

Electronically delivered

June 20, 2024

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: Reinspection Results

Event ID: YJLJ12

Dear Administrator:

On May 30, 2024, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155

Office: 651-201-4384

Email: holly.zahler@state.mn.us



Electronically delivered June 20, 2024

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390

Cycle Start Date: March 8, 2024

Dear Administrator:

On March 21, 2024, we notified you a remedy was imposed.

On Aprl 4, 2024, and April 30, 2024, we notifed you your facility continues to not to be in substantial compliance.

On May 30, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of May 17, 2024.

As authorized by CMS the remedy of:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective April 5, 2024, be discontinued as of May 17, 2024. (42 CFR 488.417 (b))

In our letter of March 21, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2024. This does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

Office: 651-201-4384

Email: holly.zahler@state.mn.us



Electronically delivered April 30, 2024

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390

Cycle Start Date: March 8, 2024

Dear Administrator:

On March 21, 2024, we informed you of imposed enforcement remedies.

On April 4, 2024, we determined your facility continues not to be in substantial compliance.

On April 11, 2024, the Minnesota Department(s) of Health and Public Safety completed a standard recertification survey, and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of these survey findings:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), is effective April 5, 2024.

This Department continues to recommend that CMS impose a 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.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 5, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 5, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of March 21, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 8, 2024.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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:

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 8, 2024 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

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/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

> Travis Z. Ahrens State Fire Safety Supervisor Health Care & Correctional Facilities MN Department of Public Safety-Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101 Email: travis.ahrens@state.mn.us

Web: www.sfm.dps.mn.gov

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155 Office: 651-201-4384

Email: holly.zahler@state.mn.us



Electronically delivered April 30, 2024

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: State Nursing Home Licensing Orders

Event ID: YJLJ11

Dear Administrator:

The above facility was surveyed on April 8, 2024 through April 11, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04 8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Elizabeth Silkey, Unit Supervisor Mankato District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Email: elizabeth.silkey@state.mn.us

Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Orville L. Freeman Building | HRD 3A 3rd Floor

PO Box 64900

625 Robert Street North

St. Paul, MN 55155 Office: 651-201-4384

Email: holly.zahler@state.mn.us

PRINTED: 05/27/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ´	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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	On 4/8/24-4/11/24, Appendix Z, Emerg Requirements, §483 standard recertificate compliance. The facility is enrolled signature is not required acknowledge receipt INITIAL COMMENT On 4/8/24-4/11/24, survey was conducted investigation was all was IN NOT in compliance of 42 CFR 483, Substandard Term Care Factorial Compliance of 42 CFR 483, Substandard Compliance of 42 CFR 4	a standard recertification ted at your facility. A complaint so conducted. Your facility inpliance with the requirements opart B, Requirements for cilities. Italiants were reviewed with NO 0099237) 0091448) 0097558) 0098060) 0099410) 0087616) Italiant was reviewed and in er a related deficiency was 0102383) with a deficiency	F 00		
	Departments accep	f compliance upon the tance. Because you are our signature is not required			
ABORATOR)	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE

05/10/2024

Electronically Signed

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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	involving abuse, nemistreatment, included source and misappeare reported immed hours after the allegath that cause the allegath that cause the allegations bodily injury the events that cause and do not retain the administrator of officials (including the administrator of officials (including the adult protective sent for jurisdiction in lor accordance with Stapprocedures. §483.12(c)(4) Report investigations to the designated represent accordance with Stapprocedures accordance with Stapproce	re that all alleged violations glect, exploitation or ding injuries of unknown repriation of resident property, liately, but not later than 2 gation is made, if the events ration involve abuse or result in a control of the allegation do not involve esult in serious bodily injury, to the facility and to other to the State Survey Agency and vices where state law provides and the law through established of the results of all the administrator or his or her intative and to other officials in the law, including to the State alleged violation is verified.				

