Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 26, 2026

Administrator
Pathstone Living
718 MOUND AVENUE
MANKATO, MN 56001

RE: CCN:245390
Cycle Start Date: March 6, 2026

Dear Administrator:

On March 6, 2026, a survey was completed at your facility by the Minnesota Department of Health 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:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

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 June 6, 2026, (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 September 6, 2026, (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 26, 2026

Administrator
Pathstone Living
718 MOUND AVENUE
MANKATO, MN 56001

Re: State Nursing Home Licensing Orders
Event ID: 1F2790-H1

Dear Administrator:

The above facility survey was completed on March 6, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Lisa Krebs, Regional Operations Supervisor RR
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us

Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst

Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
June 9, 2026

Administrator
Pathstone Living
718 MOUND AVENUE
MANKATO, MN 56001

RE: CCN: 245390
Cycle Start Date: March 6, 2026

Dear Administrator:

On May 15, 2026, 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

June 9, 2026

Administrator
Pathstone Living
718 MOUND AVENUE
MANKATO, MN 56001

Re: Reinspection Results
Event ID: 1F2790-H2

Dear Administrator:

On May 15, 2026 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 March 6, 2026. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pathstone Living	**718 MOUND AVENUE , MANKATO, Minnesota, 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
F0000	INITIAL COMMENTS On 3/4/26, 3/5/26, and 3/6/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H53903763C (2717725), and H53905222C (2732612) with deficiencies issued at F684 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.	F0000		03/26/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to administer long-acting insulin at consistent times for 2 of 3 residents (R1, R4), failed to appropriately respond to abnormal blood glucose levels, and failed to ensure monitoring and follow-up	F0684	The alleged deficiencies for [R1] and [R4] have been corrected. The Director of Nursing and/or designee were responsible for implementing the correction. [R1]'s long-acting insulin order has been updated to indicate a specific daily administration time. LPN-B (LPN Brenda) education/coaching conversation completed and documented? [R4]'s long-acting insulin order has been updated to indicate a specific daily administration time. The alleged deficiencies have the potential to impact any facility resident who has diagnosis of diabetes. The facility completed an audit of all resident insulin orders to ensure the insulin administration time is scheduled for a specific time versus a range of time. The following measures and systemic changes have been made to ensure the alleged deficient practices will not reoccur:	05/10/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

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Pathstone Living	**718 MOUND AVENUE , MANKATO, Minnesota, 56001**

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F0684 SS = D	Continued from page 1 after interventions for hypoglycemia for 1 of 3 residents (R1) reviewed for diabetic management. R1's face sheet dated 3/5/26, identified a diagnosis type 2 diabetes mellitus. R1's comprehensive Minimum Data Set (MDS) dated 12/18/25, identified R1 had no cognition issues. R1 was on a therapeutic diet and received insulin injections seven days per week. R1's care plan revised on 3/4/25, identified a focus of risk for complications related to altered glucose metabolism. Diagnosis of diabetes mellitus with retinopathy (damage to retina of the eye). Interventions included: administer medication(s) to control glucose levels and/or insulin as ordered. Monitor for side effects and effectiveness. Report adverse effects to provider as needed. If infection is present, consult provider regarding any changes in diabetic medications as applicable. Follow up as indicated. Care: ALTERED GLUCOSE METABOLISM. General. Avoid exposure to extreme heat/cold. Moisturize dry skin daily. DO NOT apply lotion over breaks in skin or wounds. Provide and serve diet as ordered. Ensure that all solids/liquids meet dietary recommendations/orders and offer substitutes for foods not eaten as needed/if desired. Report changes in mentation, skin abnormalities, tremor/shaking, sweating, or changes in ability to perform activities of daily living (ADL)'s to nurse promptly. Care: ALTERED GLUCOSE METABOLISM. Nurse. Blood sugars per glucose monitor as ordered and as needed. Perform skin checks and observe for breaks in skin and treat new skin concerns promptly per orders and/or facility protocols as needed. Report abnormalities to provider. Refer to podiatrist/foot care nurse to cut long nails and determine foot care needs as needed. Report BGT (unknown what that stands for) outside of ordered parameters or significant blood sugar or intake trends to provider as needed. Follow up and document as indicated. Care: HYPOGLYCEMIA. Nurse. Blood sugars per glucose monitor as ordered or as needed. Administer rapid source of glucose per orders and/or facility protocols based on level of consciousness and route of glucose administration as needed. Obtain a blood sugar promptly if a diabetic patient has a significant change in mental status or loss of consciousness. Report BGT outside	F0684	Continued from page 1 •All current resident insulin orders were audited to ensure the insulin administration time is scheduled for a specific time versus a range of time •Facility held a mandatory nurse and TMA meeting on 03/27/2026; this meeting agenda included a review of newly implemented Diabetes Management Resource Binders that include: Copy of facility standing orders, Dexcom device user manual, Dexcom device user guide, Dexcom device sensor application instructions and checklist, Dexcom blood glucose instructions and checklist and Relias information guide "The Management of Blood Glucose Levels – Understanding Diabetes Mellitus" A quick reference guide was created, and laminated for each medication cart, detailing blood sugar times, insulin administration times, hypoglycemic perimeters of when to use the hypoglycmeic standing order set, and guidance to the new Diabetic Management binder, and a prompt to document. •Diabetes Management education completed with facility nurses and Health Unit Coordinators (HUCs). This education included information on long-acting versus short-acting insulin (Action, onset, duration and timing), expectation that insulin orders must be entered with specific administration time, expectation of delegation of daily diabetes management responsibilities for nurses and TMAs, viewing of education videos for use and management of Dexcom blood glucose monitoring device. •Facility nurses completed a competency quiz for use and management of Dexcom blood glucose monitoring device Once non- patient Dexcoms were available, in person Dexcom competency training was provided to the nurses, starting 3/31/2026, which included a teach- back of knowledge of Dexcom Glucose Monitoring Sensor Application from each nurse. Nurses who are trained then trained other nurses, and the on-call nurses will complete the education upon their next scheduled shift to allow in person training The DON spoke with the pharmacist consultant to alert him to the deficiency and for awareness of the plan of correction. The DON spoke with the Medical Director to alert of the deficiency and for an awareness of the plan of correction and made her aware of the residents	05/10/2026

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F0684 SS = D	Continued from page 2 of ordered parameters or significant blood sugar trends to provider as needed. Follow up and document as indicated. Dietary Consult. Registered Dietician (RD) to monitor/record/document the residents usual eating habits, nutritional status, and patterns to assist with determining nutritional approaches that will enhance management of altered glucose metabolism. RD to evaluate and make dietary changes/recommendations and discuss food preference with the resident as needed. Encourage adequate nutrition and hydration. Consult with RD and/or provider regarding supplemental protein, amino acids, vitamins, and minerals as needed. Education: ALTERED GLUCOSE METABOLISM. Resident/family/caregiver; stress importance of compliance with ordered regimes and general health maintenance. Instruct on recognizing/preventing complications. Impress upon the resident the importance of adhering to dietary recommendations and RD consultation. Discuss possible barriers to success and solutions to minimize. Instruct on daily foot observations/care and appropriate footwear. Instruct to avoid over the counter corn/callous treatments and to consult podiatrist as needed. Notify primary physician immediately with blood sugar concerns, then hospice, then family. Monitor/document/report as needed compliance with diet and disease and/or medication management. Document problems and report noncompliance to provider. Follow up as indicated and as needed. Obtain and monitor lab/diagnostic work as ordered. Fasting serum blood sugars and hemoglobin(Hgb)A1C (lab that determines blood glucose levels over a three month time span) as ordered. Report abnormalities to provider and follow up as indicated and as needed. Resident has a Dexcom he uses to monitor blood sugars. Nursing will assist with changing Dexcom every 10 days. Signs/Symptoms: HYPERGLYCEMIA: monitor/document/report as needed any signs/symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep, rapid, and labored breathing pattern), acetone breath (smells fruity), stupor (state of	F0684	Continued from page 2 receiving long-acting insulin at irregular intervals, and potentially effecting A1C and insulin dosing over time. If there are any insulin order changes, the HUC's will notify the nurse managers to review those changes to identify that the blood glucose monitoring and insulin administration times are correctly transcribed. Audit 50% of all diabetic residents for 3 weeks, 04/06/2026 through 04/24/2026 reviewing orders to note the blood glucose monitoring and administration times are correct. If they are incorrect, the HUC's and nurses will be notified immediately for re-education. An in person Diabetic Education Training will be completed by all nurses by May 10, 2026. This education includes the following objectives: Diabetic Education Objectives: 1. Learners will be able to identify the onset/peak/duration and action of long acting and fast acting insulins, including the impact administration time has acutely and chronically on the residents. 2. Learners will be able to identify the signs and symptoms of Hypo/hyperglycemia. 3.Learners will identify what to do when a resident's blood sugar is out of a safe range. 4.Learners will be able to identify where to find the hypo/hyperglycemic standing orders, and interventions to stabilize blood sugars. 5.Learners will be able to state the process for blood sugar correction until it is stable using the standing order set. 6.Learner will be able to state when to notify the medical provider regarding blood sugar management The Director of Nursing and Nurse Managers provided 1:1 education/coaching with LPN-B regarding Dexcom usage including when to do a fingerstick if the Dexcom reads high or low (per	05/10/2026

