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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YXJ2

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 **5/18/2021** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **69** (L18)

13.Total Certified Beds **69** (L17)

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

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 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 :
Elizabeth Silkey, Unit Supervisor — 05/19/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 05/19/2021 (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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 19, 2021

CMS Certification Number (CCN): 245390

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Dear Administrator:

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 26, 2021 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 19, 2021

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: March 25, 2021

Dear Administrator:

On April 15, 2021, we notified you a remedy was imposed. On May 18, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 26, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 30, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of April 15, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 30, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on April 26, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YXJ2

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Facility ID: 00036

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(L3) **PATHSTONE LIVING**
(L4) **718 MOUND AVENUE**
(L5) **MANKATO, MN** (L6) **56001**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/25/2021** (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
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To (b) :

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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 :
Craig Rosfjord, HFE NE II 05/07/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 05/18/2021 (L20)

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

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

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 15, 2021

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: March 25, 2021

Dear Administrator:

On March 25, 2021, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective May 30, 2021.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective May 30, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 30, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for

new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by May 30, 202, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Pathstone Living will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 30, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 25, 2021 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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 _____	C 03/25/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 03/22/21 through 03/25/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 03/22/21 through 03/25/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be not compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be unsubstantiated: H5390030C (MN68176), H5390031C (MN62402), and H5390032C (MN59945). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2021

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 _____	C 03/25/2021

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	Continued From page 1 regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to	F 578		4/23/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 03/25/2021

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 578	Continued From page 2 provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident advanced directives (AD) were included in the medical record, while pending physician orders for 1 of 14 residents (R109) reviewed for AD. Findings include: Review of R109's admission record indicated the resident was admitted to the facility on 3/19/21. The record identified R109 as having diagnosis that included hypertension, iron deficiency anemia, hyperlipidemia and spinal stenosis. Review of R109's current physician orders dated 3/19/21, did not include an AD or physician ordered life-sustaining treatment (POLST). Review of R109"s electronic and paper medical record, did not include a resident/POA signed AD or POLST. Interview on 3/22/21, at 6:30 p.m., registered nurse (RN)-A confirmed R109 did not have an AD in the medical record. RN-A indicated a POLST is kept in the residents paper medical record for the staff to review. RN-A stated if there is not a POLST in the medical record or the plan of care he would not know what the residents AD status was, if the resident were to go in to cardiac arrest. RN-A further stated he would probably initiate cardiac pulmonary necessitation (CPR).	F 578	1.Immediate corrective action was taken during the MDH survey and a POLST was placed in the resident□s chart. 2.All current resident charts have been checked for a POLST. 3.The POLST policy and procedure has been reviewed with the admission□s nurse, nurse managers, floor nurses and the social worker. No changes were made to the existing procedure or process. 4.All existing charts have been checked for POLST forms. Weekly audits will be conducted on new admissions to ensure POLST is in the residents chart. Audits will be weekly for 4 weeks and then frequency of audits will be determined by the QAPI committee. 5.House wide audit completed on 4/23/21. Audits to be ongoing at this time.	

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F 578	Continued From page 3 Interview on 3/23/21, at 10:30 a.m., nurse manager (NM)-A confirmed R109 did not have a AD or POLST in the medical record. NM-A indicated the facility social worker (SW) keeps a copy of the residents POLST in her office, until the physician has signed the original document. The signed POLST is then placed in the residents medical record. Interview on 3/23/21, at 1:45 p.m., the facility SW and facility director of nursing (DON) confirmed R109 did not have an AD nor a POLST in the medical record. The SW indicated upon admission a POLST is completed with the resident and POA by the admission nurse. The SW indicated the POLST is then signed by the resident or POA and a copy is placed in the residents paper medical record, until the original is signed by the physician. The DON indicated R109 had a POLST completed, but a copy was not placed in R109's medical record. Interview on 3/23/21, at 2:30 p.m., RN-B and RN-C both confirmed R109 did not have a an AD nor a coy of a POLST in the medical record. RN-B and RN-C both indicated a copy of the residents POLST is placed in the paper medical record for staff to review. They both indicated they did not know what R109's AD status was and would probably initiate CPR, if the resident would go in to cardiac arrest. Review of the facility policy Advance Directives, revised 7/20, included a procedure that directs staff to place a copy of the residents POLST form in the resident medical record, until the original is signed by the physician. The procedure also directed staff to include the AD in the residents	F 578		

