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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OXKL

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 **05/08/2015** (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: * Code: **A** (L12)

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

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 :
Pamela Manzke, HFE NE II 05/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/19/2015 (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
Posted 06/19/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/11/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245390

June 19, 2015

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

Dear Ms. Pfeffer:

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

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

Effective April 30, 2015 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, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

May 19, 2015

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

RE: Project Number S5390024

Dear Ms. Pfeffer:

On April 13, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 2, 2015. 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 May 8, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 18, 2015 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 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 2, 2015, effective April 30, 2015 and therefore remedies outlined in our letter to you dated April 13, 2015, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245390	A. Building B. Wing	5/8/2015

Name of Facility	Street Address, City, State, Zip Code
PATHSTONE LIVING	718 MOUND AVENUE MANKATO, MN 56001

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	04/13/2015	ID Prefix F0242 Reg. # 483.15(b) LSC	04/24/2015	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	04/30/2015
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	05/19/2015	28591	05/08/2015
CMS RO				

Followup to Survey Completed on: 4/2/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245390	A. Building B. Wing **01 - MAIN BUILDING**	5/18/2015

Name of Facility	Street Address, City, State, Zip Code
PATHSTONE LIVING	718 MOUND AVENUE MANKATO, MN 56001

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **04/17/2015**	ID Prefix	Correction Completed **04/07/2015**	ID Prefix	Correction Completed **04/20/2015**
Reg. # **NFPA 101** LSC K0029		Reg. # **NFPA 101** LSC K0069		Reg. # **NFPA 101** LSC K0076	
ID Prefix	Correction Completed **04/09/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0147		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/19/2015	35482	05/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/31/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OXKL

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 **04/02/2015** (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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * 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 :
Kathy Hahn, HFE NE II 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/11/2015 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 6060

April 13, 2015

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

RE: Project Number S5390024

Dear Ms. Pfeffer:

On April 2, 2015, 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - 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
Minnesota Department of Health
1400 East Lyon Street
Marshall, MN 56258-2529

Email: kathryn.serie@state.mn.us
Office: (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 May 12, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 2, 2015 (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 2, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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.

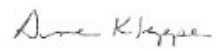
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

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 _____ B. WING _____	04/02/2015

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'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 241** 1. Corrective action: A. Affected resident was reassessed for ability to feed self and need for supervision by nursing staff. It was determined and communicated to staff that the affected resident did not require staff assistance and therefore would not need to wait for nursing staff and could be served promptly upon presenting to dining room for meals. 4/13/15 2. Corrective action as it applies to other residents: A. All residents assigned to tables requiring the presence of nursing staff before being served were assessed for their ability to feed self or need for supervision. B. Reorganization of the dining room tables was completed for those residents that did not require staff assistance or supervision to sit a table that allows them to be served promptly. 4/13/15	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified and timely dining experience for 1 of 10 residents (R33) observed during meal service who were located in the assisted dining area. Findings include: On 3/31/15, at 11:55 a.m. R33 was observed seated in his wheelchair (w/c) in the dining room during the noon meal service, waiting for staff assistance. After waiting 40 minutes (12:35 p.m.) for staff to place his food order, R33 received his meal tray at 12:39 p.m. R33 consumed the food items independently and did not require staff	F 241	approved exmt 4/27/15	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 4/24/15

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.

RECEIVED
APR 27 2015
Minnesota Department of Health
Marshall

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 _____ B. WING _____	04/02/2015