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Pathstone Living	**718 MOUND AVENUE , MANKATO, Minnesota, 56001**

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F0684 SS = D	Continued from page 3 near-unconsciousness), and coma. Report significant abnormalities and/or BGT outside of usual resident parameters to provider and follow up as indicated and needed. Signs/symptoms: HYPOGLYCEMIA. Monitor/document/report any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Report significant abnormalities and/or BGT below parameters that is unresponsive to facility protocols to provider. Follow up as indicated and as needed. Nursing will change Dexcom sensor every 10 days. Order supplies from Veterans Affairs. Place Dexcom in night stand at hour of sleep. When asking resident what he would like for a snack at 7:00 p.m. please offer choices. Do not ask yes or no questions. R1’s physician order dated 12/1/25, included glucose oral tablet chewable-give 4 tablets by mouth as needed for low blood sugar (54-70 milligrams (mg)/deciliter (dl). Chew 4 tablets as needed for low blood sugar. R1’s physician order dated 12/1/25, included a sliding scale for Novolog (short-acting) insulin which included to call provider if blood glucose was above 379. R1’s physician order dated 12/1/25, directed to notify provider right away if two blood glucose readings are below 70 or above 400 in a 24-hour timeframe and/or change in condition. If no change in condition, notify provider on the next business day. R1’s physician order dated 12/16/25, included Glargine (type of insulin) 22 units subcutaneously daily. R1’s medication administration record (MAR) for the month of January 2026, included the order for Glargine 22 units subcutaneously every day shift with an administration times between 6:30 a.m. – 1:00 p.m. In review of administration times in conjunction with documented blood glucose readings indicated when the insulin was administered later in the day, blood glucose levels were increased in the afternoon and evening. Excerpts from January glargine administration times with blood glucose readings for the day included:	F0684	Continued from page 3 standing orders) before giving glucose tabs or glucagon , management of hypoglycemic event, including processes to follow when a resident leaves the building against advice, and documentation of expectations on February 03, 2026. Ecumen Pathstone Living will monitor its performance to make sure corrections noted above are sustained. To ensure ongoing compliance, results will be presented to the QAPI committee. The committee will review and provide recommendations regarding the frequency and content of further audits and new interventions as indicated. Ecumen Pathstone Living will be in substantial compliance May 10, 2026.	05/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

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Pathstone Living	**718 MOUND AVENUE , MANKATO, Minnesota, 56001**

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F0684 SS = D	Continued from page 4 1/1/26-1/4/26 Glargine administered between 9:30 a.m. and 9:45 a.m. 1/5/26 glargine administered at 10:34 a.m. R1's record identified that Glargine was not administered on 1/6/26, with no indication provided. 1/7/26 Glargine administered at 9:22 a.m. glucose 84 at 8:33 a.m., 334 at 1:03 p.m., 257 at 4:31 p.m., and 127 at 7:05 p.m. 1/8/26 Glargine administered at 11:28 a.m. Glucose 106 at 7:57 a.m., 145 at 11:17 a.m., 234 at 4:11 p.m., and 219 at 7:12 p.m. 1/9/26 Glargine administered at 9:18 a.m. Glucose 120 at 9:11 a.m., 138 at 12:38 p.m., 112 at 4:17 p.m., and 154 at 7:04 p.m. 1/10/26 Glargine administered at 12:17 p.m. Glucose 123 at 12:15 p.m., 314 at 5:29 p.m., 258 at 7:59 p.m. 1/11/26 Glargine administered at 11:35 a.m. Glucose 115 at 9:44 a.m., 429 at 4:42 p.m., 214 at 9:23 p.m. 1/18/26 Glargine administered at 1:09 p.m. Glucose 86 at 9:56 a.m., 133 at 1:08 p.m., 258 at 8:09 p.m. 1/19/26 Glargine administered at 10:54 a.m. Glucose 52 at 3:51 a.m., 78 at 4:30 a.m., 108 at 4:59 a.m., 127 at 8:40 a.m., 156 at 11:55 a.m., 164 at 4:03 p.m., 150 at 7:03 p.m., 83 at 11:43 p.m. R1's progress notes from 1/19/26, did not identify physician notification or interventions provided for R1's blood glucose readings of 52 and 78.	F0684		05/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/06/2026

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Pathstone Living	**718 MOUND AVENUE , MANKATO, Minnesota, 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
F0684 SS = D	Continued from page 5 1/20/26 Glargine administered at 9:35 a.m. Glucose 121 at 1:20 a.m., 103 at 7:28 a.m., 126 at 12:14 p.m., 109 at 4:16 p.m., 241 at 8:34 a.m. 1/21/26 Glargine administered at 12:14 p.m. Glucose 87 at 8:34 a.m., 174 at 11:41 a.m., 177 at 3:40 p.m., 129 at 4:33 p.m., 169 at 7:48 p.m. 1/22/26 Glargine administered at 9:25 a.m. Glucose 94 at 9:12 a.m., 54 at 10:44 a.m., 130 at 3:56 p.m., 338 at 7:00 p.m. 1/23/26 Glargine administered at 2:45 p.m. Glucose 97 at 9:26 a.m., 129 at 11:56 a.m., 243 at 4:17 p.m., 190 at 7:10 p.m. R1's Dexcom G7 Manual undated, identified the sensor sends a glucose reading to the receiver every five minutes. R1's physician order dated 1/22/26, included glucagon injection to inject1 milligram (mg) intramuscularly one time for low blood sugar. R1's progress note dated 1/22/6 at 10:48 a.m., identified R1's blood glucose was 54. Gave R1 orange juice to drink, R1 could not drink it all. Retook blood glucose 57. R1 leaving for appointment. Administered glucagon per house standing orders. R1 then left for appointment. R1's progress note dated 1/22/26, identified a Situation, Background, Assessment, Recommendation/Response was completed at 11:31 a.m., identified R1's blood sugar 54. R1 leaving for appointment. R1 was alert and able to communicate. Sluggish. Gave a glass of orange juice but R1 did not want to drink it. R1 did take about 90 cubic centimeters (cc). Rechecked blood glucose 57. Administered glucagon out of emergency kit per house standing orders. R1 left for appointment. Recommended to family member (FM)-A to recheck blood glucose in half an hour. Called nurse practitioner and hospice and informed of situation. R1's record review did not identify a comprehensive assessment that was completed for signs/symptoms of hypoglycemia and not evident monitoring was	F0684		05/10/2026