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	This REQUIREMENT by: Based on interview facility failed to ensimisappropriation of state agency (SA) with established point (R1) revited from the fit. Findings include: R1's facesheet prinary diagnoses of macural disease that causes communication defined from the fit of the fit of the facility was at a police of ficer the phone. According the money had not the facility was and a police of ficer the phone. According the money had not the facility was and a police of ficer the phone. According the money had not the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the phone of the facility was and a police of ficer the facility was and the facility was a police of ficer the facility of facility and facility o	ive action must be taken. NT is not met as evidenced and document review, the ure an allegation of property was reported to the vithin 24 hours, in accordance licies and procedures, for 1 of ewed for allegation of money ted on 4/11/24, included lar degeneration (an eye s vision loss) and cognitive icit. mum Data Set (MDS) dated R1 was cognitively intact, had d hearing, clear speech, was e to understand. R1 was lost activities of daily living. Ited on 8/18/23, indicated R1 olem of paranoia related to d have fewer episodes of on 4/8/24 at 1:20 p.m., R1 stolen from his room a couple mately \$70 in a pouch. R1 as aware of the missing cash had talked to him about it over ng to R1, as of today (4/8/24),	F 6	In continuing compliance we Reporting of Alleged Violation Pathstone Living corrected by educating R1 and their fastoring valuables in a locked provided in the room. R1's coare sheet were updated to practice. Staff are instructed and notify the administrator designee if R1 and/or their fouse the provided lock book A Vulnerable Adult report was by the facility on 4/10/24, and confirmed and documented identified and found the allestems on 4/4/24. To correct the deficiency and the problem does not recur, nurses were educated on the items policy, the Vulnerable Reporting Process and door grievances and incidents on by the IDON and/or designed forms and incident reports were reviewed during daily IDT state meetings to determine the rewhether there is a need for state officials. The IDON and/or designee audits of grievance forms and reports weekly for four week bi-weekly for an additional the ensure that all alleged violating reported according to stand	ons, Ecumen the deficiency amily about d drawer care plan and reflect this d to document and/or family refuse as directed. as filed for R1 and it was that R1 had ged missing Adult umentation of a 5/13-5/14/24 see Grievance will be tand-up next steps and escalation to will complete and incident as and wo weeks to tions are		

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F 609	informed staff all hit taken but was unsure reported this to nure. A progress note daindicated SW (sociation police department the missing cash. A grievance report dated 3/12/24, indicated 3/12/24, indicated 3/12/24, indicated indicated and over the different times. R1 person or time whe was interviewed an objects existed and room was searched money clip. The first and \$10's went mist folded and put in the time, the five-dollar time, the five-dollar time, the change was about two days a personal two days as personal two days as personal to put his belonging. During an interview licensed social work aware of R1's alleg when informed of it not found it. LSW-Abeen notified and a stated a report had because law enforce would file a MAARO	m. The note indicated R1 s dollars and change were are of the exact amount. Writer se manager and social worker. ted 3/14/24 at 10:23 a.m., al worker) contacted the local to report R1's allegation of the second money clip. It course of about a week; three had not suspected a specific en it may have occurred. R1 d also FM-A to verify the I validity of the report. R1's d and did not find a purse or set time it occurred, the \$20's sesing and two dollars were see money clip. The second bills were gone and the last as gone. Each happened art. Filed a police report with e phone. Police filed a MAARC inctioning key and lock in which		comprehensive approach air maintain compliance with F6 prevent the recurrence of sin deficiencies, ensuring a safe environment for all residents	09 and milar and secure	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING ` CON			E SURVEY PLETED	
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F 609	found the cash in h stated R1's family repouch of cash to the and then took the period they had questioned really missing since stories. During an interview regional nurse constant had informed her or reporting it to the Schave expected the to SA within the required the facility policy. The facility Investig Misappropriation of revised date of Aprilex Misappropriation, theft or property were prominvestigated. Residiffrom exploitation, the personal property. It case of the ft, explores ident property wor his/her designee or agencies within appropriate: state lies.	onference, R1 reported he is underwear drawer. LSW-A nember (FM)-A brought the e care conference that day ouch home. LSW-A stated d whether the cash was ever R1 tended to fabricate on 4/11/24 at 1:45 p.m., sultant (RNC)-B stated LSW-A f the allegation, including not A. RNC-B stated she would missing money to be reported uired time frame indicated in Resident Property with I 2021, indicated all reports of misappropriation of resident aptly and thoroughly ents had the right to be free neft and/or misappropriation of an alleged or suspected itation or misappropriation of as reported, the administrator notified the following persons 24 hours of such incident as censing and certification an, resident representative,	F 60	9		
	adult protective ser Accuracy of Assess CFR(s): 483.20(g)	vices, law enforcement. sments	F 64	1		5/15/24
	§483.20(g) Accurace The assessment more resident's status.	cy of Assessments. ust accurately reflect the				