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 241	Continued From page 1 assistance with eating. It was observed that R33 abruptly left the dining area at 12:46 p.m. and had not yet finished eating his noon meal. Later, at approximately 1:30 p.m. R33 was observed seated in his room with a fresh tray of food. Without any staff present, R33 independently consumed the remaining of his noon meal. When interviewed at this time, R33 indicated he had to leave the dining room earlier (12:46 p.m.) because "nature was calling". On 4/2/15, at 7:32 a.m. R33 was observed seated in his w/c in the dining room during the breakfast meal service. At 7:55 a.m. R33 was interviewed and stated his food order had not been taken yet and he was getting "hungry". R33 started tapping the table with two fingers stating, "I'm in the wrong corner." It was observed that R33 rolled back and forth in the w/c while watching other residents enter the dining room and receive their food trays. Nursing and dietary staff were noted to walk past R33 without offering to take his food order. Thirty minutes later, at 8:02 a.m. R33 expressed being hungry while registered nurse (RN)-A placed hearing aids in his ears. RN-A indicated she did not hear any stomach growling yet and walked away to retrieve his medications. Upon return with the medications at 8:05 a.m., R33 again expressed that he was hungry. At 8:07 a.m. RN-A proceeded to take R33's breakfast food order. At 8:17 a.m. R33 was finally served his breakfast meal (45 minutes after entering the dining room). It was noted that residents from 10 other tables located throughout the dining room were served prior to R33, even though R33 had entered the dining area before the other residents; their orders were taken immediately and meals served promptly.	F 241	3. Date of Completion: 4/13/15 4. Reoccurance will be prevented by: A. Staff were instructed that residents who could feed themselves may be brought to the dining room and dining staff will serve them promptly. Either dining or nursing staff may assist with set up. B. Dining staff were educated on 4/13 and nursing staff on 4/15 about the change in the meal service process. C. Residents' eating ability will be assessed a least quarterly or as needed when their condition changes. D. Will conduct dining room observation audits monthly for 6 months to ensure compliance. 5. The correction will be monitored by: A. Dining Specialist or designee B. Audit findings will be reported at the Quality Council meeting in October 2015.	

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F 241	Continued From page 2 R33's care plan with last revision noted 3/16/15, indicated: "Resident is able to eat independently does occasionally need set up assist. Resident does need verbal cues to continue to eat." When interviewed on 4/2/15, at 10:39 a.m. the dining director (DD) stated the dining room is divided into different areas with six assisted eating tables. DD stated that nursing staff must be present when residents at the assisted tables are eating and they are also responsible for taking meal orders at those tables. DD stated that when a resident is hungry and located at an assisted table, they will find nursing staff to help them. When interviewed on 4/2/15, at 1:41 p.m. the director of nursing (DON) stated she would expect staff to not transport residents into the dining room until they are ready to eat. The DON stated the expectation would be for residents to only wait five to ten minutes for their food. She further indicated that a resident who is independent with eating should be served their meal upon arrival to the dining room as it isn't fair for the resident to have to wait a long time for service. The DON confirmed the extended wait time for meal service identified during the noon meal on 3/31/15 and during the breakfast meal on 4/2/15 for R33 was an undignified dining experience and the facility would need to reassess the situation.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care;	F 242	**F242** 1. Corrective action: A. On 4/2/15 affected resident was asked his bathing preferences and bathing schedule was changed accordingly. 2. Corrective action as it applies to other residents: A. All residents will be asked their preference for bathing upon admission. B. Preferences will be identified on the bathing schedule and care plan. C. Bathing preferences will be reviewed at care conference. D. Handbook will be updated to include information for residents about allowing choice in bathing preferences.	

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F 242	Continued From page 3 interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to honor resident bathing preference for 1 of 3 residents (R71) reviewed for choices. Findings include: R71's admission Minimum Data Set (MDS) dated 3/13/15, revealed R71 was cognitively intact with no delusions, hallucinations nor refusal of care concerns noted. R71 required physical assistance during transfers only for bathing needs. The MDS document revealed R71 was hospitalized from 3/16/15 until 3/20/15. During resident interview on 3/31/15, at 1:47 p.m., R71 was asked "Do you choose how many times a week you take a bath or shower?" R71 responded "no" and reported he would choose at least two baths a week but currently only received a bath on Saturday. When interviewed on 4/2/15, at 10:05 a.m. R71 was again asked how many baths he wanted a week. R71 independently recalled surveyor had previously asked him that question and responded that his answer would remain the same, two baths a week. R71 indicated that no staff had ever asked him the number of baths he desired/week nor which day was his preference, except when the surveyor posed the question. R71 further indicated that due to a regular commitment on Saturday nights, he had to refuse, at times, the scheduled bathing	F 242	3. Date of Completion: 4/24/15 4. Reoccurrence will be prevented by: A. Nursing staff were educated about this revised process at a nurses meeting on 4/15/15. B. Will conduct monthly audits for 6 months to ensure compliance of residents' right to make choices about bathing preferences. 5. The correction will be monitored by: A. Clinical Director or designee B. Audit findings will be reported at the Quality Council meeting in October 2015.	