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F0684 SS = D	Continued from page 6 completed to ensure blood glucose returned to safe levels after administering the glucagon. R1 did not have his blood glucose read again until 3:56 p.m. During an interview on 3/4/26 at 2:47 p.m., licensed practical nurse (LPN)-B stated R1 had a Dexcom (continuous blood glucose monitoring system). There was a button on the monitor that when pressed it showed the blood glucose readings. R1 did not show signs or symptoms with high or low blood glucose readings. LPN-B had not ever seen R1 have really high or low blood glucose levels. R1 was not on her list of residents to take care of on 1/22/26, R1 was either cared for by the trained medication aide (TMA) or “the other nurse”. On 1/22/26, R1 and family member (FM)-A were in the dining room. FM-A was upset because R1 had low blood glucose and had appointments that he was supposed to be leaving the facility to attend. LPN-B thought either a TMA or a nursing assistant (NA) had alerted her that R1’s blood glucose was low. The Dexcom was not beeping when LPN-B was by R1. LPN-B could not recall if a fingerstick glucose was obtained or if only the Dexcom monitor was read. “54 is a low reading, like comatose level”, and LPN-B “was just fixing the problem by getting him safe”. LPN-B could not locate R1’s glucose tablets in the medication cart. LPN-B obtained the glucagon injection from the emergency medication kit and administered it to R1. R1’s blood glucose rose to 58 after the glucagon administration and was rising. LPN-B stated she told the van driver and told FM-A to watch the Dexcom and if it started to go low have the driver stop. LPN-B stated she was uncomfortable with R1 leaving the building. R1 was fine when he returned after his appointments. During a phone interview on 3/5/26 at 2:26 p.m., FM-A stated on 1/22/6, R1 had a breakfast tray in the dining room. FM-A sat by R1 and heard a beeping noise. FM-A was unsure what had beeped. A few minutes later, the beeping began again. FM-A realized it was R1’s Dexcom beeping because R1 was out of the range he should be in. FM-A went to the kitchen and obtained a glass of orange juice because she “knew that would help immediately”. When the Dexcom beeped again, FM-A went to the nurse’s station, found a staff member and told them the situation. The person stated they were trying to find out what they could do because the facility did not have any glucose tablets. The staff person called someone on the phone and shortly after she came to R1. No one took a manual reading of R1’s blood glucose. The staff just came out and gave him an injection. FM-A recalled the blood glucose rose two points from the original number. FM-A did not	F0684		05/10/2026

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F0684 SS = D	Continued from page 7 recognize R1 acting or behaving any different than usual. FM-A was concerned if the monitor was working properly “but the nurse went with it”. FM-A was concerned about leaving with R1 to go to his appointments and asked the nurse what to do. The response was “call 9-1-1”. The nurse did not tell FM-A to wait to make sure the blood glucose rose. FM-A stated she would have cancelled R1’s appointments if the facility showed any concern about the low blood glucose. FM-A was not used to a situation like this. “They didn’t even make sure he got out to the car, just gave the shot and left.” “It was terrifying and unnecessary. If he would have crashed, I wouldn’t have known what to do.” During a phone interview on 3/5/26 at 2:15 p.m., the van company president stated, referred to R1’s transport on 1/22/26 to the clinic and asked “how would we have known R1 had a low blood sugar?” During a phone interview on 3/5/26 at 1:02 p.m., registered nurse (RN)-V from R1’s appointment indicated they had not received any communication from the facility on 1/22/26 and they were unaware of R1’s low blood glucose reading. During a phone interview on 3/5/26 at 3:25 p.m., medical doctor (MD)-A stated R1’s blood glucose should have been manually checked on 1/22/26 to verify the Dexcom was giving correct reading. Blood glucose levels presenting that low could cause a person to go into a coma and possibly die. Administering long-acting insulin at random times each day could potentially lead to overlap and drop the resident low. R1’s record identified that glargine was not administered on 1/29/26, and no blood glucose was obtained in the sliding scale insulin given in the morning or lunchtime, with no indication provided. Blood glucose readings were 103 at 9:43 a.m. and 158 at 12:44 p.m., which indicated R1 should have been provided 2 units of insulin. At 9:11 p.m. R1’s blood glucose reading was 70. R1’s progress note dated 1/30/26 at 7:52 a.m., identified when blood glucose of 70 was obtained at hour of sleep, R1 was provided orange juice and the reading increased to 86. R1 was provided with another glass of orange juice and registered blood glucose of 110 at 11:20 p.m. R1’s progress note dated 2/2/26 at 4:39 a.m., identified Dexcom was beeping and showed a glucose reading of 70 at 12:30 a.m., denied symptoms. When nurse was informed glucose	F0684		05/10/2026

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F0684 SS = D	Continued from page 8 reading was 68, given 6 ounces of orange juice. Glucose was 97 fifteen minutes later. Rechecked four hours later and it was 73. Will provide 6 ounces orange juice and awaken R1 to drink. At 6:09 a.m., glucose was 82 and R1 had not drank the orange juice that had been provided earlier. R1's physician visit note dated 2/5/26, identified an order to decrease glargine (long-acting insulin) to 20 units daily. R1's MAR dated February 2026, identified Glargine insulin administer 20 units subcutaneously every day shift. The time to administer was 6:30 a.m.-1:00 p.m. Excerpts from February and March glargine administration times included: 2/8/26 Glargine administered at 9:19 a.m. 2/9/26 Glargine administered at 11:08 a.m. 2/10/26 Glargine administered at 9:43 a.m. R1's blood glucose reading at 7:02 p.m. was 66. At 7:31 p.m., 107. 2/12/26 Glargine administered at 1:01 p.m. R1's blood glucose reading at 10:19 a.m. was 69. At 12:53 154. No further documentation provided. 2/16/26 Glargine administered at 8:38 a.m. Glucose reading at 7:04 a.m. was 70. Progress note identified orange juice provided. No further follow-up until glucose monitored at 11:10 a.m. 129. 2/25/26 Glargine administered at 11:30 a.m. 2/26/26 Glargine administered at 9:10 a.m. 2/27/26 Glargine administered at 11:40 a.m. 3/1/26 Glargine administered at 9:30 a.m. 3/2/26 Glargine administered at 2:43 p.m. 3/3/26 Glargine administered at 8:23 a.m. 3/4/25 Glargine administered at 9:45 a.m.	F0684		05/10/2026

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F0684 SS = D	Continued from page 9 3/5/26 Glargine administered at 11:10 a.m. R1's record review between 1/1/26-3/4/26, identified an order to replace Dexcom sensor every 10 days and as needed but did not provide directions on how to change sensor, to complete a manual reading to verify results, or what to set the alarm for until 3/5/26, while surveyor was onsite. During a phone interview on 3/4/26 at 2:59 p.m., FM-A stated R1 has had diabetes for years. R1 never had the trouble with blood sugar going high and low at home or at prior facility. All of the issues with blood glucose have taken a huge toll on R1. On 1/22/26, R1 could have died, that was absolutely unacceptable. FM-A questioned if it could be the facility giving morning medications at 10:00 a.m. and giving afternoon medications an hour and a half later. "we don't know any different, we are not medical professionals". During an interview on 3/5/26 at 1:38 p.m., health unit coordinator who was also a nursing assistant, NA-E stated she was unsure why she transcribed the order for every day shift. NA-E stated it should be input for one time a day. Sometimes, the order was put in and the nurse who confirmed the order would change the times so that they were more suitable. The system would not identify if the nurse changed the administration time prior to confirming the order. During a continuous observation and interview on 3/5/26 beginning at 9:20 a.m. R1 was in his room, getting into his wheelchair with NA-B. NA-B and R1 continued with morning routine of placing hearing aids in ears, brushing teeth, and putting on glasses. During cares NA-B stated she was aware that R1 was diabetic. There was a sheet at the nurse's station that informed who was diabetic and in the charting there was a prompt that would ask if the resident had shown signs like shakiness. NA-B stated R1 had a "port" that helped with his blood glucose numbers. NA-B was unable to articulate a sign of low blood sugars other than weakness. NA-B propelled R1 out of his room and to the nurse's station to check a piece of paper. NA-B then wheeled R1 to the scale and weighed him. NA-B brought R1 to the commons room and set him up at a table that had a tray on it. NA-B put straws in the drink cups. R1 asked for peanut butter. At 10:11 a.m., R1's blood glucose had not been obtained and Glargine and sliding scale insulin had not been given. R1 began to take sips from his orange juice and coffee. NA-B placed peanut butter packet on table and left to wash her hands. R1 picked up the	F0684		05/10/2026

