 should have a palm protector in the left hand. During observation with the surveyor, RN-B verified R70 currently did not have the palm protector applied. RN-B searched R70's room and was unable to find the palm protector. During interview on 4/13/17, at 10:00 a.m. the occupational therapist inspected R70's hand and verified that R70 should be using the palm protector as defined in the plan of care.	F 309		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with grooming related to facial shaving for 1 of 1 resident (R10) reviewed for activities of daily living (ADL) and required limited staff assistance. Findings include: R10's admission Minimum Data Set (MDS) assessment dated 2/28/17, identified R10 with a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS further identified R10 as requiring limited assistance of one staff for personal hygiene (which included shaving) and no behaviors or	F 311	F311 1. Female resident (R10) was noted to have visible facial hair. Resident was shaven. Care plan was updated and follow-up monitoring by nurse was put in place. 2. All female residents of the facility will be assessed upon admission and routinely to determine if facial hair grooming needs to be completed. If the need is identified, care plan will be updated and nursing follow-up on TAR. 3. Licensed staff and NARs will be educated on personal care and shaving	5/8/17

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F 311	Continued From page 12 rejection of care. R10's care area assessment (CAA) for ADLs dated 3/3/17, indicated R10 required assistance of staff with all aspects of ADL's except eating. It further identified R10 as being alert and oriented to place and person with some periods of forgetfulness and confusion. R10's care plan last revised 3/23/17, and resident care sheet dated 4/11/17, indicated R10 required assistance of one staff member to assist in grooming. The care plan further identified R10 with impaired cognitive function/dementia and to keep R10's routine consistent to decrease confusion. During initial observation on 4/10/17, at 2:11 p.m. R10 was seated in a recliner located in her room. Gray/white whiskers were observed on R10's upper lip and chin area. The facial hair was easily visible from conversational distance. During observation on 4/11/17, at 8:12 a.m. R10 was dressed and eating breakfast in the dining room. R10 continued to have thick gray/white facial hair approximately 0.5 centimeters (cm) in length that was visible on upper lip and chin area. During interview on 4/11/17, at 11:14 a.m. R10 stated she tries to look nice everyday and would "want that off" if facial hair was present. During observation on 4/12/17, at 7:31 a.m. nursing assistant (NA)-A was shaving R10's facial hair. R10 was calm and cooperative during process. NA-A stated R10 needed assistance to shave but wasn't always cooperative. NA-A	F 311	policies and procedures at meeting on May 8, 2017. This education includes expectations for proper grooming, which includes facial shaving. 4. Care plan, NAR charting, Nurse Charting, and resident visual audits will be completed bi-weekly for the next 3 months by the DON or designee to ensure that residents are appropriately groomed or there is documentation of refusal. Audit findings will be reported to QAPI Committee in July 2017. 5. The plan of correction will be completed by May 8, 2017.	

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F 311	Continued From page 13	F 311		

indicated she had not shaved R10 the previous day because R10 had refused. NA-A further stated residents should be shaved when they need it, and refusals should be documented.

Review of NA and nurse charting for the previous 14 days did not include any care refusal from R10. This was confirmed with registered nurse (RN)-A on 4/12/17, at 8:28 a.m. During interview at this time, RN-A stated she was not aware of R10 ever refusing to be shaved. RN-A indicated R10 needs re-approaching or coaxing for cares at times but would expect staff to shave R10 for grooming needs daily or to report and document refusals so that the care plan could be revised.

During interview on 4/12/17, at 9:45 a.m. trained medication aide (TMA)-A stated R10 requires staff assistance with grooming and shaving and was unaware of shaving refusals by R10.

During interview on 4/12/17, at 9:54 a.m. NA-A stated R10's whiskers were "too long" and confirmed the gray/white thick whiskers covered her upper lip and chin area. NA-A indicated the whisker growth was more than a couple days of growth for R10.

When interviewed on 4/13/17, at 9:06 a.m. the director of nursing (DON) verified shaving is part of a resident's personal hygiene/grooming tasks to be done daily.