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F 242	Continued From page 4 time set by staff. On 4/2/15, at 9:28 a.m. the clinical coordinator/registered nurse (RN)-A reported that either the admissions nurse or the activity staff asked residents about their bathing schedule preferences. On 4/2/15, at 9:46 a.m. the activities director reported she completed the MDS section regarding resident preferences with R71, but never asked him how many baths he would want a week. The activities director reported she thought nursing staff developed the bathing schedules. On 4/2/15, at 11:47 a.m. the admission nurse (RN)-B reported she did not ask about bathing schedule preferences during her assessment. RN-B reported the nursing assistants were responsible for asking residents when regular bath days should be scheduled, but otherwise residents baths were scheduled per room number. On 4/2/15, at 1:21 p.m. the director of nursing (DON) reported the facility had no policy and procedure to ensure residents were consulted regarding bathing schedule preferences. When the DON was requested to find documentation related to bathing schedule preferences for R71, the DON was unable to find any related documentation in the medical record. On 4/2/15, at 2:01 p.m. the social service director and social service admissions specialist reported they did not ask residents about bathing schedule preferences and had no evidence R71 had been consulted regarding his preferences.	F 242		

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F 242	Continued From page 5 On 4/2/15, at 2:19 p.m. the health unit coordinator (HUC) reported she completed the bathing schedule and they were scheduled by room number unless she heard the resident requested something different. The HUC reported the nursing assistants should have informed her if R71 wanted a different bathing day and/or more than one bath/week. A few minutes later, the HUC reported she was just informed R71 had requested a change in scheduled bathing day. A review of the social service admission checklist, dated 3/6/15 included only an acknowledgement of information and authorization for the facility to complete various services for the resident. The checklist did not include ensuring residents were consulted regarding preferences. A review of the interdisciplinary progress notes, dated 3/7/15 to 4/2/15, included no indication the facility consulted R71 regarding his bathing schedule preferences. R71's admission nursing assessment, dated 3/7/15 and readmission assessment, dated 3/20/15 revealed R71 required physical help with bathing, but included no indication R71 was consulted regarding his bathing schedule preferences. A review of R71's bathing record revealed R71 was offered and declined a bath on Saturday 3/7/15 and Saturday 3/28/15 (the same time as his regularly scheduled commitment). R71 was offered and accepted a bath on 3/8/15 and 3/14/15. No other baths were offered. The bathing schedule revealed R71's was	F 242		

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F 242	Continued From page 6 scheduled for a bath on Saturday afternoon, according to his room number.	F 242		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must 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 follow the plan of care for 1 of 3 residents (R145) reviewed with pressure ulcers. Findings include: On 3/31/15, at 8:31 a.m. the clinical coordinator/registered nurse (RN)-A reported R145 had unstageable ulcers located on both of her heels. R145's Resident Care Sheet, dated 4/1/15, directed staff "float heels when in bed, heel protectors on when at rest". R145's treatment administration record (TAR) for April 2015, directed staff, "Heel protector boots to be worn at all times". The licensed nurse or trained medication aide on each shift would verify the treatment. The care plan, last updated 2/2/15 directed staff "float heels when in bed along with heel protectors on" An order from the nurse practitioner wound nurse, dated 2/4/15, directed staff, "bilateral heel boots." On 4/2/15, at 7:18 a.m. R145 was observed seated in the wheelchair in the common living	F 282	**F282** 1. Corrective action: A. Order was clarified and affected residents care plan was updated to match the TAR on 4/2/15. 2. Corrective action as it applies to other residents: A. Care plans and care sheets for all residents with pressure ulcers were reviewed to ensure that interventions were accurate and staff were following plan of care. 3. Date of completion: 4/3/15 4/30/15 added per DON Kim Rydeen, 4. Reoccurrence will be prevented by: A. On 4/15/15 nursing staff were educated about the importance of clarifying orders and ensuring that the TAR and care plan match. B. Will conduct monthly audits for 6 months to ensure accuracy of care plan interventions and staff compliance with following the care plan.	

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F 282	Continued From page 7 area of the unit. R145 was not wearing protective boots on her feet but only wearing socks. At 7:36 a.m. and 7:39 a.m. R145 was observed to remove her feet from the metal foot pedals of the wheelchair and sweep and/or swing her feet on the floor before firmly placing them back onto the foot pedals. At 8:04 a.m. RN-D provided R145 with her medications and did not offer to assist R145 with putting her bilateral protective boots on her feet. At 8:04 a.m. R145 was taken to the dining room by the education coordinator and remained there from 8:05 a.m. until 9:00 a.m. Protective boots were not applied nor offered. At 9:00 a.m. the trained medication aide (TMA)-A assisted R145 into her recliner and placed the protective boots on both of her feet. On 4/2/15, at 10:11 a.m. RN-A confirmed with the nurse practitioner wound specialist that the protective boots for R145 were to be worn at all times. RN-A verified the directions regarding protective boots were inconsistent and should have been clarified with the nurse practitioner wound specialist earlier to ensure the care plan was consistently followed for R145. During an observation with RN-D on 4/2/15, at 10:50 a.m. black circles of necrotic skin located on the bilateral heels of R145 were noted and were consistent with unstageable pressure ulcers.	F 282	5. The correction will be monitored by: A. Clinical Director or designee B. Audit findings will be reported at the Quality Council meeting in October 2015.	

