DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 17, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: April 5, 2022

Dear Administrator:

On May 5, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 17, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: Reinspection Results
Event ID: GS8H12

Dear Administrator:

On May 5, 2022 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 5, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

DEPARTMENT OF HEALTH

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Electronically delivered
April 19, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: April 19, 2022

Dear Administrator:

On April 5, 2022, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, 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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 5, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 5, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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 04/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 4/5/22, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5390037C (MN81305), with a deficiency cited at F580. The following complaint was found to be SUBSTANTIATED: H5390039C (MN82266), however NO deficiencies were cited due to actions implemented by the facility prior to survey. The following complaints were found to be UNSUBSTANTIATED: H5390036C (MN80061) and H5390038C (MN82169). 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 that substantial compliance with the regulations has been attained.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident;	F 580		4/29/22

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

Electronically Signed | 04/28/2022

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

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F 580	Continued From page 1 consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility	F 580		

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F 580	Continued From page 2 that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and resident representative were notified timely of a change in condition for 1 of 1 resident (R2) reviewed for notification of change. Findings include: R2's face sheet printed on 4/5/22, indicated diagnoses of stroke affecting left extremities, diabetes, obstructive and reflux uropathy (urine backs up into the kidney), history of kidney stones and urinary tract infection (UTI). R2's quarterly Minimum Data Set (MDS) assessment dated 2/7/22, indicated R2 was cognitively intact, had clear speech, was able to understand others and be understood. R2 required extensive assitance of staff for bed mobility, transfers, and toileting. R2 was always incontinent of urine and was always continent of bowel. R2 did not walk. R2's care plan last reviewed on 2/17/22, indicated R2 was hospitalized on 9/24/21, due to a urinary tract infection (UTI) resulting in sepsis (a potentially life threatening condition that occurs when the body's response to an infection damages it's own tissues). A care plan focus indicated R2 had bladder incontinence related to	F 580	1.R2 had a change in baseline status. Resident was sent in for further evaluation. All residents were at potential risk by the deficient practice. 2. Facility will audit change in condition documentation in Point Click Care weekly for two months by DON or designee to ensure the provider has been updated on a resident's condition. Audit findings will be reported to the QAPI committee in June 2022. 3. Licensed staff were educated on acute condition changes-clinical protocol on 4/14/22. This education includes reviewing clinical protocol, examples of what events or incidents should be reported and completion of the SBAR communication module in Relias. 4. Acute condition changes have been added to nurse onboarding and orientation checklist for new nurses as well as agency nurses. Nurse Managers will monitor shift report weekly to compare written shift reports to Point Click Care documentation to ensure change in condition has been documented in medical record and provider has been	

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F 580	Continued From page 3 impaired mobility. Interventions dated 8/19/21, included staff were to monitor and document signs and symptoms of a UTI, including fever, altered mental status and change in behavior. The care plan indicated R2's code status (type of treatment a person would receive if their heart or breathing were to stop) was to do CPR (cardiopulmonary resuscitation). During document review of the facility's complaint investigation, a note written by nursing assistant (NA)-A, who was on duty the evening of 2/20/22, read in part: on Sunday evening I came to work at 6 p.m. and witnessed the incident with R2. I don't recall the exact time this began, however I know it was sometime around 8 p.m. It started with the nurse asking one of the aides to come assist in his room because he was slouched over on his left side over the chair. When I walked in, I noticed immediately something was wrong. R2 was in pain and speaking in an odd manner. I began to ask R2 questions such as where he was and what he did today. That was when I knew he was far from his baseline based upon the conversation we had. I took a set of vital signs and recall them being out of range as his pulse was 114 and temperature was 100.5. I reported these to the nurse. R2's skin was hot to the touch and he had hard time transferring from wheelchair to bed. Once in bed, I went back to the nurses station and expressed my worries for R2; I knew something was wrong. I even suggested to call his POA (power of attorney). I told the nurse I didn't know know which of his children were POA, but she could look in this chart to find the number and name. During document review, a hospitalization note dated 2/21/22, indicated R2 was admitted with	F 580	updated. Weekly audits will occur for one month and if 100% compliance is achieved, they will move monthly for three months and then be reviewed by the QAPI committee. 5. Corrective action noted above occurred on 4/14/22. Audits will be ongoing determined by the QAPI committee.	