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F 578	Continued From page 4 plan of care.	F 578		
F 688 SS=D	. Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper extremities was implemented for 1 of 2 residents (R38), who had limited range of motion, and also failed to implement a wrist brace to prevent contractures. Findings include:	F 688	1.Resident R38 has received evaluation from OT regarding ROM and splint, OT has ordered a new splint. Resident R38□s care sheets have been undated with current plan. ROM/Splint plan has been added to TAR to ensure daily compliance. On 3/24/21 resident R38□s plan of care was updated with ROM and application of	4/30/21

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F 688	Continued From page 5 R38's face sheet, printed 3/24/21, identified admission date as 8/26/20, and diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness one on side of the body) following cerebral infarction (central nervous system injury) affecting left non-dominate side, osteoarthritis, and muscle weakness. R38's quarterly Minimum Data Set (MDS) assessment dated 2/19/21, indicated R38 had intact cognition, requires extensive assistance of two for bed mobility, transfers, dressing, and personal hygiene, and has limited range of motion (ROM) on one side. R38's plan of care included assisting with activities of daily living due to self-care performance deficit related to left sided hemiplegia/hemiparesis. The care plan did not include ROM or application of a splint. During interview and observation on 3/22/21, at 1:51 p.m., R38 was sitting in a Broda chair with platform on left hand rest, with edema glove on left hand and strapped to the platform using a Velcro strap. R38 stated he isn't able to move his hand and indicated his insurance quit paying for physical (PT) and occupational therapy (OT) awhile ago. R38 indicated the nurses do not do any ROM but do put his edema glove on every day. R38 expressed he wishes he could do more therapy and would like to get better and have more movement on the left side and because his whole left side is achy and sensitive. During interview and observation on 3/24/21, at 7:14 a.m., R38 was awake and lying in his bed with no splint on his left hand. R38 stated he has	F 688	splint. All residents affected by this deficient practice will receive chart audits and FMP (Functional Maintenance Program) review to ensure the plan of care contained the FMP. 2.All residents who have FMPs have the risk of being affected by this deficient practice. Chart reviews of these residents will be performed to ensure that the FMP was present on the plan of care. All residents who have FMPs will be audited to ensure that the FMP plan is posted in the residents rooms if stated in the care plan. All residents who have FMPs that require equipment (such as splints, AFOs, weights, etc) will be audited to ensure that the equipment is present and accessible in their rooms. 3.Rehabilitation nursing policy and procedure has been reviewed with the therapy department, nurse managers, floor nurses and CNA□s. No changes were made to the existing procedure process. 4.All residents with existing FMPs will have chart audits to ensure that patients' FMP is followed as indicated on residents care plan, and posted in residents rooms if indicated on plan of care. Weekly audits will be conducted on newly started FMP□s. Audits will be for four	

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F 688	Continued From page 6 never had a splint, but thought the doctor has ordered one for him. He further indicated he isn't sure why he has never had one, but he does wear the edema glove during the day. On the wall above R38's bed was instructions, undated and unsigned, that included: Daytime edema glove to left hand. Nighttime resting hand splint on left hand to promote extension of fingers and wrist. During interview and observation on 3/24/21, at 7:51 a.m., nursing assistant (NA)-A indicated she was not aware of any hand splint for R38. NA-A indicated they do not do ROM for R38 and that R38 complains of pain in the hand even when you touch it. Observed NA-A place edema glove on left hand. R38 complained of discomfort on the last finger insertion into the glove, but none throughout rest of application. No ROM was attempted. During interview on 3/24/21, at 9:23 a.m., registered nurse (RN)-B indicated there was no ROM ordered so they were not completing it. RN-B indicated she had never heard of a splint for him and R38 has never had one to her knowledge. During interview on 3/24/21. at 9:30 a.m., occupational therapist (OT)-A indicated she was the one who gave a resting hand splint to R38. OT-A indicated they use a form to notify the nursing department who then put it on the care plan and are responsible for completing their recommendations. During interview on 3/24/21. at 11:09 a.m., therapy department manager (TDM)-A, indicated occupational therapy ended on 12/17/20 and R38	F 688	weeks and then with quarterly assessments or with change in condition. 5.Current FMP plans audits completed by 5/23/21. Audist to be ongoing at this time.	