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F 641	This REQUIREMENt by: Based on observate review, the facility and accurately identificated for his set (MDS) assessing R21) reviewed for his findings include: R52's Face Sheet in 2/7/24, and diagnost (uncontrolled growth cells) of upper lobe of bone and heart facility facility for the facility facility facility for the facility facili	ion, interview and document ailed to ensure resident status atified in the Minimum Data nent for 2 of 2 resident (R52, aospice and pressure ulcers. Indicated admission date was ses of malignant neoplasm in and division of abnormal of lung, malignant neoplasm ailure. Ignificant change, Minimum and 3/21/24, section O, K1 nents and programs, did not be services. Section J 1400 as or chronic diseases that expectancy of less than 6 d as yes.	F 64	R52 MDS was modified to reflect status. R 21 MDS was unlocked and corprior to export to reflect that residences unlocked and corprior to export to reflect that residences. Audit all current residents on hose status to ensure MDS is coded of Audit all residents who currently I wounds to ensure MDS is coded. Remind and educate MDS team re: skin assessments must match skin condition coding, resident's status must match on the MDS the resident is receiving hospice care. Audit 10% of each MDS submitteensure accurate coding for hospi wound care weekly x4 and bi-weekly results reviewed at QAPI to determine auditing needs.	rected ent has pice orrectly. members a MDS Hospice at the cell of	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	` '	(X3) DATE SURVEY COMPLETED	
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F 641	hemiplegia and her weakness to sever or paralysis on one cerebral infarction in brain resulting from affecting left domination type 2. R21's quarterly MD for export and lock for pressure ulcer (tissue injury was all care included application ointments/medication results and lock for pressure ulcer on lock for pressure ulcer pressu	ncluded diagnoses of miparesis (mild or partial e or complete loss of strength side of body) following (area of dead tissue in the brain bleed or blood clot) ant side, and diabetes mellitus and side, indicated R21 was at risk (PU) injury but has none. Deep so answered no. PU or injury cation of ons other than to feet. The ment dated 4/4/24, indicated area on left buttock, and left heel measuring 2 cm x 3 leling edges. 14/11/24 at 12:13 p.m., RN-B, IDS coordinator, confirmed the incorrect as R21 does have sent and injury cares and onfirmed she would not have again and would have	F 64	41			
		4/10/24 at 2:37 p.m., the stated the MDS should have					
	and procedure date shall be responsible coordinating the determinent the resident assess	ssessment Coordinator policy ed 11/2019, included an RN e for conducting and evelopment and completion of sment. Each individual who n of the assessment must					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′		COMPLETED
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certify the accuracy assessment by dat	of that portion of the ing and signing the	F 64	!1	
S483.21 Comprehe Planning §483.21(a) (1) The implement a baseli that includes the interfective and persorthat meet profession. (ii) Be developed with admission. (ii) Include the mining necessary to proper including, but not like (A) Initial goals base (B) Physician order (C) Dietary orders. (D) Therapy services (E) Social services (F) PASARR recomprehensive care plan if the conficient (i) Is developed with admission. (ii) Meets the requirement (ii) Meets the requirement (iii) Meets the requirement (iv) of this section (iv) this section).	ensive Person-Centered Care e Care Plans facility must develop and ne care plan for each resident structions needed to provide on-centered care of the resident onal standards of quality care. plan must- ithin 48 hours of a resident's mum healthcare information orly care for a resident mited to- sed on admission orders. The ses. In mendation, if applicable. facility may develop a the plan in place of the baseline in prehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of		55	5/15/24
§483.21(a)(3) The	facility must provide the			
	Continued From particles of the profession of th	PROVIDER OR SUPPLIER DNE LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a) (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of	PROVIDER OR SUPPLIER DNE LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans \$483.21(a) (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section).	TONE LIVING 245390 B. WING STREET ADDRESS. CITY, STATE, ZIP CODE 718 MOUND AVENUE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MAST BE PRECEDED BY YULL REGULATORY OR LSO IDENTIFYING INFORMATION) Continued From page 7 certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. Baseline Care Plan CFR(s): 483.21(a)(1)-(3) \$483.21 (a) (1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (E) Social services. (E) PASARR recommendation, if applicable. \$483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan. (g) Is developed within 48 hours of the resident's admission. (ii) Meels the requirements set forth in paragraph (b) of this section).