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F 580	Continued From page 4 severe sepsis due to a UTI. During document review, on 2/21/22, at 10:30 a.m., registered nurse (RN)-B documented in a progress note that R2 had altered mentation, stating he didn't know where he was and didn't recall the previous day. Furthermore, the note indicated R2 required more than usual assist with transfers. RN-B documented that she spoke with family member (FM)-A who requested R2 be sent to the ER (emergency room). RN-B made arrangements, and R2 was transferred to the ER. During document review, on 2/24/2022, at 6:45 a.m., licensed practical nurse (LPN)-A, wrote a late progress note for 2/20/22, at 6:22 a.m. indicating the evening shift reported to her that R2 was more confused, had a low grade fever and had difficulty standing in the EZ-stand (equipment to assist a person with transfers); his speech was slightly slurred and had a temperature of 99.8 degrees Fahrenheit (F). During document review, on 2/23/22, at 2:33 p.m., (RN)-C documented a late progress note for 2/20/2022, 9:40 a.m. indicating R2 appeared mildly lethargic. During a telephone interview on 4/5/22, at 10:51 a.m., RN-C recalled the incident, and stated R2 was cognizant, but didn't know what day it was, but that was not uncommon. When asked why she entered a note late note, RN-C stated since R2 was hospitalized, she felt she should make a note of what happened prior, adding there was no indication R2 was sick and that no staff reported concerns about R2. During a telephone interview on 4/5/22, at 11:16	F 580		

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F 580	Continued From page 5	F 580		

a.m., FM-A stated she recalled R2 going to the hospital in February. FM-A stated she received a call from another family member who talked to R2 on 2/20/22, and told FM-A that R2 "was really out of it." FM-A stated she spoke to R2 the next day on 2/21/22, and "he was not with the program." FM-A then called and spoke to a nurse (FM-A did not recall the name of the nurse) and told the nurse that R2 was upset because he slept all day on 2/20/22, and missed the day; "That really upset him." The nurse told FM-A, "I thought he was a little out of it." FM-A asked the nurse, "Did no one go into his room on Sunday (2/20/22), and check on him? Didn't they noticed he wasn't using his call light frequently as he does?" FM-A told the nurse that R2 needed to go to the hospital, and the nurse stated she would check on R2. FM-A stated the nurse called back a while later and said R2 was in rough shape and they sent him to the hospital...this was on 2/21/22. FM-A stated the "The staff had blown him off. I blew up; it was inexcusable. This was negligence; no one assessed him on 2/20/22, and he was out of it...he was almost delusional."

During an interview on 4/5/22, at 1:27 p.m., (RN)-D was asked what she would do if a NA came to her and told her a resident didn't seem right, such as confused or weak. RN-D stated she would assess the resident, check vital signs, possibly check blood sugar. RN-D stated if the resident "looked off," she would call a provider and run it by them, or put an order in for clinical monitoring. RN-D stated she would usually talk to a nurse manager first. When asked what she would do if she felt a resident should be sent to the hospital, RN-D stated she would contact a provider. When asked if she had training on what to do when a resident had a change in condition,