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F 688	Continued From page 7	F 688		

should be using a splint per recommendation. TDM-A indicated she looked at the nursing restorative binder and the recommendation was present along with instructions for ROM and hand splint. TDM-A indicated R38 does complaint of discomfort but is cooperative with ROM when it is completed.

An OT daily treatment note dated 12/16/21, stated established restorative program for R38 today to complete three times per week while in long term care. Restorative includes passive ROM to left upper extremity hand, wrist, elbow and shoulder to promote stretching and ROM for contracture prevention. R38 to continue to wear edema glove during the day and resting hand splint at night for contracture prevention.

A form titled "Restorative Nursing Referral" dated 12/17/20, indicated R38 was to have passive ROM to left upper extremity with goal to prevent contractures in left upper extremity, and R38 to wear edema glove during the day and resting hand splint at night. ROM to include hand, wrist, elbow and shoulder. Form was signed by OT-A.

During interview on 3/25/21, at 11:32 a.m., TDM-A indicated there was no deterioration to R38's hand and shared an OT note dated 3/24/21. The OT note indicated OT-A assessed R38's left hand and wrist and found no contractures but did indicate the hand and wrist feel tighter, but with passive range of motion were able to improve the tightness. Continued recommendation is to continue ROM program and wear the hand splint at night. OT to order a new night splint.

During interview on 3/24/21, at 1:38 p.m., nursing

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manager (NM)-A indicated she is aware as of today that R38 should be wearing a splint and after searching R38's room, there was no splint found. NM-A indicated they requested another one from therapy and added a plan of care, and added ROM and splint to the nurses and nursing assistant task list. NM-A confirmed there was no plan of care for ROM or splint prior to today. NM-A indicated ROM and splint use is important for staff to do and it is her expectation staff should complete it.

During interview on 3/25/21, at 8:57 a.m., R38 asked if therapy was going to order another splint for him as he believes it would benefit him.

During interview on 3/25/21, at 10:41 a.m., the director of nursing (DON) indicated if therapy recommends ROM and a splint, she would expect staff to complete those tasks.

Review of facility policy titled "Rehabilitative Nursing Care" dated last revised 7/2013 included:

1. General rehabilitative nursing care is that which does not require the use of a qualified Professional Therapist to render such care.
2. Nursing personnel are trained to rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan.
3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence.
4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to:
-Maintaining good body alignment and proper

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F 688	Continued From page 9 positioning. -Encouraging and assisting bedfast residents to change positions at least every two hours to stimulate circulation and to prevent deceits ulcers, contractures and deformities. -Assisting residents to adjust to their disabilities, to use their prosthetic devices and to redirect their interests, if necessary. -Assisting residents to carry out prescribed therapy exercises between visits of the therapists. -Assisting residents with their routine range of motion exercises.	F 688		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755		4/26/21

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F 755	Continued From page 10 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled substance medications in 1 of 1 emergency medication kit (E-Kit) to prevent potential loss or diversion. This had the potential to affect any of the 70 residents present in the facility, who may require controlled medications from the E-Kit. Findings include: On 3/24/21, at 1:39 p.m. a tour of the 3500 Wing Medication Storage Room was conducted with registered nurse (RN)-D. The refrigerated E-Kit, identified as Narcotic Box B, contained: Tramadol, Morphine, Morphine Syrup, Norco, Oxycontin, Dilaudid, and Ativan. These medications are used for pain and/or anxiety. RN-D stated the facility staff did not have a system to reconcile controlled substances in Narcotic Box B. RN-D further stated, Narcotic Box B is not counted or looked at during the narcotic count at shift change. On 3/24/21, at 1:50 PM registered nurse clinical manager (RN)-E asked, we are not counting the E-Kit narcotics and then stated, we used to. RN-E further stated not knowing when or why the policy changed or when the counting stopped.	F 755	1.The E-Kit count has been verified by nursing staff. Total allotted emergency medications are available for residents as needed. No residents were affected by the deficient practice. 2.All residents had the potential to be affected if emergency medications were not available. 3.The E-Kit controlled substances were counted and noted to be unopened. They are kept in double locked containers in the medication room. Staff are to count all controlled substances at the end of each shift with the oncoming staff. This may consist of 2 nurses or 1 nurse and 1 TMA. A list of the E-Kit medications was placed in the narcotic box on the 3600 cart and added to the 3600 cart Narcotic book. Staff are to verify the E-Kit controlled substances count every shift and sign off when completed in the narcotic book. The Controlled Substances Policy and Procedure was reviewed with licensed staff.	