The facilities Personal Care Policy dated 10/09, indicated criteria for determining adequate and proper care includes assistance with or supervision of shaving of all residents as necessary to keep them clean and well groomed.

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F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to:	F 441		5/8/17

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 ______	04/13/2017

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 441	Continued From page 15 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff utilized proper hand hygiene and clean technique during urinary catheter bag care for 1 of 2 residents (R212) reviewed with indwelling urinary catheters. Findings include:	F 441	F441 1.Catheter cares were observed with resident (R212) and improper infection control was noted. Education on infection control and catheter cares provided on 4/14/17 to the staff member that was observed providing the catheter cares. 2.Urinary draining tubing tip cover, hand	

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F 441	Continued From page 16	F 441		

R212's face sheet, dated 4/13/17, identified current diagnoses including: sepsis, urinary retention, flaccid neuropathic bladder and benign prostatic hyperplasia (prostate enlargement).

R212 did not yet have a Care Area Assessment (CAA) nor Minimum Data Set (MDS) assessment completed, due to the date of the recent admission. However, R212's Resident Care Sheet, undated indicated he had an indwelling Foley catheter. R212's physician's orders dated 4/13/17, indicated admission orders for a 16 French Foley catheter.

R212's urology visit note, dated 2/27/17 indicated R212 would require an indwelling catheter due to an enlarged prostate, urine retention and atonic bladder.

R212's hospital progress note, dated 3/22/17 indicated R212 had recently experienced a bladder infection with Enterococcus bacteria, due to the indwelling catheter and had been treated for severe sepsis.

During interview on 4/11/17, at 1:28 p.m. R212 stated he had a urinary catheter for a "complete blockage" which prevented normal urination . R212 stated the staff switch the drainage bag for his catheter from a leg bag during the day to a drain bag at night.

During observation on 4/12/17, at 7:16 a.m. R212 was getting ready for breakfast and was assisted by nursing assistant (NA)-E. A graduate, covered with a paper towel and containing approximately 400 milliliters of dark amber urine was noted to be sitting on the back of R212's

washing, and catheter care audit to be completed bi-weekly for the next 3 months by the DON or designee to ensure that covers are on during storage, proper hand washing techniques are used, and catheter cares are done appropriately. Audit findings will be reported to QAPI Committee in July 2017.
3.Licensed staff and CNAs will be educated on disinfection of urinary drainage bag, application of leg bag, routine catheter care, infection control, and hand washing policies and procedures at meeting on May 8, 2017. This education includes expectations for proper infection control, competency of catheter cares, and hand washing.
4.The plan of correction will be completed by May 8, 2017.

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PATHSTONE LIVING	718 MOUND AVENUE MANKATO, MN 56001

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F 441	Continued From page 17 toilet. NA-E stated she had already changed R212's drain bag for the leg bag; however, had not finished cleaning R212's drainage bag. It was noted that R212's drain bag was stored in a plastic basin on a shelf in his bathroom, covered with a towel. After completing dressing and grooming cares, NA-E assisted R212 from the bathroom and proceeded to care for the drainage bag. NA-E applied gloves and removed R212's soiled urinary drainage bag from the plastic bin, lying it on a towel on the side of his hand sink. The exposed end of the catheter tubing was observed to touch the hand sink basin. It was observed that the tip of the tubing, which attached directly to the indwelling catheter was not capped. NA-E cleansed the tip of the tubing (where it joins the catheter) with an alcohol wipe, then proceeded to unclamp the lower drain end of the catheter and cleansed the bottom tip. NA-E took a large syringe from the same basin which the bag had been stored and attempted to withdraw vinegar solution from a sterile UA (urinalysis) cup twice. NA-E was unsuccessful as the syringe had a cap on it. NA-A then removed the syringe cap, inserted the tip of the syringe into the upper end of the catheter tubing and proceeded to flush the tubing with approximately 30 milliliters (ml) of vinegar. NA-E proceeded to lift the tubing up and drain the bag into R212's toilet; however, the vinegar solution in the bag drained onto the floor in front of R212's toilet as the lower clamp had not been secured after flushing. NA-E stated there , "should be a cap for this catheter; I can get one; the end should be covered." NA-E then wiped the upper tubing tip and the lower drain end of the catheter bag with the alcohol swab, coiled up the tubing and placed the syringe, the vinegar container and	F 441		