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F0684 SS = D	Continued from page 10 peanut butter and attempted to open it with his teeth. NA-B returned to the table and opened the peanut butter and spread it on a bagel. R1 took the bagel and brought it to his mouth. NA-B put brown sugar on R1's oatmeal. R1 also had 3 sausage patties, 3 bacon strips, and 2 eggs on his plate. R1's Dexcom displayed 0 and had a message to start a new sensor. R1 showed NA-B. NA-B stated she would get the nurse. At 10:24 a.m., R1 finished the bagel. At 10:29 a.m., R1 finished eating the sausage at 10:32 a.m. and completed both by 10:35 a.m. At 10:38 a.m. No nurse/TMA had gotten his blood glucose reading and no insulin had been administered. At 10:47 a.m., R1 began eating his bacon. At 10:48 a.m., TMA-A verified she had not obtained a blood glucose reading for R1 that morning. TMA-A walked over to R1 and pressed his Dexcom "I thought they just put a new one on but it isn't working, guess I will take it manually". At 10:50 a.m., TMA-A went to the medication cart to get the manual glucometer. TMA-A returned to R1 and stated LPN-A would put a new Dexcom on R1 later. At 10:52 a.m., R1's blood glucose was 153. TMA-A stated blood glucose should be obtained at 7:30 a.m. or prior to eating. R1 was not up at 10:00 a.m. and "I just got back from break". R1 had not received his long-acting insulin either, the insulin can be given anytime from 6:00 a.m.-2:30 p.m. TMA-A stated R1 has short-acting insulin and his blood glucose was usually around 90 but today he would get "around 2 units". TMA-A did not tell the nurse that she did not obtain the blood glucose prior to R1eating. At 11:04 a.m., R1 was consuming the third sausage. LPN-D stated she needed to remove him from the table, take him to his room, and administer his insulin. At 11:08 a.m., LPN-D administered 20 units of long-acting insulin and 2 units of short-acting sliding scale insulin. After administration, LPN-D brought R1 back to the commons area table to continue eating. During an interview on 3/5/26 at 11:13 a.m., LPN-D stated R1 received his long-acting insulin between 10:00 a.m.-2:00 p.m. R1 received his short-acting at the same time. Blood glucose should technically be checked before eating and insulin should also be given before meals. "he is not my patient today". Blood glucose can spike after eating, so the short-acting should be given before meals and long-acting can be given whenever the doctor prescribes. LPN-D stated she did not trust Dexcom systems, "they never work and can be off by 50". During an interview on 3/5/26 at 12:20 p.m., R1 sat in his wheelchair in his room with the overbed table in front of him, and breakfast tray with oatmeal and	F0684		05/10/2026

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F0684 SS = D	Continued from page 11 drinks. FM-C sat next to R1. FM-C stated staff would now give him R1 a rice crispy bar and yogurt for lunch. R1 stated he did not feel any different when he has high or low blood glucose. FM-C stated FM-B told her the Dexcom had not been working since 3/4/26. FM-C thought the battery was dead and took the machine and plugged it in. “Its 100%. Let’s look at the sensor and make sure it is connected”. FM-C stated there was not a sensor on R1, only a clear patch where the sensor should be. R1 stated the sensor came off during his shower on 3/4/26 and the staff did not notice. During an interview on 3/5/26 at 1:18 p.m., LPN-D stated the preference for medications to be scheduled for AM/PM/HS blocks so there was more time to administer. “If something was scheduled for a specific time, it just did not happen, there was not enough time.” R1’s physician order for Glargine dated 1/2/26 read daily (administration), and on 2/5/26, it also read to decrease to 20 units daily (administration). When the order read daily without a specific time identified, staff would pick the administration time. The nurse would then acknowledge or confirm the order. LPN-D stated she realized the error and told RN-C about it. Giving the glargine at different times could absolutely affect the blood glucose readings and the littlest difference in time administration can really affect the care. LPN-D worked the evening of 3/4/26, and was unaware that R1’s sensor had fallen off, “aides didn’t tell me”. LPN-D stated she changed the sensor once but there were no instructions on how to change it so “I do what all nurses do, I YouTube it" During an interview on 3/5/26, clinical manager RN-C stated the Dexcom instructions on how to change the Dexcom should be included in the residents MAR or treatment administration record (TAR). Fortunately, when the Dexcom had needed to be replaced, the same nurse was doing it. RN-C stated if she was inputting orders for long-acting insulin in the MAR she would have the administration times between 6:00 a.m.-10:00 a.m. RN-C acknowledged that administering long-acting insulin over various times “will bottom them out or something will happen”. On 1/22/26, when R1 was given glucagon, his blood glucose should have been checked manually. R1 should not have left the facility with a reading of 58, he should have stayed and waited until the reading was higher. RN-C stated the van driver was unaware of the low blood sugar and “that would have been awful if something happened during the ride”. RN-C stated the facility did not conduct audits on when blood glucose readings are obtained or when insulin is	F0684		05/10/2026

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F0684 SS = D	Continued from page 12 administered. R4 R4's face sheet dated 3/9/26, identified diagnoses of type 2 diabetes with chronic kidney disease with heart failure, chronic kidney disease stage 4, diabetic peripheral angiopathy without gangrene, nonproliferative diabetic retinopathy without macular degeneration bilateral, hyperglycemia, and diabetic polyneuropathy. R4's quarterly MDS dated 2/5/26, identified R4 had no cognition issues, had moderate difficulty with hearing, and had corrective lenses. R4 was independent with eating. R4 followed a therapeutic diet, and had insulin injections seven days/week. R4's physician order dated 10/14/25, identified Glargine 30 units daily. R4's MAR dated February 2026, identified Glargine 20 units daily. This order was scheduled for AM. Excerpts from February and March Glargine administration times included: 2/10/26 Glargine administered at 7:53 a.m. 2/11/26 Glargine administered at 12:10 p.m. 2/12/26 Glargine administered at 9:00 a.m. 2/19/26 Glargine administered at 7:07 a.m. 2/20/26 Glargine administered at 12:17 p.m. 2/21/26 Glargine administered at 11:33 a.m. 2/22/26 Glargine administered at 7:18 a.m. 3/1/26 Glargine administered at 8:38 a.m. 3/2/26 Glargine administered at 6:59 a.m. 3/3/26 Glargine administered at 8:33 a.m. 3/4/26 Glargine administered at 6:49 a.m. 3/5/26 Glargine administered at 8:12 a.m. During an interview on 3/5/26 at 12:37 p.m., RN-B stated long-acting insulin should be given before breakfast or at bedtime, depending on the order. It should generally not be given at anytime during the shift. Blood glucose should be obtained before	F0684		05/10/2026

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F0684 SS = D	Continued from page 13 meals and at bedtime. If taken during a meal it could skew the reading and the resident could be given too high of a dose and “crash” later. During a phone interview on 3/5/26 at 11:36 a.m., pharmacist (P)-A stated administering long-acting insulin between 6:00 a.m.-2:30 p.m. was not okay, it would need to be more specific than that. Manufacturer recommendations directed to administer at the same time every day. P-A would not be worried if the administration time was within an hour each day but if they are administering at 6:00 a.m. one day and 2:30 p.m. then the resident would not get consistent levels and would have high and low blood glucose readings. Blood glucose readings should be obtained before the resident ate and before insulin was given. If it was taken while eating, the risk is the blood glucose could still be rising, and the resident could get too much or too little insulin. The facility Diabetes-Clinical Protocol policy revised March 2025, identified For residents with confirmed diabetes, the nurse will assess and document/report the following during the initial assessment: Level of consciousness, change in orientation; Signs or symptoms of cognitive decline; History of medication management; Dose and time of most recent anti-hyperglycemic given; All other current medications; Any signs or symptoms of infection (urine, skin/wound, upper respiratory, etc.) or other acute illnesses; Foot complications; Vision or hearing impairment; Recent weight loss/failure to thrive; Usual patterns of eating and drinking; Approximate intake over the last 24 hours; Recent change in intake/thirst; Resident’s blood sugar history over 48 hours; Usual patterns (fluctuations, trends) of blood sugar	F0684		05/10/2026