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F 655	of the baseline care limited to: (i) The initial goals (ii) A summary of the dietary instructions (iii) Any services an administered by the on behalf of the factive for the comprehensions. This REQUIREMED by: Based on interview facility failed to offer baseline care plant representative for 3 R112's Admission Facture of head of and fracture (break right hip joint (hip resemble). R112's admission Facture (break right hip joint (hip resemble). R112's admission Facture (break right hip joint (hip resemble). R112's admission Facture (break right hip joint (hip resemble). R112's admission Facture (break right hip joint (hip resemble). R112's admission Facture (break right hip joint (hip resemble).	epresentative with a summary e plan that includes but is not of the resident. The resident's medications and and treatments to be a facility and personnel actinguility. The formation based on the details are care plan, as necessary. The solution of the resident as evidenced and document review, the reprovide a summary of the to the resident and/or resident of 3 residents (R29, R57, no were newly admitted. Record identified an admission hadiagnoses of displaced right radius (bone of forearm) around internal prosthetic eplacement). Minimum Data Set (MDS) tified R112 as having a brief I status (BIMS) score of 15 ent was cognitively intact. If daily living MDS section was re plan indicated R112		In continuing compliance with F65 Baseline Care Plans, Ecumen Patt Living corrected the deficiency by completing ADL MDS section for R and provided a copy of baseline ca to R112, R29 and R57. Baseline ca plans were provided to short term residents 4/11/2024. A completed Baseline Care Plan was provided t current residents as of 4/22/2024. To correct the deficiency and to en- the problem does not recur all staff educated on 4/22/24 on baseline c plan policy and expectations by IDO Nursing, social worker, dietary, and activities will have their portion of th baseline care plan completed with hours of admission. At that time, th nurse manager will provide a copy baseline care plan to the resident. DON and/or designee will audit all	enstone 112 are plan are care o all sure f were are ON. d he he of the The new	
	with extensive to ling	ssist with dressing grooming nited assistance as R112 is on right leg. Comments disc and assist of two from		admissions, weekly x4 weeks, ther bi-weekly x2, to ensure baseline can plans have been completed and a presented to resident and/or resident.	are copy	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NI IMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 655	stated she never reare and would like. During interview of indicated she did to some things about was never was off plan of care. When interviewed social worker (SW of the care plan with pass it around, but resident or family only give copies if the care plan with eating and transplant or a family substantial/maximus shower/bathe and with eating and or included pneumor mild cognitive important of the care plan resident or a family substantial/maximus shower/bathe and with eating and or included pneumor mild cognitive important captures are said to said the care plan resident or a family substantial/maximus shower/bathe and with eating and or included pneumor mild cognitive important captures are said to said the ca	on 4/8/24 at 4:15 p.m., R112 received a copy of her plan of e to have one. In 4/9/24 at 2:55 p.m., R112 reave a care conference and ther care were discussed but rered or received a copy of her on 4/10/24, at 12:41 p.m., received a copy of her on 4/10/24, at 12:41 p.m., received a copy to the member. SW-A stated "We one is requested." 4/10/24 at 2:39 p.m., the (DON) confirmed a copy of the received and the to the facility 3/5/24, had cognition, dependent on staff ansfers, required all assistance with dressing, required supervision all hygiene, and diagnoses ria, urinary tract infection, and	F 6	representative 48 hours after As part of Ecumen Pathstor ongoing commitment to quathe IDON and/or designee videntified concerns through community's QA Process.	ne Living's ality assurance, will report		