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F 580	Continued From page 6 RN-D stated yes; she had received a packet of information and read through it. During an interview on 4/5/22, at 1:46 p.m., (RN)-A stated she first became aware that R2 was transferred to the hospital on 2/21 or 2/22/22, when she picked up a voicemail message from FM-2. RN-A sensed FM-2 was upset when in her voicemail, FM-2 stated "I'm pissed," so RN-A "brought it up the chain of command." When asked what should have happened in this situation, RN-A stated R2 should have been transferred to the hospital, that the facility could potentially have responded differently, adding that nursing judgement should have guided the nursing staff. RN-A stated the nurse on duty at the time was an agency nurse, (RN)-E, who didn't know R2 as well as employed staff. However, RN-A stated RN-E could have utilized other staff on duty, reviewed R2's baseline mental status and reviewed progress notes. RN-A was asked about a note written by NA-A regarding the events of 2/20/22. RN-A stated she had asked NA-A to write down what she recalled from that evening, and stated she based a lot of her opinion on NA-A's recollection of events. RN-A stated when she reviewed nursing progress notes, R2's condition started deteriorating the night of 2/19/22. When asked what staff should have done in this incidence, RN-A stated the provider, who is available 24-hours via a call system, should have been contacted, adding that during this time, no nurse contacted a provider to update him/her on R2's change in condition. In addition, RN-A stated the nurses should have looked at R2's code status, asked R2 what he would like to do and contacted the family as to what they wanted. RN-A stated nurses should have initiated clinical monitoring for vital signs, and because R2	F 580		

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F 580	Continued From page 7	F 580		

had a long history of UTI's, do UTI monitoring, monitor lung sounds and mental status. RN-A stated she did not talk to RN-E following this incident. RN-A was unaware if the director of nursing (DON) employed at that time talked to RN-E. RN-A was unaware if agency nurses received training for what to do when a resident had a change in condition, but stated the staff scheduler might know.

During an interview on 4/5/22, at 2:11 p.m., nursing staff scheduler (NSS)-C provided a completed Nurse Orientation Checklist for agency nurse RN-E, dated 2/20/22. The checklist referenced 22 training items under the title "On the floor training." There was no training specific to change in a residents condition. At 2:50 p.m., NSS-C provided a document titled Change in Cognition, Charting and Precaution, undated, which provided guidance on identifying change of condition and what to do when it occurred. Attached to the document was the facility policy titled Acute Condition Changes - Clinical Protocol, with revised date of 3/2018. Stapled to this was a sign-off sheet for registered nurses indicating they read the material. This training took place in July 2021.

During an interview on 4/5/22,at 3:01 p.m., NA-A was given a copy of the note she wrote. NA-A stated she wrote it on 2/22/22, at the request of RN-A, for the incident that occurred on 2/20/22. NA-A stated she reported her concerns to RN-E that evening, that R2 was out of sorts, baseline off, leaning, confused, could it be a stroke? RN-E and NA-A went to R2's room together where NA-A explained her concerns. RN-E asked NA-A to obtain vital signs and that's when they noticed a fever and fast heart rate. NA-A suggested to

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F 580	Continued From page 8	F 580		

RN-E to notify R2's family. NA-A stated she may have also suggested that RN-E call the on-call provider. NA-A stated she didn't think RN-E called the family or the on-call provider. NA-A stated she showed RN-E where to find family member information. NA-A stated she also informed the overnight nurse, LPN-A about her concerns regarding R2's condition, including his fever and that he was out of it. When informed the increase pulse and temperature were not recorded in the electronic medical record (EMR), NA-A stated extra vital signs like that were told to the nurse and the nurse would document them. NA-A stated had this been one of the employed nurses instead of an agency nurse, this would have been handled differently - the provider and family would have been notified. NA-A stated this was the first night that RN-E worked at the facility and RN-E was stressed as it was, not knowing her role. NA-A stated she expressed her concerns to RN-A on 2/22/22, and RN-A asked her to write a formal accounting of what she saw and did. NA-A stated it was hard to work with an agency nurse...they're supposed to be the lead. NA-A stated she thought about telling her concerns to another nurse that night, but didn't think she should, adding that she had never been in that position before.