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F 755	Continued From page 11 Review of the facility policy Controlled Substances -Counting, reviewed 2/2014, directed: count what is in the narcotic drawer/cabinet (or refrigerator) against amount shown on the narcotic book page and two nurses are to sign the narcotic book.	F 755	4.Controlled Substance audits will be conducted monthly x3 then reviewed. Monthly audits to continue until 100% compliance is achieved. 5.Corrective action noted above occurred on 4-23-2021. The Controlled Substances Policy and Procedure was reviewed and revised 3/2021 it was reviewed with licensed staff on 4-23-2021. Audits will be ongoing.	
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		4/22/21

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F 758	Continued From page 12 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's Face Sheet printed on 3/25/21, included an admission date of 4/12/2017, and included diagnosis of major depressive disorder, recurrent, in partial remission. R40's Consultant Pharmacist's Medication Review dated 10/1/20 and 10/6/20, identified R40	F 758	1.The resident(R40) discussed in this situation has continued to be evaluated by the rounding provider. The provider has addressed the pharmacy recommendation of a gradual dose reduction and discontinuation of the Cymbalta completely on 3/2/2021. 2.All residents with outstanding recommendations had the potential to be affected. The facility reviewed all outstanding pharmacy recommendations with the consulting pharmacist on 4-21-2021. Nurse managers have sent communication to providers on outstanding pharmacy recommendations.	

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F 758	Continued From page 13 was taking Cymbalta delayed release particles 60 mg, and to give 1 capsule by mouth two times a day related to major depressive disorder, recurrent, in partial remission. R40 was also taking BuPropion HCL ER (SL) tablet extended release, 300 mg, give 1 tablet by mouth one time a day related to major depressive disorder, recurrent in partial remission. The consultant pharmacist recommendation was to please evaluate if Duloxetine could be reduced to 30 mg by mouth twice a day to ensure lowest effective dose. A provider note dated 11/3/20, indicated R40 remained on Duloxetine HCL 60 mg orally one by mouth two times daily with no change in dose. R40's subsequent Pharmacist's Medication Review dated 11/3/20 identified no recommendations. The Pharmacist's Medication Review dated 12/20/20, indicated R40 remained on 60 mg, 1 capsule two times per day and to please evaluate if dose could be reduced to 30 mg by mouth twice a day to ensure lowest effective dose. A physician/prescriber response indicated see visit note from 1/5/21, and included started gradual dose reduction and will follow-up in two weeks. A provider note dated 1/5/21, included Duloxetine 60 mg twice a day was to be reduced to 30 mg in the mornings and 60 mg in the evenings for two weeks and to follow-up in two weeks if appropriate for further reduction. A subsequent provider note dated 2/16/21, indicated R40 was taking Duloxetine 60 mg by mouth daily.	F 758	A Root Cause Analysis was completed with IDT team. It was identified that the facility did not have a tracking or follow up process in place for pharmacy recommendations that were given to the providers to address. 3.A tracking procedure was developed to ensure that pharmacy recommendations are addressed and followed up on in a timely manner. A binder was created for each wing. Nurse managers are to place a copy of all pharmacy recommendations in the binder and remove once it has been addressed by the provider. All outstanding recommendations will be discussed with Nurse Managers and the consulting pharmacist monthly (ongoing). Nurse managers are responsible for contacting the provider if no response is received. The pharmacist stated she documents immediate attention required on the recommendation if there is a safety concern. She will repeat the recommendation the following month in her review if it has not been addressed by the provider. 4.This process is to be reviewed at the monthly QAPI meeting. An monthly audit will be conducted between the pharmacist and Nurse Managers list of outstanding recommendations. 5.Meeting was held 4-21-2021. New system initiated on 4-22-2021.	