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F 441	Continued From page 18	F 441		

the catheter drain bag back into the plastic basin, covering it with a towel. The tubing tip remained exposed. NA-E then removed her gloves, and began to wash her hands, stating, "if there were soap, I would use it." No soap was observed to be utilized during hand hygiene. NA-E dried her hands with a paper towel, and with ungloved hands took a bath towel and cleaned up the vinegar solution in front of R212's toilet that had drained from the soiled urine drainage bag.
NA-E disposed of the towel into a soiled utility receptacle, and proceeded to take the urine graduate/container located on the back of R212's toilet. NA-E noted the urine output and dumped the urine into R212's toilet. Without rinsing the graduate, NA-E grabbed a paper towel from the wall dispenser and inverted the graduate on top of it. NA-E gathered her transfer belt and proceeded to answer another call light across the hall, without cleansing her hands.

During interview on 4/12/17, at 7:42 a.m. trained medication aide (TMA)-F stated catheters were always stored in the resident rooms in a basin, and should be flushed with vinegar. The TMA or nurse on the unit retrieved the vinegar for the staff and put it into a sterile cup.

When interviewed on 4/12/17, at 9:26 a.m. registered nurse (RN)/Education Director (ED) stated staff should be cleaning urinary catheter drain bags in the soiled utility room, over a hopper with a 1:3 vinegar solution, after which they were capped and stored in a clean basin in the resident's room. The RN/ED also stated they recently had a skills fair which included catheter care/handwashing procedures. The RN/ED (also Infection Control Coordinator) stated NA-E

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F 441	Continued From page 19 should have worn gloves to clean up the floor in R212's room, and should have been using soap to wash her hands. During a follow-up observation and interview on 4/13/17, at 8:12 a.m. R212's urinary drainage bag was observed in a basin without a cap on the tubing end. NA-G stated the urinary drainage tubing tip covers usually got thrown out "unless they are brand new." The bag was also noted to have a whitish residue on the interior. The syringe used for cleansing/flushing with the vinegar solution was stored in the basin with the soiled catheter bag. The facility policy, entitled Disinfection of Urinary Drainage Bag, undated indicated the connecting ends of the catheter should not touch other surfaces to avoid contamination, and the drain bags should be stored after cleansing with vinegar on a clean towel or in a clean plastic bag, allowing the exterior to air dry. The facility policy, entitled Hand Hygiene Policy and Procedure, undated indicated hands should be washed when they are visibly dirty or contaminated with proteinaceous material or are visibly soiled with blood or other body fluids. Additionally, the policy indicated hands should be washed with soap and water after contact with body fluids or excretions, mucous membranes, non-intact skin and would dressings even if hands are not visibly soiled.	F 441		

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING **01 - MAIN BUILDING** B. WING ______	**04/13/2017**