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F 655	R57's admission M R57 was admitted to cognitive impairment personal hygiene, is walking and diagnoto understand or exfollowing cerebral intotal body function of stroke) affecting rigweakness, anxiety diabetes. R57's baseline care of 3/14/24. On 4/11/24 at 9:49 known as the region was not current factoresident or resident baseline care plan. The facility Care Plans procedure dated 3/2-A baseline plan of immediate health a for each resident was a written summary language that the resident inderstand) that incomplete the stated go resident; The stated go resident;	DS dated 3/21/24, indicated the facility 3/14/24, had severe nt, required supervision with sit to stand, chair transfer, and ses included aphasia (ability press speech), hemiplegian fract (paralysis of partial or on one side of the body after a ht side, tobacco use, muscle disorder, depression, and e plan indicated effective date a.m., registered nurse (RN)-C, nal nurse coordinator, stated it ility practice to provide the representative a copy of the ans-Baseline policy and		55		
	dietary instructions;					

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F 655	on behalf of the factory and the complete of t	facility and personnel acting	F 65	5		
F 679 SS=D	Activities Meet Inter CFR(s): 483.24(c) (1) §483.24(c) (1) The fithe comprehensive and the preferences program to support activities, both facility individual activities designed to meet the physical, mental, are each resident, encound interaction in the This REQUIREMENT by: Based on observatoreview, the facility face	facility must provide, based on assessment and care plan s of each resident, an ongoing residents in their choice of ty-sponsored group and and independent activities, he interests of and support the hd psychosocial well-being of ouraging both independence he community. No is not met as evidenced siled to ensure individualized ided for 1 of 1 resident (R29)	F 67	In continuing compliance with F679 Ecumen Pathstone Living corrected deficiency by updating Resident 29 (R29) care plan to include R29's acceptated interests, and interventions related activities. R29's care plan was updated include daily invites and orientation	9, d the 's tivities, to ated to	5/15/24
	3/11/24, indicated F 3/5/24, had moderated dependent on staff required substantial shower/bathe and of	nimum Data Set (MDS) dated 29 was admitted to the facility tely intact cognition, for toileting and transfers, l/maximal assistance with dressing, required supervision hygiene, identified it was very		activities offered each day, including invites when R29 has family and/or visitors present. R29's eMAR and present tasks were updated to include documentation of invites to activities documentation of refusals. R29's a preferences will be reviewed and upper services and upper se	g point of es and ctivity	