During an interview on 4/5/22, at 3:35 p.m., the administrator stated she was informed that FM-A was upset when R2 had a condition change and wasn't sent to the hospital. The administrator recalled being informed of this incident on either 2/21 or 2/22/22, and the DON at the time started an investigation and kept her updated. The administrator made the decision to report the incident to the State agency. The administrator was not aware if anyone interviewed NA-E during their investigation, adding someone should have

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	245390	A. BUILDING _____ B. WING _____	C 04/05/2022

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

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talked to her to educate and create awareness of her role in this situation.

During a telephone interview on 4/5/22, at 3:59 p.m, agency nurse RN-E stated she had worked five shifts at the facility and that her first shift was on 2/20/22, when she oriented with another RN from 12 p.m. to 2 p.m., and worked on the floor from 2 p.m. to 10:30 p.m. RN-E recalled R2, and stated she didn't know a lot about him that day. RN-E recalled that in the evening between 8:00 p.m. and 9:00 p.m., R2 slumped over to the side in his wheelchair. RN-E stated she assessed R2, thinking he seemed confused, but didn't know his baseline, although staff told her that was abnormal for him, and that he had a temperature of 100.4 F. RN-E stated his pulse was elevated too so was checked on frequently. RN-E stated she reported this to the on-coming RN at shift change. When asked if she documented her assessment and vital signs in the EMR, RN-E admitted she did not document anything in the EMR, but did write a note on a paper 24 hours shift-change report. RN-E stated didn't feel R2 needed to go to the hospital and didn't think about notifying a physician, adding it was her first day, and she didn't even know how to do that. RN-E stated R2 didn't appear ill and that she wasn't aware of his past hx of UTI's.

A paper 24 Hour Shift Report was reviewed for 2/20/22, and for R2 indicated he received Tylenol at 9:15 p.m., had a temperature of 100.5 F, recommend changing to hoyer lift, leaning to the left and having behaviors. The note did not indicate who wrote the notes.

Facility policy titled Acute Condition Changes - Clinical Protocol, with revised date of 3/2018,

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F 580	Continued From page 10 indicated before contacting a physician about someone with an acute change of condition, the nursing staff would collect pertinent details to report to the physician such as history of present illness and previous and recent test results for comparison. Phone calls to attending or on-call physicians would be made by an adequately prepared nurse who had collected and organized pertinent information, including the residents current symptoms and status. The nursing staff would contact a physician based upon the urgency of the situation. The nurse and physician would discuss and evaluate the situation. If after review, care could not be provided in the facility, the physician would authorize transfer to the hospital.	F 580		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 19, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: State Nursing Home Licensing Orders
Event ID: GS8H11

Dear Administrator:

The above facility was surveyed on April 5, 2022 through April 5, 2022 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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/05/2022

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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 4/5/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5390037C (MN81305) with a licensing order issued at 0265. The following complaint was found to be SUBSTANTIATED: H5390039C (MN82266), however NO licensing orders were issued. The following complaint was found to be UNSUBSTANTIATED: H5390036C (MN80061) and H5390038C (MN82169). 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 surveyor's 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html 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	2 000		

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2 000	Continued From page 2 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening	2 265		4/29/22

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2 265	Continued From page 3 conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the physician and resident representative were notified timely of a change in condition for 1 of 1 resident (R2) reviewed for notification of change. Findings include: R2's face sheet printed on 4/5/22, indicated diagnoses of stroke affecting left extremities, diabetes, obstructive and reflux uropathy (urine backs up into the kidney), history of kidney stones and urinary tract infection (UTI). R2's quarterly Minimum Data Set (MDS) assessment dated 2/7/22, indicated R2 was cognitively intact, had clear speech, was able to understand others and be understood. R2 required extensive assitance of staff for bed mobility, transfers, and toileting. R2 was always incontinent of urine and was always continent of bowel. R2 did not walk. R2's care plan last reviewed on 2/17/22, indicated R2 was hospitalized on 9/24/21, due to a urinary	2 265	completed	