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	245390	A. BUILDING _____ B. WING _____	C 03/25/2021

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

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F 758	Continued From page 14 A provider note dated 2/23/21, included orders for Duloxetine 30 mg to take one capsule by mouth twice a day for 1 week then decrease to one capsule by mouth daily then discontinue. No length of time was identified for taking Duloxetine 30 mg daily or when to discontinue. During interview on 3/25/21, at 12:24 p.m., nurse manager (NM)-A stated she was not at the facility in October or November and returned in December when the gradual dose reduction was addressed by her with the provider. NM-A further indicated another case manager should be taking over when she isn't at the facility and that the recommendation could have been given to the provider but she cannot confirm if it was or wasn't. The NM-A did confirm no action was taken until January 5th, 2021. During interview on 3/25/21, at 1:16 p.m., the director of nurses (DON) indicated generally the pharmacist recommendations should be completed on the next rounds but this one could have just been missed. The facilities "Psychotropic Medications" dated 9/2010 included: -Purpose is to assure that psychotropic medication is not administered unnecessarily. -Residents receiving psychotropic medications will receive gradual dose reductions unless a reduction is clinically contraindicated, and contraindication is documented by a physician.	F 758		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		4/20/21

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F 880	Continued From page 15 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 880		

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F 880	Continued From page 16 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. 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 follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 58 residents residing in the facility as well as facility staff. Findings include: During observation on 3/22/21, at 12:17 p.m. registered nurse (RN)-F was observed in the	F 880	COVID testing has been removed from a resident area to ensure appropriate social distancing. All residents were monitored for signs and symptoms of COVID at least daily since potential exposure along with PCR testing on 4/12/2021, noting all residents had negative results. The facility implemented immediate corrective measures on March 24th, 2021 during the MDH survey to prevent further potential exposure. The testing site was	

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F 880	Continued From page 17 facility front lounge area near the main entrance door, preparing to collect nasal specimens from facility staff for COVID-19 testing. Also present were two staff from the assisted living facility located on the second floor of the building. RN-F was observed collecting a nasal specimen from facility staff, while other staff and visitors walked past the area within 3-5 feet. The elevator to the second floor was also located near the testing area and a resident was observed seated in a wheelchair waiting to get on the elevator while the testing was being completed. When interviewed at approximately 12:35 p.m., RN-F confirmed any visitors coming into the facility would enter through the front entrance and walk directly past the testing area. When interviewed on 3/23/21, at 12:52 p.m. RN-F confirmed they hadn't really thought about the potential for visitors walking past the open lounge area near the front entrance when conducting testing until yesterday. RN-F stated they previously had been conducting testing in the chapel but for the last several weeks the chapel was being utilized for activities. RN-F confirmed COVID-19 testing for employees had been completed weekly in the front lounge area since 1/21/21. RN-F further confirmed the conference room could be utilized for COVID-19 testing as it was close to the front entrance and also would prohibit staff not already working from walking through the building. The policy titled, COVID-19: Infection Prevention & Control dated 9/2/20, indicated: All testing of residents and staff in skilled nursing communities and hospice will occur in accordance with CMS requirements.	F 880	moved to the chapel and no residents were allowed inside during testing. COVID testing site for team members has since been relocated to the employee entrance and screening area which is not open to residents and visitors. Signage on Restricted Area for Employees Only displayed during testing times. Education on Social Distancing was provided to all staff during COVID testing and extra signage on social distancing added to the cafe area on 4/19/2021. Daily audits to be completed on staff and resident social distancing daily for 4 weeks until 100 % compliance is achieved. Will review audit results with the QAPI committee to determine frequency of audits after the initial four week period. Policy and Procedure for Social Distancing for residents during dining and activities were reviewed with the IDT. Daily audits to be completed on staff and resident social distancing (during various activities) daily for 4 weeks until 100 % compliance is achieved. COVID testing will continue to occur in non resident and visitor areas. Corrective actions have all been implemented as of 4-20-2021, audits to be ongoing to monitor for compliance.	