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

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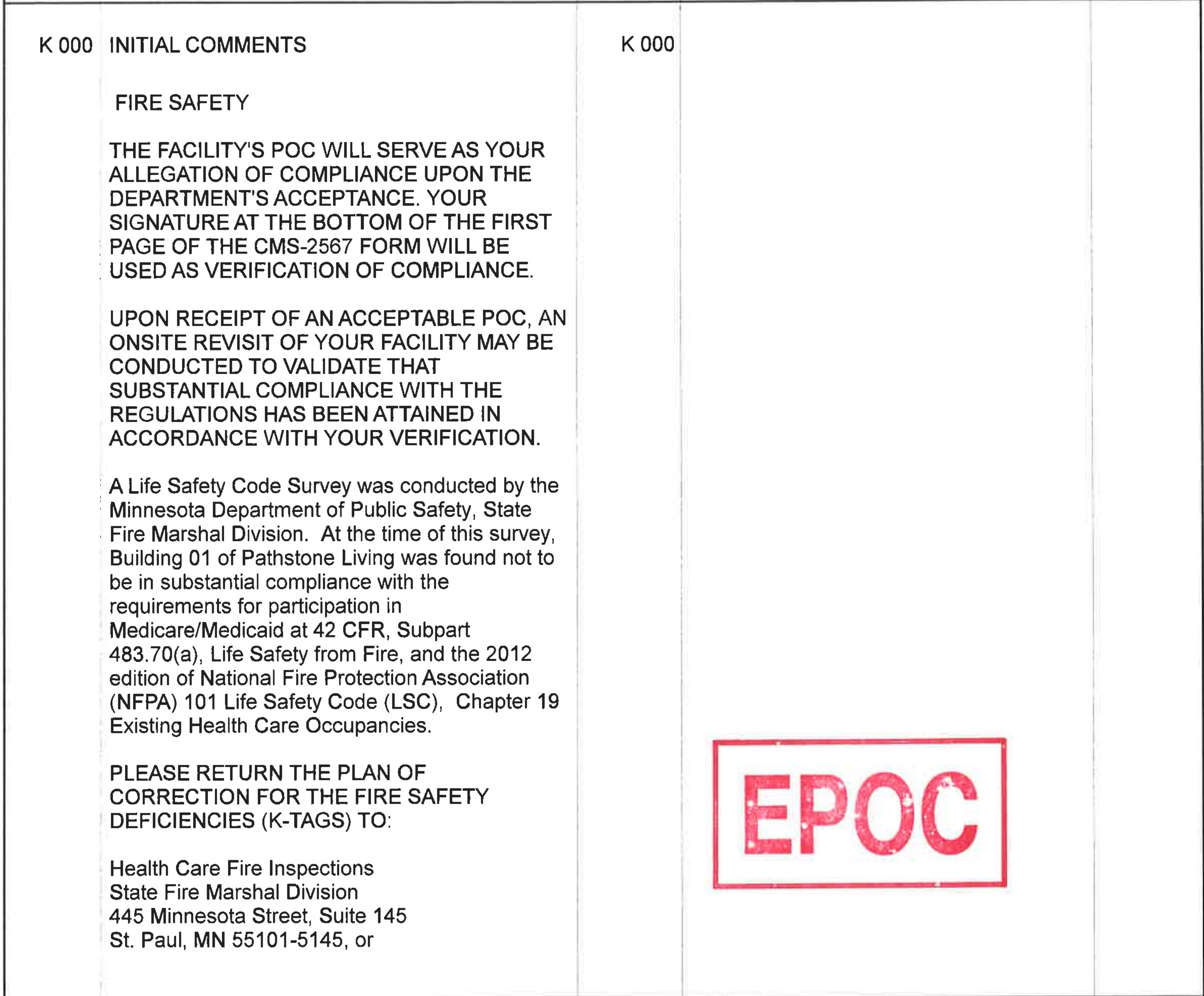

K 000 INITIAL COMMENTS — K 000

FIRE SAFETY

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.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Building 01 of Pathstone Living was found not to be in substantial 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.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/05/2017

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING 01 - MAIN BUILDING B. WING	04/13/2017

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K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

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 67 at time of the survey.

These Buildings are being surveyed as one

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	245390	A. BUILDING **01 - MAIN BUILDING** B. WING	**04/13/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 2 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 requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 291 SS=E	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This **STANDARD** is not met as evidenced by: Based on observation and interview, the Facility failed to maintain emergency lighting in accordance with 7.9. The deficient practice could affect 67 out of 67 residents. Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 FINDINGS INCLUDE: On facility tour between 12:00 PM and 4:00 PM on 04/13/2017, documentation could not be located to indicate that the emergency light located near the emergency generator had received a 30 second test monthly and the annual 90 minute test. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 291	1. Documentation could not be located regarding the generator emergency lighting. A 90 minute test was completed in April 2017. 2. The testing of the generator emergency light was added to the Preventative Maintenance Schedule in the auto-generated computer system for maintenance. The 90 minute test is scheduled for annually in April and the 30 second test has been scheduled for the remaining eleven months. The computer system leaves the work order open until completed. The Executive Director is notified of any incomplete work orders for the month via email.	5/5/17