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2 265	Continued From page 4 tract infection (UTI) resulting in sepsis (a potentially life threatening condition that occurs when the body's response to an infection damages it's own tissues). A care plan focus indicated R2 had bladder incontinence related to impaired mobility. Interventions dated 8/19/21, included staff were to monitor and document signs and symptoms of a UTI, including fever, altered mental status and change in behavior. The care plan indicated R2's code status (type of treatment a person would receive if their heart or breathing were to stop) was to do CPR (cardiopulmonary resuscitation). During document review of the facility's complaint investigation, a note written by nursing assistant (NA)-A, who was on duty the evening of 2/20/22, read in part: on Sunday evening I came to work at 6 p.m. and witnessed the incident with R2. I don't recall the exact time this began, however I know it was sometime around 8 p.m. It started with the nurse asking one of the aides to come assist in his room because he was slouched over on his left side over the chair. When I walked in, I noticed immediately something was wrong. R2 was in pain and speaking in an odd manner. I began to ask R2 questions such as where he was and what he did today. That was when I knew he was far from his baseline based upon the conversation we had. I took a set of vital signs and recall them being out of range as his pulse was 114 and temperature was 100.5. I reported these to the nurse. R2's skin was hot to the touch and he had hard time transferring from wheelchair to bed. Once in bed, I went back to the nurses station and expressed my worries for R2; I knew something was wrong. I even suggested to call his POA (power of attorney). I told the nurse I didn't know know which of his children were POA, but she could look in this	2 265		

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2 265	Continued From page 5 chart to find the number and name. During document review, a hospitalization note dated 2/21/22, indicated R2 was admitted with severe sepsis due to a UTI. During document review, on 2/21/22, at 10:30 a.m., registered nurse (RN)-B documented in a progress note that R2 had altered mentation, stating he didn't know where he was and didn't recall the previous day. Furthermore, the note indicated R2 required more than usual assist with transfers. RN-B documented that she spoke with family member (FM)-A who requested R2 be sent to the ER (emergency room). RN-B made arrangements, and R2 was transferred to the ER. During document review, on 2/24/2022, at 6:45 a.m., licensed practical nurse (LPN)-A, wrote a late progress note for 2/20/22, at 6:22 a.m. indicating the evening shift reported to her that R2 was more confused, had a low grade fever and had difficulty standing in the EZ-stand (equipment to assist a person with transfers); his speech was slightly slurred and had a temperature of 99.8 degrees Fahrenheit (F). During document review, on 2/23/22, at 2:33 p.m., (RN)-C documented a late progress note for 2/20/2022, 9:40 a.m. indicating R2 appeared mildly lethargic. During a telephone interview on 4/5/22, at 10:51 a.m., RN-C recalled the incident, and stated R2 was cognizant, but didn't know what day it was, but that was not uncommon. When asked why she entered a note late note, RN-C stated since R2 was hospitalized, she felt she should make a note of what happened prior, adding there was no indication R2 was sick and that no staff reported	2 265		