Electronically delivered
April 15, 2021

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: State Nursing Home Licensing Orders
Event ID: YXJ211

Dear Administrator:

The above facility was surveyed on March 22, 2021 through March 25, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 03/22/21 through 03/25/21, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the Minnesota State Licensure and the following correction orders are issued: 0890 Rehabilitation and Range of Motion, 1390 Infection Control,	2 000		

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2 000	Continued From page 1 1600 E-Kit Medication Reconciliation, 1830 Health Care Directive. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed. A complaint investigation was also conducted and your facility was the following complaints were found to be unsubstantiated: H5390030C (MN68176), H5390031C (MN62402), and H5390032C (MN59945). Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper extremities was implemented for 1 of 2 residents (R38), who had limited range of motion, and also failed to implement a wrist	2 890	Submitted plan of correction here	4/30/21

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2 890	Continued From page 3 brace to prevent contractures. Findings include: R38's face sheet, printed 3/24/21, identified admission date as 8/26/20, and diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness one on side of the body) following cerebral infarction (central nervous system injury) affecting left non-dominate side, osteoarthritis, and muscle weakness. R38's quarterly Minimum Data Set (MDS) assessment dated 2/19/21, indicated R38 had intact cognition, requires extensive assistance of two for bed mobility, transfers, dressing, and personal hygiene, and has limited range of motion (ROM) on one side. R38's plan of care included assisting with activities of daily living due to self-care performance deficit related to left sided hemiplegia/hemiparesis. The care plan did not include ROM or application of a splint. During interview and observation on 3/22/21, at 1:51 p.m., R38 was sitting in a Broda chair with platform on left hand rest, with edema glove on left hand and strapped to the platform using a Velcro strap. R38 stated he isn't able to move his hand and indicated his insurance quit paying for physical (PT) and occupational therapy (OT) awhile ago. R38 indicated the nurses do not do any ROM but do put his edema glove on every day. R38 expressed he wishes he could do more therapy and would like to get better and have more movement on the left side and because his whole left side is achy and sensitive. During interview and observation on 3/24/21, at	2 890		

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2 890	Continued From page 4 7:14 a.m., R38 was awake and lying in his bed with no splint on his left hand. R38 stated he has never had a splint, but thought the doctor has ordered one for him. He further indicated he isn't sure why he has never had one, but he does wear the edema glove during the day. On the wall above R38's bed was instructions, undated and unsigned, that included: Daytime edema glove to left hand. Nighttime resting hand splint on left hand to promote extension of fingers and wrist. During interview and observation on 3/24/21, at 7:51 a.m., nursing assistant (NA)-A indicated she was not aware of any hand splint for R38. NA-A indicated they do not do ROM for R38 and that R38 complains of pain in the hand even when you touch it. Observed NA-A place edema glove on left hand. R38 complained of discomfort on the last finger insertion into the glove, but none throughout rest of application. No ROM was attempted. During interview on 3/24/21, at 9:23 a.m., registered nurse (RN)-B indicated there was no ROM ordered so they were not completing it. RN-B indicated she had never heard of a splint for him and R38 has never had one to her knowledge. During interview on 3/24/21. at 9:30 a.m., occupational therapist (OT)-A indicated she was the one who gave a resting hand splint to R38. OT-A indicated they use a form to notify the nursing department who then put it on the care plan and are responsible for completing their recommendations. During interview on 3/24/21. at 11:09 a.m., therapy department manager (TDM)-A, indicated	2 890		

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2 890	Continued From page 5	2 890		

occupational therapy ended on 12/17/20 and R38 should be using a splint per recommendation. TDM-A indicated she looked at the nursing restorative binder and the recommendation was present along with instructions for ROM and hand splint. TDM-A indicated R38 does complaint of discomfort but is cooperative with ROM when it is completed.

An OT daily treatment note dated 12/16/21, stated established restorative program for R38 today to complete three times per week while in long term care. Restorative includes passive ROM to left upper extremity hand, wrist, elbow and shoulder to promote stretching and ROM for contracture prevention. R38 to continue to wear edema glove during the day and resting hand splint at night for contracture prevention.

A form titled "Restorative Nursing Referral" dated 12/17/20, indicated R38 was to have passive ROM to left upper extremity with goal to prevent contractures in left upper extremity, and R38 to wear edema glove during the day and resting hand splint at night. ROM to include hand, wrist, elbow and shoulder. Form was signed by OT-A.

During interview on 3/25/21, at 11:32 a.m., TDM-A indicated there was no deterioration to R38's hand and shared an OT note dated 3/24/21. The OT note indicated OT-A assessed R38's left hand and wrist and found no contractures but did indicate the hand and wrist feel tighter, but with passive range of motion were able to improve the tightness. Continued recommendation is to continue ROM program and wear the hand splint at night. OT to order a new night splint.