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F0684 SS = D	Continued from page 14 over recent months; Onset, duration of any changes; and Recent labs. The staff will incorporate orders and reporting parameters into the Medication Administration Record and care plan. An example of an appropriate hypoglycemia treatment protocol is: For a conscious resident: administer 15 g of carbohydrate; recheck the resident's blood glucose in 15 minutes; if blood glucose is still below 70 mg/dL, administer another 15 g of carbohydrates and recheck; repeat until blood glucose increases to at least 70 mg/dL or resident is without symptoms and then; offer a snack or meal containing carbohydrates and protein. For an unconscious resident: Call 911 (in accordance with the resident's advance directive); administer 1mg of glucagon subcutaneously or intravenous 50% glucose (if there is IV access); obtain IV access, as soon as possible; glucagon peak effect is reached in 30 minutes. Do not administer glucagon more than twice. recheck blood sugar every 15 minutes until blood glucose is above 70 mg/dL and/or resident is without symptoms and then; offer snack or meal with carbohydrates. Staff will notify the practitioner immediately (but not delay intervention) when the resident's blood glucose is less than 70 mg/dL AND is unresponsive OR consecutive blood glucose readings are less than 70 mg/dL. Hyperglycemia Staff will notify the practitioner as soon as possible	F0684		05/10/2026

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F0684 SS = D	Continued from page 15 when: the resident has two or more blood glucose readings higher than 250 mg/dL within a 24-hour period accompanied by a new medical problem or a change in condition or functional status; the resident has blood glucose readings higher than 300 mg/dL during all or part of 2 consecutive days; the resident is not eating well or is vomiting, or an antidiabetic medication has been held; the resident is not eating well or consuming sufficient fluids and has 1 or more additional symptoms suggesting an acute illness. The facility Insulin Administration policy revised March 2025, identified long-acting insulin glargine had an onset time of 2-4 hours, peak was flat, duration of 20-24 hours. The facility Standing Orders dated 10/3/25 and signed by the Medical Director, identified if the patient has a continuous glucose monitor, initiate the below orders: set alarms for <100 LOW and >400 HIGH with first application do fingerstick 2 times 3 hours apart and document both fingerstick and continuous glucose monitor readings. Notify provider if readings are >20 points difference finger stick as needed if blood glucose is <100 or >400, change in condition, or concerns arise of continuous glucose monitor accuracy or not reading. Charge display every night- keep within 20 ft of the patient. Apply a new sensor every 14 days or per sensor instructions.	F0684		05/10/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **03/06/2026**

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20000	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 3/4/26, 3/5/26, and 3/6/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed. The following complaints were reviewed: H53903763C (2717725), and H53905222C (2732612) with licensing orders issued at: and 20830.	20000		03/26/2026

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

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20000	Continued from page 1 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 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.	20000		03/26/2026
20830	Adequate and Proper Nursing Care; General CFR(s): MN Rule 4658.0520 Subp. 1 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or	20830	Corrected	05/10/2026

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20830	Continued from page 2 the resident prefers to remain in bed. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to administer long-acting insulin at consistent times for 2 of 3 residents (R1, R4), failed to appropriately respond to abnormal blood glucose levels, and failed to ensure monitoring and follow-up after interventions for hypoglycemia for 1 of 3 residents (R1) reviewed for diabetic management. Findings include: R1’s face sheet dated 3/5/26, identified a diagnosis type 2 diabetes mellitus. R1’s comprehensive Minimum Data Set (MDS) dated 12/18/25, identified R1 had no cognition issues. R1 was on a therapeutic diet and received insulin injections seven days per week. R1’s care plan revised on 3/4/25, identified a focus of risk for complications related to altered glucose metabolism. Diagnosis of diabetes mellitus with retinopathy (damage to retina of the eye). Interventions included: administer medication(s) to control glucose levels and/or insulin as ordered. Monitor for side effects and effectiveness. Report adverse effects to provider as needed. If infection is present, consult provider regarding any changes in diabetic medications as applicable. Follow up as indicated. Care: ALTERED GLUCOSE METABOLISM. General. Avoid exposure to extreme heat/cold. Moisturize dry skin daily. DO NOT apply lotion over breaks in skin or wounds. Provide and serve diet as ordered. Ensure that all solids/liquids meet dietary recommendations/orders and offer substitutes for foods not eaten as needed/if desired. Report changes in mentation, skin abnormalities, tremor/shaking, sweating, or changes in ability to perform activities of daily living (ADL)’s to nurse promptly. Care: ALTERED GLUCOSE METABOLISM. Nurse. Blood sugars per glucose monitor as ordered and as needed. Perform skin checks and observe for breaks in skin and treat new skin concerns promptly per orders and/or facility protocols as needed. Report abnormalities to provider. Refer to podiatrist/foot care nurse to cut long nails and determine foot care needs as needed. Report BGT (unknown what that	20830		05/10/2026

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20830	Continued from page 3 stands for) outside of ordered parameters or significant blood sugar or intake trends to provider as needed. Follow up and document as indicated. Care: HYPOGLYCEMIA. Nurse. Blood sugars per glucose monitor as ordered or as needed. Administer rapid source of glucose per orders and/or facility protocols based on level of consciousness and route of glucose administration as needed. Obtain a blood sugar promptly if a diabetic patient has a significant change in mental status or loss of consciousness. Report BGT outside of ordered parameters or significant blood sugar trends to provider as needed. Follow up and document as indicated. Dietary Consult. Registered Dietician (RD) to monitor/record/document the residents usual eating habits, nutritional status, and patterns to assist with determining nutritional approaches that will enhance management of altered glucose metabolism. RD to evaluate and make dietary changes/recommendations and discuss food preference with the resident as needed. Encourage adequate nutrition and hydration. Consult with RD and/or provider regarding supplemental protein, amino acids, vitamins, and minerals as needed. Education: ALTERED GLUCOSE METABOLISM. Resident/family/caregiver; stress importance of compliance with ordered regimes and general health maintenance. Instruct on recognizing/preventing complications. Impress upon the resident the importance of adhering to dietary recommendations and RD consultation. Discuss possible barriers to success and solutions to minimize. Instruct on daily foot observations/care and appropriate footwear. Instruct to avoid over the counter corn/callous treatments and to consult podiatrist as needed. Notify primary physician immediately with blood sugar concerns, then hospice, then family. Monitor/document/report as needed compliance with diet and disease and/or medication management. Document problems and report noncompliance to provider. Follow up as indicated and as needed. Obtain and monitor lab/diagnostic work as ordered. Fasting serum blood sugars and hemoglobin(Hgb)A1C (lab that determines blood glucose levels over a three month time span) as ordered. Report abnormalities to provider and follow up as indicated and as needed.	20830		05/10/2026

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20830	Continued from page 4 Resident has a Dexcom he uses to monitor blood sugars. Nursing will assist with changing Dexcom every 10 days. Signs/Symptoms: HYPERGLYCEMIA: monitor/document/report as needed any signs/symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep, rapid, and labored breathing pattern), acetone breath (smells fruity), stupor (state of near-unconsciousness), and coma. Report significant abnormalities and/or BGT outside of usual resident parameters to provider and follow up as indicated and needed. Signs/symptoms: HYPOGLYCEMIA. Monitor/document/report any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Report significant abnormalities and/or BGT below parameters that is unresponsive to facility protocols to provider. Follow up as indicated and as needed. Nursing will change Dexcom sensor every 10 days. Order supplies from Veterans Affairs. Place Dexcom in night stand at hour of sleep. When asking resident what he would like for a snack at 7:00 p.m. please offer choices. Do not ask yes or no questions. R1's physician order dated 12/1/25, included glucose oral tablet chewable-give 4 tablets by mouth as needed for low blood sugar (54-70 milligrams (mg)/deciliter (dl). Chew 4 tablets as needed for low blood sugar. R1's physician order dated 12/1/25, included a sliding scale for Novolog (short-acting) insulin which included to call provider if blood glucose was above 379. R1's physician order dated 12/1/25, directed to notify provider right away if two blood glucose readings are below 70 or above 400 in a 24-hour timeframe and/or change in condition. If no change in condition, notify provider on the next business day. R1's physician order dated 12/16/25, included Glargine (type of insulin) 22 units subcutaneously daily.	20830		05/10/2026