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2 265	Continued From page 6 concerns about R2. During a telephone interview on 4/5/22, at 11:16 a.m., FM-A stated she recalled R2 going to the hospital in February. FM-A stated she received a call from another family member who talked to R2 on 2/20/22, and told FM-A that R2 "was really out of it." FM-A stated she spoke to R2 the next day on 2/21/22, and "he was not with the program." FM-A then called and spoke to a nurse (FM-A did not recall the name of the nurse) and told the nurse that R2 was upset because he slept all day on 2/20/22, and missed the day; "That really upset him." The nurse told FM-A, "I thought he was a little out of it." FM-A asked the nurse, "Did no one go into his room on Sunday (2/20/22), and check on him? Didn't they noticed he wasn't using his call light frequently as he does?" FM-A told the nurse that R2 needed to go to the hospital, and the nurse stated she would check on R2. FM-A stated the nurse called back a while later and said R2 was in rough shape and they sent him to the hospital...this was on 2/21/22. FM-A stated the "The staff had blown him off. I blew up; it was inexcusable. This was negligence; no one assessed him on 2/20/22, and he was out of it...he was almost delusional." During an interview on 4/5/22, at 1:27 p.m., (RN)-D was asked what she would do if a NA came to her and told her a resident didn't seem right, such as confused or weak. RN-D stated she would assess the resident, check vital signs, possibly check blood sugar. RN-D stated if the resident "looked off," she would call a provider and run it by them, or put an order in for clinical monitoring. RN-D stated she would usually talk to a nurse manager first. When asked what she would do if she felt a resident should be sent to the hospital, RN-D stated she would contact a	2 265		

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2 265	Continued From page 7	2 265		

provider. When asked if she had training on what to do when a resident had a change in condition, RN-D stated yes; she had received a packet of information and read through it.

During an interview on 4/5/22, at 1:46 p.m., (RN)-A stated she first became aware that R2 was transferred to the hospital on 2/21 or 2/22/22, when she picked up a voicemail message from FM-2. RN-A sensed FM-2 was upset when in her voicemail, FM-2 stated "I'm pissed," so RN-A "brought it up the chain of command." When asked what should have happened in this situation, RN-A stated R2 should have been transferred to the hospital, that the facility could potentially have responded differently, adding that nursing judgement should have guided the nursing staff. RN-A stated the nurse on duty at the time was an agency nurse, (RN)-E, who didn't know R2 as well as employed staff. However, RN-A stated RN-E could have utilized other staff on duty, reviewed R2's baseline mental status and reviewed progress notes. RN-A was asked about a note written by NA-A regarding the events of 2/20/22. RN-A stated she had asked NA-A to write down what she recalled from that evening, and stated she based a lot of her opinion on NA-A's recollection of events. RN-A stated when she reviewed nursing progress notes, R2's condition started deteriorating the night of 2/19/22. When asked what staff should have done in this incidence, RN-A stated the provider, who is available 24-hours via a call system, should have been contacted, adding that during this time, no nurse contacted a provider to update him/her on R2's change in condition. In addition, RN-A stated the nurses should have looked at R2's code status, asked R2 what he would like to do and contacted the family as to what they wanted. RN-A stated nurses should have initiated

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2 265	Continued From page 8	2 265		

clinical monitoring for vital signs, and because R2 had a long history of UTI's, do UTI monitoring, monitor lung sounds and mental status. RN-A stated she did not talk to RN-E following this incident. RN-A was unaware if the director of nursing (DON) employed at that time talked to RN-E. RN-A was unaware if agency nurses received training for what to do when a resident had a change in condition, but stated the staff scheduler might know.

During an interview on 4/5/22, at 2:11 p.m., nursing staff scheduler (NSS)-C provided a completed Nurse Orientation Checklist for agency nurse RN-E, dated 2/20/22. The checklist referenced 22 training items under the title "On the floor training." There was no training specific to change in a residents condition. At 2:50 p.m., NSS-C provided a document titled Change in Cognition, Charting and Precaution, undated, which provided guidance on identifying change of condition and what to do when it occurred. Attached to the document was the facility policy titled Acute Condition Changes - Clinical Protocol, with revised date of 3/2018. Stapled to this was a sign-off sheet for registered nurses indicating they read the material. This training took place in July 2021.

