



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 31, 2023

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: December 20, 2022

Dear Administrator:

On January 20, 2023, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: December 20, 2022

Dear Administrator:

On December 20, 2022, 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:

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, Minnesota 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 March 20, 2023 (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 June 20, 2023 (six months after the

Pathstone Living
December 30, 2022
Page 3

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,



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 AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 12/20/22, 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 complaints were found to be SUBSTANTIATED: H53906756C (MN89335) and H53906686C (MN89324), however NO deficiencies were cited due to actions implemented by the facility prior to survey. However related deficiencies were cited at (F609). 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown	F 609			12/29/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/06/2023

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

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

PRINTED: 01/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 1 source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse were reported to the state agency (SA) within 2 hours, in accordance with established policies and procedures, for 2 of 3 residents (R1, R2) reviewed for allegations of resident to resident sexual abuse. Findings include: R2 A vulnerable adult report to the SA dated 12/12/22, at 4:23 p.m. indicated an allegation of resident to resident sexual abuse to R2 which occurred on 12/11/22, (no time indicated).	F 609	Retraining and re-education provided to staff at CNA/Nurses Meeting on 12/21/22, regarding timelines for reporting suspected abuse or neglect to the facility Director of Nursing or Executive Director. A review of situations that would require immediate reporting and filing of a VA within 2 hours vs. 24 hours was also reviewed with staff. Review of Resident-to-Resident Altercation Policy was shared with all clinical staff on 12/14/22 and again at All Staff meetings on 12/28/22 and 12/29/22. Director of Nursing will complete an Audit following each Incident to ensure Initial		

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

PRINTED: 01/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 2 R2's face sheet printed on 12/20/22, included congenital absence of bilateral upper limbs. R2's quarterly Minimum Data Set (MDS) assessment dated 10/13/22, indicated R2 was cognitively intact, had adequate hearing and vision; was totally dependent upon, or required extensive assistance of staff for most activities of daily living. R2 was able to travel independently about the facility in an electric wheelchair. During an interview on 12/20/22, at 9:16 a.m., licensed practical nurse (LPN)-A stated she observed the alleged perpetrator (AP)-C in his wheelchair, next to R2's bed on 12/11/22, at approximately 9:30 a.m. to 9:45 a.m. with his hand under the covers on R2's leg. LPN-A immediately removed AP-C from R2's room. LPN-A later discussed her observation with co-workers, but did not think to report it to the director of nursing, stating, "I didn't really think of it as abuse, but now I know it is and would report anything like that to the director of nursing (DON)." According to a training record provided by the DON, LPN-A completed an online learning module titled "Preventing, Recognizing and Reporting Abuse" on 7/12/22. R1 A vulnerable adult report to the SA dated 12/12/22, at 8:54 p.m. indicated an allegation of resident to resident sexual abuse to R1 which occurred on 12/10/22, (no time indicated). R1's face sheet printed on 12/20/22, included stroke, dementia and altered mental status.	F 609	Report is done timely and within 24 hours and that follow up investigation is completed within 5 working days. Vulnerable Adult Policy and Reporting will be reviewed at each Nurse/CNA monthly meeting for the next 2 months (January and February 2023) and then annually thereafter. This is also reviewed with new employees during on-boarding, and we have added a review of the Resident-to Resident Altercation Policy. The male resident (AP-C) is currently meeting with rounding Psychologist bi-monthly. He will also meet with facility Social Worker bi-monthly to discuss his feelings, discuss if he has felt any impulses, check for potential mood changes, provide positive interaction with him. These visits with Social Worker will be documented in resident's progress notes. (AP-C)'s Care plan has been updated and he is now escorted to and from all activities and meals. If the resident is outside of his room, staff monitor him at all times. If staff are unable to monitor him, he will be redirected to his room or to an activity where staff can be present. Staff monitor for mood changes every shift including irritability, depressed mood, withdrawal, or agitation. Staff also provide opportunities for positive interaction. Resident is alert and oriented, he requires assistance from one for transfers. He can alert staff when he would like to leave his		