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20830	Continued from page 5 R1's medication administration record (MAR) for the month of January 2026, included the order for Glargine 22 units subcutaneously every day shift with an administration times between 6:30 a.m. – 1:00 p.m. In review of administration times in conjunction with documented blood glucose readings indicated when the insulin was administered later in the day, blood glucose levels were increased in the afternoon and evening. Excerpts from January glargine administration times with blood glucose readings for the day included: 1/1/26-1/4/26 Glargine administered between 9:30 a.m. and 9:45 a.m. 1/5/26 glargine administered at 10:34 a.m. R1's record identified that Glargine was not administered on 1/6/26, with no indication provided. 1/7/26 Glargine administered at 9:22 a.m. glucose 84 at 8:33 a.m., 334 at 1:03 p.m., 257 at 4:31 p.m., and 127 at 7:05 p.m. 1/8/26 Glargine administered at 11:28 a.m. Glucose 106 at 7:57 a.m., 145 at 11:17 a.m., 234 at 4:11 p.m., and 219 at 7:12 p.m. 1/9/26 Glargine administered at 9:18 a.m. Glucose 120 at 9:11 a.m., 138 at 12:38 p.m., 112 at 4:17 p.m., and 154 at 7:04 p.m. 1/10/26 Glargine administered at 12:17 p.m. Glucose 123 at 12:15 p.m., 314 at 5:29 p.m., 258 at 7:59 p.m. 1/11/26 Glargine administered at 11:35 a.m. Glucose 115 at 9:44 a.m., 429 at 4:42 p.m., 214 at 9:23 p.m. 1/18/26 Glargine administered at 1:09 p.m. Glucose 86 at 9:56 a.m., 133 at 1:08 p.m., 258 at 8:09 p.m.	20830		05/10/2026

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20830	Continued from page 6 1/19/26 Glargine administered at 10:54 a.m. Glucose 52 at 3:51 a.m., 78 at 4:30 a.m., 108 at 4:59 a.m., 127 at 8:40 a.m., 156 at 11:55 a.m., 164 at 4:03 p.m., 150 at 7:03 p.m., 83 at 11:43 p.m. R1's progress notes from 1/19/26, did not identify physician notification or interventions provided for R1's blood glucose readings of 52 and 78. 1/20/26 Glargine administered at 9:35 a.m. Glucose 121 at 1:20 a.m., 103 at 7:28 a.m., 126 at 12:14 p.m., 109 at 4:16 p.m., 241 at 8:34 a.m. 1/21/26 Glargine administered at 12:14 p.m. Glucose 87 at 8:34 a.m., 174 at 11:41 a.m., 177 at 3:40 p.m., 129 at 4:33 p.m., 169 at 7:48 p.m. 1/22/26 Glargine administered at 9:25 a.m. Glucose 94 at 9:12 a.m., 54 at 10:44 a.m., 130 at 3:56 p.m., 338 at 7:00 p.m. 1/23/26 Glargine administered at 2:45 p.m. Glucose 97 at 9:26 a.m., 129 at 11:56 a.m., 243 at 4:17 p.m., 190 at 7:10 p.m. R1's Dexcom G7 Manual undated, identified the sensor sends a glucose reading to the receiver every five minutes. R1's physician order dated 1/22/26, included glucagon injection to inject1 milligram (mg) intramuscularly one time for low blood sugar. R1's progress note dated 1/22/6 at 10:48 a.m., identified R1's blood glucose was 54. Gave R1 orange juice to drink, R1 could not drink it all. Retook blood glucose 57. R1 leaving for appointment. Administered glucagon per house standing orders. R1 then left for appointment. R1's progress note dated 1/22/26, identified a Situation, Background, Assessment, Recommendation/Response was completed at 11:31 a.m., identified R1's blood sugar 54. R1 leaving for appointment. R1 was alert and able to communicate.	20830		05/10/2026

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20830	Continued from page 7 Sluggish. Gave a glass of orange juice but R1 did not want to drink it. R1 did take about 90 cubic centimeters (cc). Rechecked blood glucose 57. Administered glucagon out of emergency kit per house standing orders. R1 left for appointment. Recommended to family member (FM)-A to recheck blood glucose in half an hour. Called nurse practitioner and hospice and informed of situation. R1's record review did not identify a comprehensive assessment that was completed for signs/symptoms of hypoglycemia and not evident monitoring was completed to ensure blood glucose returned to safe levels after administering the glucagon. R1 did not have his blood glucose read again until 3:56 p.m. During an interview on 3/4/26 at 2:47 p.m., licensed practical nurse (LPN)-B stated R1 had a Dexcom (continuous blood glucose monitoring system). There was a button on the monitor that when pressed it showed the blood glucose readings. R1 did not show signs or symptoms with high or low blood glucose readings. LPN-B had not ever seen R1 have really high or low blood glucose levels. R1 was not on her list of residents to take care of on 1/22/26, R1 was either cared for by the trained medication aide (TMA) or "the other nurse". On 1/22/26, R1 and family member (FM)-A were in the dining room. FM-A was upset because R1 had low blood glucose and had appointments that he was supposed to be leaving the facility to attend. LPN-B thought either a TMA or a nursing assistant (NA) had alerted her that R1's blood glucose was low. The Dexcom was not beeping when LPN-B was by R1. LPN-B could not recall if a fingerstick glucose was obtained or if only the Dexcom monitor was read. "54 is a low reading, like comatose level", and LPN-B "was just fixing the problem by getting him safe". LPN-B could not locate R1's glucose tablets in the medication cart. LPN-B obtained the glucagon injection from the emergency medication kit and administered it to R1. R1's blood glucose rose to 58 after the glucagon administration and was rising. LPN-B stated she told the van driver and told FM-A to watch the Dexcom and if it started to go low have the driver stop. LPN-B stated she was uncomfortable with R1 leaving the building. R1 was fine when he returned after his appointments. During a phone interview on 3/5/26 at 2:26 p.m., FM-A stated on 1/22/6, R1 had a breakfast tray in the dining room. FM-A sat by R1 and heard a beeping noise. FM-A was unsure what had beeped. A few minutes later, the beeping began again. FM-A realized it was R1's Dexcom beeping because R1 was out of the range he should be in. FM-A went to	20830		05/10/2026

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20830	Continued from page 8 the kitchen and obtained a glass of orange juice because she “knew that would help immediately”. When the Dexcom beeped again, FM-A went to the nurse’s station, found a staff member and told them the situation. The person stated they were trying to find out what they could do because the facility did not have any glucose tablets. The staff person called someone on the phone and shortly after she came to R1. No one took a manual reading of R1’s blood glucose. The staff just came out and gave him an injection. FM-A recalled the blood glucose rose two points from the original number. FM-A did not recognize R1 acting or behaving any different than usual. FM-A was concerned if the monitor was working properly “but the nurse went with it”. FM-A was concerned about leaving with R1 to go to his appointments and asked the nurse what to do. The response was “call 9-1-1”. The nurse did not tell FM-A to wait to make sure the blood glucose rose. FM-A stated she would have cancelled R1’s appointments if the facility showed any concern about the low blood glucose. FM-A was not used to a situation like this. “They didn’t even make sure he got out to the car, just gave the shot and left.” “It was terrifying and unnecessary. If he would have crashed, I wouldn’t have known what to do.” During a phone interview on 3/5/26 at 2:15 p.m., the van company president stated, referred to R1’s transport on 1/22/26 to the clinic and asked “how would we have known R1 had a low blood sugar?” During a phone interview on 3/5/26 at 1:02 p.m., registered nurse (RN)-V from R1’s appointment indicated they had not received any communication from the facility on 1/22/26 and they were unaware of R1’s low blood glucose reading. During a phone interview on 3/5/26 at 3:25 p.m., medical doctor (MD)-A stated R1’s blood glucose should have been manually checked on 1/22/26 to verify the Dexcom was giving correct reading. Blood glucose levels presenting that low could cause a person to go into a coma and possibly die. Administering long-acting insulin at random times each day could potentially lead to overlap and drop the resident low. R1’s record identified that glargine was not administered on 1/29/26, and no blood glucose was obtained in the sliding scale insulin given in the morning or lunchtime, with no indication provided. Blood glucose readings were 103 at 9:43 a.m. and 158 at 12:44 p.m., which indicated R1 should have been provided 2 units of insulin. At 9:11 p.m. R1’s blood glucose reading was 70.	20830		05/10/2026