During an interview on 4/5/22,at 3:01 p.m., NA-A was given a copy of the note she wrote. NA-A stated she wrote it on 2/22/22, at the request of RN-A, for the incident that occurred on 2/20/22. NA-A stated she reported her concerns to RN-E that evening, that R2 was out of sorts, baseline off, leaning, confused, could it be a stroke? RN-E and NA-A went to R2's room together where NA-A explained her concerns. RN-E asked NA-A to obtain vital signs and that's when they noticed a fever and fast heart rate. NA-A suggested to

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	00036	A. BUILDING: _____ B. WING _____	C 04/05/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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RN-E to notify R2's family. NA-A stated she may have also suggested that RN-E call the on-call provider. NA-A stated she didn't think RN-E called the family or the on-call provider. NA-A stated she showed RN-E where to find family member information. NA-A stated she also informed the overnight nurse, LPN-A about her concerns regarding R2's condition, including his fever and that he was out of it. When informed the increase pulse and temperature were not recorded in the electronic medical record (EMR), NA-A stated extra vital signs like that were told to the nurse and the nurse would document them. NA-A stated had this been one of the employed nurses instead of an agency nurse, this would have been handled differently - the provider and family would have been notified. NA-A stated this was the first night that RN-E worked at the facility and RN-E was stressed as it was, not knowing her role. NA-A stated she expressed her concerns to RN-A on 2/22/22, and RN-A asked her to write a formal accounting of what she saw and did. NA-A stated it was hard to work with an agency nurse...they're supposed to be the lead. NA-A stated she thought about telling her concerns to another nurse that night, but didn't think she should, adding that she had never been in that position before.

During an interview on 4/5/22, at 3:35 p.m., the administrator stated she was informed that FM-A was upset when R2 had a condition change and wasn't sent to the hospital. The administrator recalled being informed of this incident on either 2/21 or 2/22/22, and the DON at the time started an investigation and kept her updated. The administrator made the decision to report the incident to the State agency. The administrator was not aware if anyone interviewed NA-E during their investigation, adding someone should have talked to her to educate and create awareness of

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her role in this situation.

During a telephone interview on 4/5/22, at 3:59 p.m, agency nurse RN-E stated she had worked five shifts at the facility and that her first shift was on 2/20/22, when she oriented with another RN from 12 p.m. to 2 p.m., and worked on the floor from 2 p.m. to 10:30 p.m. RN-E recalled R2, and stated she didn't know a lot about him that day. RN-E recalled that in the evening between 8:00 p.m. and 9:00 p.m., R2 slumped over to the side in his wheelchair. RN-E stated she assessed R2, thinking he seemed confused, but didn't know his baseline, although staff told her that was abnormal for him, and that he had a temperature of 100.4 F. RN-E stated his pulse was elevated too so was checked on frequently. RN-E stated she reported this to the on-coming RN at shift change. When asked if she documented her assessment and vital signs in the EMR, RN-E admitted she did not document anything in the EMR, but did write a note on a paper 24 hours shift-change report. RN-E stated didn't feel R2 needed to go to the hospital and didn't think about notifying a physician, adding it was her first day, and she didn't even know how to do that. RN-E stated R2 didn't appear ill and that she wasn't aware of his past hx of UTI's.

A paper 24 Hour Shift Report was reviewed for 2/20/22, and for R2 indicated he received Tylenol at 9:15 p.m., had a temperature of 100.5 F, recommend changing to hoyer lift, leaning to the left and having behaviors. The note did not indicate who wrote the notes.

Facility policy titled Acute Condition Changes - Clinical Protocol, with revised date of 3/2018, indicated before contacting a physician about someone with an acute change of condition, the

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2 265	Continued From page 11 nursing staff would collect pertinent details to report to the physician such as history of present illness and previous and recent test results for comparison. Phone calls to attending or on-call physicians would be made by an adequately prepared nurse who had collected and organized pertinent information, including the residents current symptoms and status. The nursing staff would contact a physician based upon the urgency of the situation. The nurse and physician would discuss and evaluate the situation. If after review, care could not be provided in the facility, the physician would authorize transfer to the hospital. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures regarding notification of change of condition. The DON or designee could educate all appropriate staff on the policies and procedure on notification of change of condition. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results of monitoring to the facility Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		