During interview on 3/24/21, at 1:38 p.m., nursing

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2 890	Continued From page 6 manager (NM)-A indicated she is aware as of today that R38 should be wearing a splint and after searching R38's room, there was no splint found. NM-A indicated they requested another one from therapy and added a plan of care, and added ROM and splint to the nurses and nursing assistant task list. NM-A confirmed there was no plan of care for ROM or splint prior to today. NM-A indicated ROM and splint use is important for staff to do and it is her expectation staff should complete it. During interview on 3/25/21, at 8:57 a.m., R38 asked if therapy was going to order another splint for him as he believes it would benefit him. During interview on 3/25/21, at 10:41 a.m., the director of nursing (DON) indicated if therapy recommends ROM and a splint, she would expect staff to complete those tasks. Review of facility policy titled "Rehabilitative Nursing Care" dated last revised 7/2013 included: 1. General rehabilitative nursing care is that which does not require the use of a qualified Professional Therapist to render such care. 2. Nursing personnel are trained to rehabilitative nursing care. Our facility has an active program of rehabilitative nursing which is developed and coordinated through the resident's care plan. 3. The facility's rehabilitative nursing care program is designed to assist each resident to achieve and maintain an optimal level of self-care and independence. 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to: -Maintaining good body alignment and proper positioning.	2 890		

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	00036	A. BUILDING: _____ B. WING _____	C 03/25/2021

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

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2 890	Continued From page 7 -Encouraging and assisting bedfast residents to change positions at least every two hours to stimulate circulation and to prevent deceits ulcers, contractures and deformities. -Assisting residents to adjust to their disabilities, to use their prosthetic devices and to redirect their interests, if necessary. -Assisting residents to carry out prescribed therapy exercises between visits of the therapists. -Assisting residents with their routine range of motion exercises. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could develop and implement policies and procedures related to the facility restorative program. The DON, or designee, could provide training for all nursing staff related to the policies and procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and	21375	Corrected	4/20/21

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21375	Continued From page 8	21375		

Centers for Disease Control (CDC) guidelines by appropriately implementing preventive measures to prevent the spread of COVID-19. This had the potential to affect all 58 residents residing in the facility as well as facility staff.

Findings include:

During observation on 3/22/21, at 12:17 p.m. registered nurse (RN)-F was observed in the facility front lounge area near the main entrance door, preparing to collect nasal specimens from facility staff for COVID-19 testing. Also present were two staff from the assisted living facility located on the second floor of the building. RN-F was observed collecting a nasal specimen from facility staff, while other staff and visitors walked past the area within 3-5 feet. The elevator to the second floor was also located near the testing area and a resident was observed seated in a wheelchair waiting to get on the elevator while the testing was being completed. When interviewed at approximately 12:35 p.m., RN-F confirmed any visitors coming into the facility would enter through the front entrance and walk directly past the testing area.

When interviewed on 3/23/21, at 12:52 p.m. RN-F confirmed they hadn't really thought about the potential for visitors walking past the open lounge area near the front entrance when conducting testing until yesterday. RN-F stated they previously had been conducting testing in the chapel but for the last several weeks the chapel was being utilized for activities. RN-F confirmed COVID-19 testing for employees had been completed weekly in the front lounge area since 1/21/21. RN-F further confirmed the conference room could be utilized for COVID-19 testing as it was close to the front entrance and also would

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21375	Continued From page 9 prohibit staff not already working from walking through the building. The policy titled, COVID-19: Infection Prevention & Control dated 9/2/20, indicated: All testing of residents and staff in skilled nursing communities and hospice will occur in accordance with CMS requirements. Suggested Method of Correction: The Director of Nursing (DON) or designee could review and revise policies and procedures related infection control practices including performing COVID testing in facility. The DON or designee could educate staff and perform audits to ensure the policies are being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by:	21525		4/21/21