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20830	Continued from page 9 R1's progress note dated 1/30/26 at 7:52 a.m., identified when blood glucose of 70 was obtained at hour of sleep, R1 was provided orange juice and the reading increased to 86. R1 was provided with another glass of orange juice and registered blood glucose of 110 at 11:20 p.m. R1's progress note dated 2/2/26 at 4:39 a.m., identified Dexcom was beeping and showed a glucose reading of 70 at 12:30 a.m., denied symptoms. When nurse was informed glucose reading was 68, given 6 ounces of orange juice. Glucose was 97 fifteen minutes later. Rechecked four hours later and it was 73. Will provide 6 ounces orange juice and awaken R1 to drink. At 6:09 a.m., glucose was 82 and R1 had not drank the orange juice that had been provided earlier. R1's physician visit note dated 2/5/26, identified an order to decrease glargine (long-acting insulin) to 20 units daily. R1's MAR dated February 2026, identified Glargine insulin administer 20 units subcutaneously every day shift. The time to administer was 6:30 a.m.-1:00 p.m. Excerpts from February and March glargine administration times included: 2/8/26 Glargine administered at 9:19 a.m. 2/9/26 Glargine administered at 11:08 a.m. 2/10/26 Glargine administered at 9:43 a.m. R1's blood glucose reading at 7:02 p.m. was 66. At 7:31 p.m., 107. 2/12/26 Glargine administered at 1:01 p.m. R1's blood glucose reading at 10:19 a.m. was 69. At 12:53 154. No further documentation provided. 2/16/26 Glargine administered at 8:38 a.m. Glucose reading at 7:04 a.m. was 70. Progress note identified orange juice provided. No further follow-up until glucose monitored at 11:10 a.m. 129. 2/25/26 Glargine administered at 11:30 a.m. 2/26/26 Glargine administered at 9:10 a.m.	20830		05/10/2026

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20830	Continued from page 10 2/27/26 Glargine administered at 11:40 a.m. 3/1/26 Glargine administered at 9:30 a.m. 3/2/26 Glargine administered at 2:43 p.m. 3/3/26 Glargine administered at 8:23 a.m. 3/4/25 Glargine administered at 9:45 a.m. 3/5/26 Glargine administered at 11:10 a.m. R1's record review between 1/1/26-3/4/26, identified an order to replace Dexcom sensor every 10 days and as needed but did not provide directions on how to change sensor, to complete a manual reading to verify results, or what to set the alarm for until 3/5/26, while surveyor was onsite. During a phone interview on 3/4/26 at 2:59 p.m., FM-A stated R1 has had diabetes for years. R1 never had the trouble with blood sugar going high and low at home or at prior facility. All of the issues with blood glucose have taken a huge toll on R1. On 1/22/26, R1 could have died, that was absolutely unacceptable. FM-A questioned if it could be the facility giving morning medications at 10:00 a.m. and giving afternoon medications an hour and a half later. "we don't know any different, we are not medical professionals". During an interview on 3/5/26 at 1:38 p.m., health unit coordinator who was also a nursing assistant, NA-E stated she was unsure why she transcribed the order for every day shift. NA-E stated it should be input for one time a day. Sometimes, the order was put in and the nurse who confirmed the order would change the times so that they were more suitable. The system would not identify if the nurse changed the administration time prior to confirming the order. During a continuous observation and interview on 3/5/26 beginning at 9:20 a.m. R1 was in his room, getting into his wheelchair with NA-B. NA-B and R1 continued with morning routine of placing hearing aids in ears, brushing teeth, and putting on glasses. During cares NA-B stated she was aware that R1 was diabetic. There was a sheet at the nurse's station that informed who was diabetic and in the charting there was a prompt that would ask if the resident had shown signs like shakiness. NA-B stated R1 had a "port" that helped with his blood glucose numbers. NA-B was unable to articulate a sign of low blood sugars other than weakness. NA-B propelled R1 out of his room and to the nurse's	20830		05/10/2026

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20830	Continued from page 11 station to check a piece of paper. NA-B then wheeled R1 to the scale and weighed him. NA-B brought R1 to the commons room and set him up at a table that had a tray on it. NA-B put straws in the drink cups. R1 asked for peanut butter. At 10:11 a.m., R1's blood glucose had not been obtained and Glargine and sliding scale insulin had not been given. R1 began to take sips from his orange juice and coffee. NA-B placed peanut butter packet on table and left to wash her hands. R1 picked up the peanut butter and attempted to open it with his teeth. NA-B returned to the table and opened the peanut butter and spread it on a bagel. R1 took the bagel and brought it to his mouth. NA-B put brown sugar on R1's oatmeal. R1 also had 3 sausage patties, 3 bacon strips, and 2 eggs on his plate. R1's Dexcom displayed 0 and had a message to start a new sensor. R1 showed NA-B. NA-B stated she would get the nurse. At 10:24 a.m., R1 finished the bagel. At 10:29 a.m., R1 finished eating the sausage at 10:32 a.m. and completed both by 10:35 a.m. At 10:38 a.m. No nurse/TMA had gotten his blood glucose reading and no insulin had been administered. At 10:47 a.m., R1 began eating his bacon. At 10:48 a.m., TMA-A verified she had not obtained a blood glucose reading for R1 that morning. TMA-A walked over to R1 and pressed his Dexcom "I thought they just put a new one on but it isn't working, guess I will take it manually". At 10:50 a.m., TMA-A went to the medication cart to get the manual glucometer. TMA-A returned to R1 and stated LPN-A would put a new Dexcom on R1 later. At 10:52 a.m., R1's blood glucose was 153. TMA-A stated blood glucose should be obtained at 7:30 a.m. or prior to eating. R1 was not up at 10:00 a.m. and "I just got back from break". R1 had not received his long-acting insulin either, the insulin can be given anytime from 6:00 a.m.-2:30 p.m. TMA-A stated R1 has short-acting insulin and his blood glucose was usually around 90 but today he would get "around 2 units". TMA-A did not tell the nurse that she did not obtain the blood glucose prior to R1eating. At 11:04 a.m., R1 was consuming the third sausage. LPN-D stated she needed to remove him from the table, take him to his room, and administer his insulin. At 11:08 a.m., LPN-D administered 20 units of long-acting insulin and 2 units of short-acting sliding scale insulin. After administration, LPN-D brought R1 back to the commons area table to continue eating. During an interview on 3/5/26 at 11:13 a.m., LPN-D stated R1 received his long-acting insulin between 10:00 a.m.-2:00 p.m. R1 received his short-acting at the same time. Blood glucose should technically be checked before eating and insulin should also be	20830		05/10/2026