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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 _____	03/31/2015

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

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K 000	INITIAL COMMENTS 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, on March 31, 2015. 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 2000 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	K 000	POC FB 5-4-15 RECEIVED APR 27 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 4-9-15 DC: 5-12-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Executive Director	4/23/15

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and 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. This facility will be surveyed as two separate buildings. Pathstone Living was original constructed in 1992, is one-story, with no 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 68 at time of the survey.	K 000		
K 029 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 2 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 20 out of 68 residents. Findings include: On facility tour between 9:00 AM and 2:00 PM on 03/31/2015, observation revealed that the following was found: 1. There is an open penetration in south wall , around cabling, of the Boiler Room. 2. The door from the Loading Dock/Storage room going into the corridor has a gap between the double doors exceeding 1/8 inch. These deficient practices were confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 029	Jim Gatchell, Environmental services Director, completed all the following; 1. Fire caulking was added around the cable on the south side of the boiler room. 2. The upper hinge on the door was replaced, the door was leveled, and a protective edge was added one of the doors to decrease the gap to 1/8 inch or under.	4/13/15 4/17/15

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069 K 069 SS=D	Continued From page 3 NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on visual observation, the facility's commercial kitchen cooking equipment was not maintained in accordance with NFPA 101 (2000) Section 9.2.3 and NFPA 96 (1998) Section 9-1.2.3 . This deficient practice could adversely affect 20 out of 68 residents and staff. FINDINGS INCLUDE: On facility tour between 9:00 AM and 2:00 PM on 03/31/2015, observation revealed that there was not a 16 inch separation or an 8 inch baffle between the deep fat fryer and the open flame stove. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 069 K 069	A 12 inch Stainless Steel baffle was added to the right side of the fryer next to the stove to create a splash barrier.	4/7/15
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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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 _____	03/31/2015

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
K 076	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, the facility was storing medical gas cylinders in a manner not in conformance with NFPA 99 (1999 edition) Chapter 4, Section 4-3.1.1.1 and Chapter 8, Section 8-3.1.1. . This deficient practice could adversely affect residents, staff or visitors in the vicinity of the Oxygen Storage Room. FINDINGS INCLUDE: On facility tour between 9:00 AM and 2:00 PM on 03/31/2015, observation revealed six (6) oxygen "E" cylinders were not secured properly to prevent tanks from falling over in the Oxygen Storage Room on the 3500 Nurses Station. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 076	The Oxygen storage room has been added to my weekly tour, a sign has been placed on the wall reminding staff that all tanks must be in the protective racks, and all nursing staff will be reminded at the next nursing in-service about securing O2 tanks on 4/15/15.	4/20/15
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain electrical wiring and/or equipment in accordance with the requirement at NFPA 101 (2000) Chapter 9, Section 9.1.2. This deficient practice could adversely affect 20 out of 68	K 147		

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 _____	03/31/2015

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

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K 147	Continued From page 5 residents. FINDINGS INCLUDE: On facility tour between 9:00 AM and 2:00 PM on 03/31/2015, observation revealed in the Dining Room, above the lay in ceiling, the power cord for the charting kiosk was run in the wall without proper conduit. NOTE: All power sources for all the charting kiosks throughout the facility should be checked for this deficiency. This deficient practice was confirmed by the Facility Maintenance Director (JG) at the time of discovery.	K 147	BLK Electric was contracted to put all kiosk wiring in protective conduit, fire caulk around outside of conduit and put fire putty inside the conduit on both ends.	4/9/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING 02 - 2008 ADDITION B. WING:	03/31/2015

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
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 March 31, 2015. At the time of this survey, Building 02 of Pathstone Living was found 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 2000 edition of National Fire Protection Association (NFPA) 101 Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. This facility will be surveyed as two separate buildings. Pathstone Living, 2008 addition is a 2-story building with with a partial basement. The 2008 addition was determined to be of Type II(111) construction and is fully fire sprinkler protected. 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. The facility has a capacity of 69 beds and had a census of 68 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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APR 27 2015
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

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.