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21525	Continued From page 10 Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon for 1 of 5 residents (R40) reviewed for unnecessary medication use. Findings include: R40's Face Sheet printed on 3/25/21, included an admission date of 4/12/2017, and included diagnosis of major depressive disorder, recurrent, in partial remission. R40's Consultant Pharmacist's Medication Review dated 10/1/20 and 10/6/20, identified R40 was taking Cymbalta delayed release particles 60 mg, and to give 1 capsule by mouth two times a day related to major depressive disorder, recurrent, in partial remission. R40 was also taking BuPropion HCL ER (SL) tablet extended release, 300 mg, give 1 tablet by mouth one time a day related to major depressive disorder, recurrent in partial remission. The consultant pharmacist recommendation was to please evaluate if Duloxetine could be reduced to 30 mg by mouth twice a day to ensure lowest effective dose. A provider note dated 11/3/20, indicated R40 remained on Duloxetine HCL 60 mg orally one by mouth two times daily with no change in dose. R40's subsequent Pharmacist's Medication Review dated 11/3/20 identified no recommendations. The Pharmacist's Medication Review dated 12/20/20, indicated R40 remained on 60 mg, 1 capsule two times per day and to please evaluate if dose could be reduced to 30 mg by mouth twice	21525	submitt plan of correction here	

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21525	Continued From page 11	21525		

a day to ensure lowest effective dose. A physician/prescriber response indicated see visit note from 1/5/21, and included started gradual dose reduction and will follow-up in two weeks.

A provider note dated 1/5/21, included Duloxetine 60 mg twice a day was to be reduced to 30 mg in the mornings and 60 mg in the evenings for two weeks and to follow-up in two weeks if appropriate for further reduction.

A subsequent provider note dated 2/16/21, indicated R40 was taking Duloxetine 60 mg by mouth daily.

A provider note dated 2/23/21, included orders for Duloxetine 30 mg to take one capsule by mouth twice a day for 1 week then decrease to one capsule by mouth daily then discontinue. No length of time was identified for taking Duloxetine 30 mg daily or when to discontinue.

During interview on 3/25/21, at 12:24 p.m., nurse manager (NM)-A stated she was not at the facility in October or November and returned in December when the gradual dose reduction was addressed by her with the provider. NM-A further indicated another case manager should be taking over when she isn't at the facility and that the recommendation could have been given to the provider but she cannot confirm if it was or wasn't. The NM-A did confirm no action was taken until January 5th, 2021.

During interview on 3/25/21, at 1:16 p.m., the director of nurses (DON) indicated generally the pharmacist recommendations should be completed on the next rounds but this one could have just been missed.

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21525	Continued From page 12 The facilities "Psychotropic Medications" dated 9/2010 included: -Purpose is to assure that psychotropic medication is not administered unnecessarily. -Residents receiving psychotropic medications will receive gradual dose reductions unless a reduction is clinically contraindicated, and contraindication is documented by a physician. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure follow up review are conducted by primary provider following pharmacist review of medication regime. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21525		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for periodic reconciliation of controlled substance	21600	Corrected	4/23/21

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21600	Continued From page 13 medications in 1 of 1 emergency medication kit (E-Kit) to prevent potential loss or diversion. This had the potential to affect any of the 70 residents present in the facility, who may require controlled medications from the E-Kit. Findings include: On 3/24/21, at 1:39 p.m. a tour of the 3500 Wing Medication Storage Room was conducted with registered nurse (RN)-D. The refrigerated E-Kit, identified as Narcotic Box B, contained: Tramadol, Morphine, Morphine Syrup, Norco, Oxycontin, Dilaudid, and Ativan. These medications are used for pain and/or anxiety. RN-D stated the facility staff did not have a system to reconcile controlled substances in Narcotic Box B. RN-D further stated, Narcotic Box B is not counted or looked at during the narcotic count at shift change. On 3/24/21, at 1:50 PM registered nurse clinical manager (RN)-E asked, we are not counting the E-Kit narcotics and then stated, we used to. RN-E further stated not knowing when or why the policy changed or when the counting stopped. Review of the facility policy Controlled Substances -Counting, reviewed 2/2014, directed: count what is in the narcotic drawer/cabinet (or refrigerator) against amount shown on the narcotic book page and two nurses are to sign the narcotic book. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), consultant pharmacist or designee could review and revise policies and procedures to include processes for monitoring controlled substances stored in the E-Kit. The administrator, DON,	21600		

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21600	Continued From page 14 consultant pharmacist or designee could perform random observational audits to ensure compliance. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21600		

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

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	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**03/24/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Pathstone Living was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition NFPA 99, Health Care Facilities Code. 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. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 69 beds and had a census of 60 at the time of the survey.	K 000		

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

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

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	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**03/24/2021**

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