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

PRINTED: 01/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 3 R1's significant change Minimum Data Set (MDS) assessment dated 11/17/22, indicated severe cognitive impairment. R1 required extensive assistance of one or two staff for most activities of daily living. During an interview on 12/20/22, at 9:21 a.m. LPN-A stated AP-C liked to visit with R1 and they often talked at the table by the nurses station. On 12/10/22, (specific time not recalled, but in the morning), nursing assistant (NA)-A saw AP-C put his hand on R1's leg and reported it to LPN-A. The two residents were immediately seperated. LPN-A then discussed the incident with (LPN)-B who was also on duty, but did not report it to the DON stating she knew it was inappropriate, but did not consider it abuse. During a telephone interview on 12/20/22, at 11:14 a.m., LPN-B recalled LPN-A talking to her about an incident that occurred on 12/10/22, when AP-C put his hand on R1's leg. They talked about preventing AP-C from further contact with R1, but did not talk about reporting it to the DON. LPN-B stated she assumed LPN-A was going to do that. LPN-B stated she was aware possible allegations of abuse needed to be reported to the DON right away. During a telephone interview on 12/20/22, at 11:26 a.m. (NA)-A stated on 12/10/22, right after breakfast she was at nurses desk and observed AP-C and R1 in the seating area by the TV, talking, when suddenly NA-A observed AP-C rubbing R1's thigh. NA-A immediately reported it to LPN-A and the two residents were seperated. During an interview on 12/20/22, at 12:36 p.m.	F 609	room and staff assist him into his wheelchair. If staff were to find (AP-C) out of their room, unattended, they would immediately intervene and direct resident to an activity or area where staff are present. Staff will then interview any other residents near (AP-C) and determine if they have had unwanted contact with him. Staff will encourage positive and friendly interactions between (AP-C) and other residents when he is directly supervised. Rounding provider has increased (AP-C) anti-depressant, Sertraline to 25mg/day. They will continue to monitor and adjust dosage as needed. Staff monitor the effectiveness of this medication and for side effects. The Life Enrichment Director will update residents Care Plan and invite the resident to activities regularly where he can be monitored and encourage positive interactions with his peers. The Spiritual Care Director will offer on-going visits with resident.		

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

PRINTED: 01/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 4 with the DON and social worker (SW)-A, the DON stated the two allegations of sexual abuse occurred on Saturday 12/10/22, and Sunday 12/11/22, but neither she, the administrator or SW-A had been notified by staff at the time the incidents occurred. The DON stated she became aware of it on Monday morning 12/12/22, when at the daily leadership meeting, she was informed of it by the dining director who had heard it from her staff that morning. As soon as leadership became aware of the allegations, they started the investigations. The DON stated she recently took over the position of DON and while the facility had a policy on abuse reporting, she had not established a process for staff to report allegations of abuse to her, such as calling or texting her right away. The DON stated NA's were to inform a nurse of any possible incidents of abuse and the nurse was to immediately inform her. Both the DON and SW-A were aware allegations of abuse were to be reported to the state agency within two hours, and the facility policy indicated the same. Facility policy titled Abuse Prevention Plan, with revised date of March 2022, indicate: ensure all alleged violations involving abuse are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse. Facility policy titled Resident to Resident Altercations, with revised date of September 2022, indicated behaviors that may provoke a reaction by residents included sexually aggressive behavior such as inappropriate touching and wandering into others' rooms. Occurrences of such incidents were promptly reported to the nurse supervisor, DON, and to the	F 609			

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

PRINTED: 01/14/2023
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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 609	Continued From page 5 administrator. The administrator would report the incident in accordance with the facility reporting policy.	F 609			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 30, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: Event ID: J4ZK11

Dear Administrator:

The above facility survey was completed on December 20, 2022 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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
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 12/20/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure. The following complaint was found to be	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

01/06/23

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/20/2022
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 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
2 000	Continued From page 1 SUBSTANTIATED: H53906756C (MN89335) and H53906686C (MN89324, however NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000			