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20830	Continued from page 12 given before meals. “he is not my patient today”. Blood glucose can spike after eating, so the short-acting should be given before meals and long-acting can be given whenever the doctor prescribes. LPN-D stated she did not trust Dexcom systems, “they never work and can be off by 50”. During an interview on 3/5/26 at 12:20 p.m., R1 sat in his wheelchair in his room with the overbed table in front of him, and breakfast tray with oatmeal and drinks. FM-C sat next to R1. FM-C stated staff would now give him R1 a rice crispy bar and yogurt for lunch. R1 stated he did not feel any different when he has high or low blood glucose. FM-C stated FM-B told her the Dexcom had not been working since 3/4/26. FM-C thought the battery was dead and took the machine and plugged it in. “Its 100%. Let’s look at the sensor and make sure it is connected”. FM-C stated there was not a sensor on R1, only a clear patch where the sensor should be. R1 stated the sensor came off during his shower on 3/4/26 and the staff did not notice. During an interview on 3/5/26 at 1:18 p.m., LPN-D stated the preference for medications to be scheduled for AM/PM/HS blocks so there was more time to administer. “If something was scheduled for a specific time, it just did not happen, there was not enough time.” R1’s physician order for Glargine dated 1/2/26 read daily (administration), and on 2/5/26, it also read to decrease to 20 units daily (administration). When the order read daily without a specific time identified, staff would pick the administration time. The nurse would then acknowledge or confirm the order. LPN-D stated she realized the error and told RN-C about it. Giving the glargine at different times could absolutely affect the blood glucose readings and the littlest difference in time administration can really affect the care. LPN-D worked the evening of 3/4/26, and was unaware that R1’s sensor had fallen off, “aides didn’t tell me”. LPN-D stated she changed the sensor once but there were no instructions on how to change it so “I do what all nurses do, I YouTube it" During an interview on 3/5/26, clinical manager RN-C stated the Dexcom instructions on how to change the Dexcom should be included in the residents MAR or treatment administration record (TAR). Fortunately, when the Dexcom had needed to be replaced, the same nurse was doing it. RN-C stated if she was inputting orders for long-acting insulin in the MAR she would have the administration times between 6:00 a.m.-10:00 a.m. RN-C acknowledged that administering long-acting insulin over various times “will bottom them out or	20830		05/10/2026

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20830	Continued from page 13 something will happen". On 1/22/26, when R1 was given glucagon, his blood glucose should have been checked manually. R1 should not have left the facility with a reading of 58, he should have stayed and waited until the reading was higher. RN-C stated the van driver was unaware of the low blood sugar and "that would have been awful if something happened during the ride". RN-C stated the facility did not conduct audits on when blood glucose readings are obtained or when insulin is administered. R4 R4's face sheet dated 3/9/26, identified diagnoses of type 2 diabetes with chronic kidney disease with heart failure, chronic kidney disease stage 4, diabetic peripheral angiopathy without gangrene, nonproliferative diabetic retinopathy without macular degeneration bilateral, hyperglycemia, and diabetic polyneuropathy. R4's quarterly MDS dated 2/5/26, identified R4 had no cognition issues, had moderate difficulty with hearing, and had corrective lenses. R4 was independent with eating. R4 followed a therapeutic diet, and had insulin injections seven days/week. R4's physician order dated 10/14/25, identified Glargine 30 units daily. R4's MAR dated February 2026, identified Glargine 20 units daily. This order was scheduled for AM. Excerpts from February and March Glargine administration times included: 2/10/26 Glargine administered at 7:53 a.m. 2/11/26 Glargine administered at 12:10 p.m. 2/12/26 Glargine administered at 9:00 a.m. 2/19/26 Glargine administered at 7:07 a.m. 2/20/26 Glargine administered at 12:17 p.m. 2/21/26 Glargine administered at 11:33 a.m. 2/22/26 Glargine administered at 7:18 a.m. 3/1/26 Glargine administered at 8:38 a.m. 3/2/26 Glargine administered at 6:59 a.m. 3/3/26 Glargine administered at 8:33 a.m.	20830		05/10/2026

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20830	Continued from page 14 3/4/26 Glargine administered at 6:49 a.m. 3/5/26 Glargine administered at 8:12 a.m. During an interview on 3/5/26 at 12:37 p.m., RN-B stated long-acting insulin should be given before breakfast or at bedtime, depending on the order. It should generally not be given at anytime during the shift. Blood glucose should be obtained before meals and at bedtime. If taken during a meal it could skew the reading and the resident could be given too high of a dose and “crash” later. During a phone interview on 3/5/26 at 11:36 a.m., pharmacist (P)-A stated administering long-acting insulin between 6:00 a.m.-2:30 p.m. was not okay, it would need to be more specific than that. Manufacturer recommendations directed to administer at the same time every day. P-A would not be worried if the administration time was within an hour each day but if they are administering at 6:00 a.m. one day and 2:30 p.m. then the resident would not get consistent levels and would have high and low blood glucose readings. Blood glucose readings should be obtained before the resident ate and before insulin was given. If it was taken while eating, the risk is the blood glucose could still be rising, and the resident could get too much or too little insulin. The facility Diabetes-Clinical Protocol policy revised March 2025, identified For residents with confirmed diabetes, the nurse will assess and document/report the following during the initial assessment: Level of consciousness, change in orientation; Signs or symptoms of cognitive decline; History of medication management; Dose and time of most recent anti-hyperglycemic given; All other current medications; Any signs or symptoms of infection (urine, skin/wound, upper respiratory, etc.) or other acute illnesses; Foot complications; Vision or hearing impairment; Recent weight loss/failure to thrive;	20830		05/10/2026

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20830	Continued from page 15 Usual patterns of eating and drinking; Approximate intake over the last 24 hours; Recent change in intake/thirst; Resident’s blood sugar history over 48 hours; Usual patterns (fluctuations, trends) of blood sugar over recent months; Onset, duration of any changes; and Recent labs. The staff will incorporate orders and reporting parameters into the Medication Administration Record and care plan. An example of an appropriate hypoglycemia treatment protocol is: For a conscious resident: administer 15 g of carbohydrate; recheck the resident’s blood glucose in 15 minutes; if blood glucose is still below 70 mg/dL, administer another 15 g of carbohydrates and recheck; repeat until blood glucose increases to at least 70 mg/dL or resident is without symptoms and then; offer a snack or meal containing carbohydrates and protein. For an unconscious resident: Call 911 (in accordance with the resident’s advance directive); administer 1mg of glucagon subcutaneously or intravenous 50% glucose (if there is IV access); obtain IV access, as soon as possible; glucagon peak effect is reached in 30 minutes. Do not administer glucagon more than twice. recheck blood sugar every 15 minutes until blood glucose is above 70 mg/dL and/or resident is without symptoms and then; offer snack or meal with carbohydrates.	20830		05/10/2026

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20830	Continued from page 16 Staff will notify the practitioner immediately (but not delay intervention) when the resident's blood glucose is less than 70 mg/dL AND is unresponsive OR consecutive blood glucose readings are less than 70 mg/dL. Hyperglycemia Staff will notify the practitioner as soon as possible when: the resident has two or more blood glucose readings higher than 250 mg/dL within a 24-hour period accompanied by a new medical problem or a change in condition or functional status; the resident has blood glucose readings higher than 300 mg/dL during all or part of 2 consecutive days; the resident is not eating well or is vomiting, or an antidiabetic medication has been held; the resident is not eating well or consuming sufficient fluids and has 1 or more additional symptoms suggesting an acute illness. The facility Insulin Administration policy revised March 2025, identified long-acting insulin glargine had an onset time of 2-4 hours, peak was flat, duration of 20-24 hours. The facility Standing Orders dated 10/3/25 and signed by the Medical Director, identified if the patient has a continuous glucose monitor, initiate the below orders: set alarms for <100 LOW and >400 HIGH with first application do fingerstick 2 times 3 hours apart and document both fingerstick and continuous glucose monitor readings. Notify provider if readings are >20 points difference finger stick as needed if blood glucose is <100 or >400, change in condition, or concerns arise of continuous glucose monitor accuracy or not reading. Charge display every night- keep within 20 ft of the patient. Apply a new sensor every 14 days or per sensor instructions. SUGGESTED METHOD OF CORRECTION: the	20830		05/10/2026

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20830	Continued from page 17 director of nursing (DON) or designee could review facility devices and ensure competencies are completed. The DON or designee could review procedures for long and short-acting insulins with nurses to ensure all are educated and competent with diabetic management. The DON or designee could review hypo/hyperglycemia protocols with designated staff to ensure outcomes are followed, administration times are accurate, and staff are aware of when diabetic medication and/or blood glucose readings should be obtained. The DON or designee could audit staff administration times, order input, and outcomes for diabetic residents. The DON or designee could review findings at Quality Assurance Performance Improvement (QAPI) meetings. TIME FRAME FOR CORRECTION: Twenty-one (21) days.	20830		05/10/2026