Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 20, 2024

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: September 12, 2024

Dear Administrator:

On September 12, 2024, 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 immediate jeopardy (Level J),

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMOVAL OF IMMEDIATE JEOPARDY

On September 9, 2024, the situation of immediate jeopardy to potential health and safety cited at F684 was removed.

REMEDIES

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

- Civil money penalty, (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency

evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 12, 2024. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS location may notify you of their determination regarding any imposed remedies.

SUBSTANDARD QUALITY OF CARE (SQC)

SQC was identified at your facility. Sections 1819(g)(5)(C) and § 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) requires that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at § 1819(f)(2)(B) and § 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Pathstone Living is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective September 12, 2024. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Operations Supervisor, Rapid Response
Licensing and Certification Program
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

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with

which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

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

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,

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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September 20, 2024

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: Event ID: EARI11

Dear Administrator:

The above facility survey was completed on September 12, 2024 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING ______ B. WING ______	C 09/12/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 9/12/24, a standard abbreviated survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The following complaint was reviewed H53908109C (MN00106549) and a deficiency was issued at F684 at PAST NON-COMPLIANCE. Although the provider had implemented corrective action prior to survey, immediate jeopardy was sustained prior to the survey. No plan of correction is required for a finding of past non-compliance; however, the facility must acknowledge receipt of the electronic documents.	F 000		
F 684 SS=J	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 interview and record review, the facility failed to recognize a sudden change of condition which resulted in a delay of treatment for 1 of 3 resident (R1) reviewed with change condition. As a result R1 experienced chest pain was	F 684	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/20/2024

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

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F 684	Continued From page 1	F 684		

hospitalized and died.

The immediate jeopardy (IJ) began on 9/9/24 when licensed nursing staff failed to comprehensively assess and monitor R1 after he voiced he was having chest pain. The Administrator and Director of Nursing (DON) were notified of the IJ on 9/12/24 at 4:30 p.m. The IJ was removed on 9/9/24 but non-compliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not IJ.

Findings include:

R1's face sheet dated 9/12/24, identified R1 admitted 7/24. R1 had diagnoses of non-st elevation myocardial infarction (heart attack that happens when part of your heart is not getting enough oxygen), atrial fibrillation (irregular heart rhythm in the heart's upper chambers), history of stroke (blood supply to part of the brain is blocked or reduced), nonrheumatic aortic stenosis (heart valve problem that affects the blood flow to the heart and body), and gastroesophageal reflux disease (GERD) (chronic condition where stomach acid flows back into the mouth from the esophagus).

R1's admission Minimum Data Set (MDS) dated 8/6/24, identified R1 had moderate cognitive impairment. R1 had no impairments to upper or lower body and used a walker and wheelchair to move around the facility. R1 required substantial assistance to dress lower body, and supervision assistance with upper body, toileting, and transferring. R1 had an indwelling urinary catheter.

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F 684	Continued From page 2	F 684		

Continued From page 2

R1's care plan dated 7/31/24, identified R1 had altered cardiovascular status and would remain free from cardiac complication. Interventions included to monitor vital signs and notify the medical doctor of significant abnormalities.

R1's provider visit note dated 8/5/24, identified nonrheumatic aortic valve stenosis had caused recurrent chest pain, staff were to monitor for any signs of recurring chest pain, signs, or symptoms of fluid overload and to call provider if noted.

During an interview on 9/12/24 at 10:41 a.m., licensed practical nurse (LPN)-C stated R1 was always good at telling her when something was wrong physically with him such as if he had a concern about his catheter or blood sugar readings.

R1's progress note dated 9/8/24 at 8:47 p.m., identified R1 had 2+ pitting edema to bilateral lower extremities, crackles noted at base of lungs. R1 denied shortness of breath (SOB). Vital signs were blood pressure (BP) 132/75 (normal range 120/80), temperature (T) 98.2 (normal 95.9-99.5), pulse (P) 71 (normal 60-100), 95% oxygen (O2) room air (normal 95-100%), respirations (R) 18 (normal 12-20). "On rounds to notify provider and put a message in Teams for nurse manager."

R1's late entry progress note documented on 9/10/24 at 5:11 p.m. identified on 9/9/24 at 6:15 a.m., an aide reported R1 was complaining of chest pain. R1 was talking normally, did not complain of any radiating in his extremities. R1's vital signs were within normal limits (R1's record did not include recorded vital signs between 6:00 a.m. 7:00 a.m.). R1 had 2+ pitting edema to

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F 684	Continued From page 3 bilateral lower extremities (BLE) and wheezing in the lower lobes with a six-pound weight gain in a week and a half. Monitor R1 for increased chest pain, radiating, and difficulty breathing and address with provider when they are at the facility at 8:00 a.m. R1's late entry progress note documented on 9/10/24 at 5:40 p.m. for 9/9/24 at 7:11 a.m., identified R1 was sitting in recliner and did not appear to be distressed or anxious. R1 stated pain was in the center of his chest. R1 stated the pain was not radiating anywhere and he did not have pain anywhere else. R1 reported pain between 4-6/10. R1 had been to the bathroom prior to nurse entering room and R1 denied SOB or increased pain with movement. R1 had increased blood sugar (BS) of 204 (normal BS range is 80-130 before meals), which was noted to be high for R1. R1 complained of nausea and nursing assistant brought yogurt for R1 and he declined Tylenol. R1's late entry progress note documented on 9/10/24 at 5:40 p.m. for entry from 9/9/24 at 7:58 a.m., identified R1 had 1,000 milligrams (mg) of Tylenol for pain. R1's family member (FM)-A was present in room and R1 appeared calm and was sitting in the recliner. R1's late entry progress note documented on 9/10/24 and 5:40 p.m. for entry from 9/9/24 at 8:05 a.m., identified R1 was complaining of chest pain and nausea. R1 did not complain of increased pain with breathing and pain was not radiating. R1 did have a small, clear emesis with continued nausea. Continue to monitor symptoms and notified nurse manager and told her it was put on rounds for the provider to address when	F 684		

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F 684	Continued From page 4	F 684		

she arrived.

R1's vital sign record on 9/9/24 at 8:15 a.m. were BP 115/71, T 97.5, P 61, R 16, 02 99% room air.

R1's late entry progress note documented on 9/10/24 at 5:45 p.m. for entry from 9/9/24 at 8:29 a.m., identified R1's family member (FM-A) came to the nurse's station after the provider recommendation to be sent to the emergency room. Nurse asked FM-A if they wanted to transport R1 or if the facility should call the ambulance.

R1's late entry progress note documented on 9/10/24 at 5:43 p.m. for 9/9/24 at 8:30 a.m., identified LPN-B called provider about R1's symptoms and physician requested R1 be sent to the emergency room.

In review of R1's record on 9/9/24, the record did not identify continuous monitoring of R1's condition and did not include a comprehensive assessment of R1's cardiac status.

R1's Interact Transfer to Hospital form dated 9/9/24 at 8:30 a.m., identified most recent vital signs were on:
9/5/24- BP 133/72, R 18, T 98.7, P 80, 02 97%,
9/9/24, vital signs were not recorded, Pain level 6

R1's progress note dated 9/9/24 at 8:38 a.m., identified R1 stated pain was 4-6, not radiating and not worse when he takes a deep breath or with exertion. Vitals within normal limits and 2+ pitting edema to BLE. R1 stated Tylenol was not effective, provider notified and recommended to send to emergency room. Ambulance called and FM-A was with R1.

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R1's late entry progress note dated 9/9/24 at 8:45 a.m., identified ambulance was dispatched to facility. Fire department arrived and said the ambulance was approximately 45 minutes out. R1 complained of pain radiating in the upper extremities to the fire department.

R1's progress note dated 9/10/24 at 9:37 a.m., identified R1 discharged to the hospital on 9/9/24 at 9:00 a.m.

R1's hospital records dated 9/12/24, identified on 9/9/24, R1 had an electrocardiogram performed which showed acute anterior STEMI (severe type of heart attack that affects the lower chambers of the heart and can cause permanent damage or death). R1 had a surgical procedure however after procedural intervention, R1 suffered complications that included cardiogentic shock and pulmonary hemorrhage (acute bleeding from the lung).R1 transferred to comfort cares and expired on 9/11/24 at 7:50 p.m., with preliminary cause of death listed as cardiac arrest.

During an interview on 9/12/24 at 11:42 a.m., licensed practical nurse LPN-A stated on 9/9/24 an aide came to her around 6:00 a.m. and informed her R1 had chest pain. LPN-A stated R1 had never had chest pain before. LPN-A stated she went and "did a little check on him." LPN-A examined his legs and noted they were bigger than she had seen them before. LPN-A listened to R1's lungs and noted wheezing in the lower lobes and heard it more in the left than the right. LPN-A asked R1 if the pain radiated, any SOB or hurting with taking a deep breath, and took a set of vital signs. R1's vital signs "were as close to perfect as anyone could get which did not seem

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like they would be for someone in distress." However, LPN-A could not recall what R1's vital signs were that she had collected. At that point she left the room and told R1 to call if he had any questions and she would be back to check on him. LPN-A told LPN-B of her findings and they both felt the R1's symptoms were associated with the six-pound weight gain in 1.5 weeks and made sure that R1 was on the rounding sheet for physician to see him later that morning. Sometime before before 8:00 a.m., R1 had an emesis bag in his hand and had "spit up of clear fluid, no frothiness". LPN-A reported R1's emesis to LPN-B who told her "it is something that would happen with fluid build-up in the lungs." At 8:00 a.m. LPN-A informed the nurse managers (NM) of R1's condition and R1 was on rounds for later that morning. Around 8:25 a.m., NM-A came over with R1's family member (FM)-A and asked her what we were doing with the situation. LPN-A explained to FM-A that they were waiting for physician rounds. NM-A then told LPN-A to call the provider and not wait. LPN-B called provider while LPN-A called the ambulance.

During an interview on 9/12/24 at 2:43 p.m., LPN-B indicated on 9/9/24 at approximately 6:00 a.m., during morning shift report LPN-A mentioned R1 had chest pain and she assessed him, so LPN-B began the medication pass. LPN-B entered R1's room around 7:00 a.m. and checked his blood sugar. R1 and LPN-B discussed the high reading and the new symptom of nausea. LPN-B did not see any emesis in the emesis bag and did not listen to his lungs. LPN-B stated R1 explained the pain was above the belly button at the center of his chest and not worse with movement and not radiating. LPN-B had R1 eat a yogurt because he had a diagnosis of

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F 684	Continued From page 7	F 684		

GERD; the yogurt would coat his stomach lining and relieve his nausea. She offered R1 Tylenol for the chest pain but R1 declined. He did request the Tylenol a short time later when his family member was present. A short time later R1' FM-A came out of R1's room and told her the Tylenol was not working and the pain had increased. LPN-B went straight to the phone and called the physician who ordered R1 to be sent to the hospital urgently.

During a phone interview on 9/12/24 at 4:10 p.m., family member (FM)-A stated she got a call from (R1) around 7:00 a.m. complaining he had heavy chest pain and had been trying to reach staff and was told by staff the provider would be at the facility around 8:00 a.m. "I was irritated and told them to call the doctor, how can you provide better service in that situation because clearly he was having a major heart attack!".

During an interview on 9/12/24 at 1:24 p.m., NM-A stated on 9/9/24 around 8:00-8:30 a.m., she was informed FM-A was upset and at the nursing desk, so she went to talk with her. NM-A explained that was when she found out R1 had chest pain. When she asked LPN-A and LPN-B they informed her the physician had not been notified of R1's chest pain but his was added to the physician round list to be seen that morning, NM-A directed them to call the physician immediately because R1 had chest pain and could be a cardiac event which would need emergency intervention. In those cases we should call 911 and notify the physician after.

During an interview on 9/12/24 at 10:13 a.m., nurse practitioner (NP)-A stated R1 was very in tune with his body and would ask questions about

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8	F 684		

the healing process and about anything that happened during his stay health related. NP-A received a call from the facility at 8:26 a.m., R1 had been having chest pain since 5:30 a.m. "I would expect the facility to call for chest pain, any word of chest pain. We were already behind [with emergency treatment]when they did call because they had not called at the onset of chest pain and I said to send him in immediately." R1 died last evening from complications, whether R1 died as a result of delayed treatment or surgery NP-A was unsure. NP-A stated R1 was planning to discharge home in the next couple of weeks when therapy was complete.

During an interview on 9/12/24 at 1:38 p.m., administrator stated she expected the staff to notify the doctor for a change in condition and not wait until the provider is going to round on the resident, even if the provider is scheduled to come the next morning. Administrator stated after the incident occurred the facility began immediate actions to remedy the situation by providing education to all nursing staff, which included re-education on change of condition, signs and symptoms of cardiac conditions, a quiz that inquired of nurses what they considered a change of condition, and what do nurses do when a change of condition occurs along with a nurse meeting that was scheduled for next week to again review change of condition. Administrator and DON reviewed all residents by running a report and reviewing all other residents with recent changes in condition and identified no other at-risk residents.

The facility Change in a Resident's Condition or Status policy revised February 2021 directed:
-Our facility promptly notifies the resident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING ______ B. WING ______	C 09/12/2024

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F 684	Continued From page 9 attending physician and resident representative of changes in the residents medical/mental condition and/or status. -significant change in resident's physical/emotional/mental condition 2. A "significant change" of condition is a major decline or improvement in the resident's status that: -will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions -impacts more than one area of the resident's health status -requires interdisciplinary review and /or review on to the care plan; and -ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider; including information prompted by the Interact SBAR Communication Form. 8. the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition of status. The facility Resident Examination and Assessment revised February 2014 directed the facility to examine and assess the resident for nay abnormalities in health status, which provides a basis for the care plan. Physical Exam included: -vital signs (blood pressure, pulse, respirations, and temperature) -cardiovascular (heart rate and rhythm, peripheral pulses, capillary refill) -respiratory (lung sounds, irregular or labored respirations, cough, sputum)	F 684		

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F 684	Continued From page 10	F 684		

-neurological (alertness and orientation, speech clarity)
-genitourinary (urine clear or cloudy, presence of catheter)

The past non-compliance IJ that began on 9/9/24 and was removed on 9/12/24 when it was verified the facility implemented the following:
1) re-education on change of condition with nurse management team prior to next shift
2) posters of signs/symptoms of cardiac episodes posted at nurses stations and reviewed with all staff
3) quiz for each nurse to take asking what do nurses do when a change of condition occurs, what is considered a change of condition
4) review of like residents and no one else was at-risk
5) nurse meeting scheduled for the week of 9/15/24 to reiterate presented education.

Minnesota Department of Health

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	00036	A. BUILDING: ______ B. WING ______	C **09/12/2024**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 9/12/24, 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. Minnesota Department of Health is documenting the State Licensing Correction Orders using	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/20/24

Minnesota Department of Health

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2 000	Continued From page 1 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		