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F 679	the news, participate outside to get fresh to have reading mathings with groups included pneumoni mild cognitive imparticipate included pneumoni mild cognitive imparticipate in activities. R29's care plan data R29's activities, into activities. R29's baseline care coordinator (AC)-A independently choordinator (AC)-A independently choordinator incom and schedus sporting events, reaplaying cards, lister activities to attend to activities to attend to Activities/Initial revisited activities to participate independent activities to facility, enjoyed possible to facility, enjoyed possible to the compart of the proposition of the compart of the	favorite activities, keep up with te in religious services, and go air, and somewhat important aterial, listen to music, and do of people and diagnoses a, urinary tract infection, and airment,. ted 3/5/24, did not include erests or interventions related e plan dated 3/5/24, activities indicated R29 will use activity of choice with both alled events, enjoys watching ads the daily newspapers, ning to music, may decline therapy sessions and rest. ew document dated 3/11/24, and to participate in activities, the in group activities, does not in 1:1 with staff, and liked tes, expressed interest in as tolerated once acclimated olaying cards in the past buck euchre), independently in, especially sporting events, sistance should be provided to be activity. e.m., R29 was observed in his heelchair, television on, and 1)-H present. R29 was what, if any, activities he fered. R29 stated he could not	F 6	at quarterly care conference R29's request. To correct the deficiency and problem does not recur, may education on Activity Programs associated staff expectation and nurses was completed 5/13-5/14/2024. Mandatory the Activity Director was concommunity Life Director on and mandatory education for Life Enrichment team regar Program expectations and completed on 5/8/2024. State attend will be required to reeducation materials. The Life Supervisor will complete concare plans. Life enrichment designee will attend quarter council meetings per council gather feedback from resident attendance. The Community Life Director and will ensure that residents win the facility for more than an individualized compreher plan. Audits will also be concensure residents are invited once weekly for 4 weeks, the	and ensure the andatory staff ams and as for CNAs on education for appleted by the 4/19/2024, or the entire ding Activity policy was aff who did not view the fe Enrichment apprehensive staff and/or rly resident cil request to ents in and/or and/or and/or designee ho have been 20 days have ensive care appleted to activities, nen bi-weekly		
		to attend activities and stated any activities attended while at		for 2 weeks. As part of Ecu Pathstone Living's ongoing			

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F 679	participate in activition enjoyed playing carmusic. FM-H stated days and stayed all observed staff offer stated staff have of the stated staff have of the stated staff have of the completed staff have of the calendar was posted and activities listed. On 4/9/24 at 7:49 at completed R29's at and activities listed. On 4/9/24 at 7:49 at completed R29's at and activities prefer activities R29 enjoy assessment is used to offer those activities R29 enjoy assessment is used to offer those activities R29 enjoy assessment is used to offer those activities R29 enjoy assessment is used to offer those activities. Accepted to offer R assessment which music. AC-C stated assumed since he want to participate it were not expected wanted to participate it wanted to participate	ge 13 ressed he would like ries, if offered. R29 stated he d games and listening to d she was at the facility most day, and stated she had not R29 any activities. FM-H fered him to take naps. r.m., R29 was seated in a om and FM-H was present. rities of choice would include s, cards, music, and stated he ries if the facility had tated R29 had gone to church ras aware of. A activity red in R29's room and R29 reen offered to attend the red. AC-C stated the d for the activity coordinators red. AC-C stated the d for the activity coordinators rities to residents. AC-A stated nent indicated R29 loved red. interested in sports and rent indicated noce he was recility he would participate in rec stated activity staff were 29 activities based of the would include cards and red. she wondered if staff red company he would not n activities and stated staff red ask a resident if they red in an activity when company red room. AC-C stated if the wife		to quality assurance, the ID designee will report identifie through the community's Q/	ed concerns		
	•	t would expect activities staff					

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F 679	staff to ask resident interest. AC-C state was not able to find participated in activition. On 4/9/24 at 9:00 at not offered R29 to was not sure if other activities. AC-B state care and AC-A compactivities for short to the control of the control	participate and would expect to play cards based of his ed in the medical record she documentation R29 had vities at the facility. I.m., AC-B confirmed she had participate in any activities and er staff had offered R29 ted R29 was on short term upleted the intakes and erm care residents. I.m., AC-A stated she was are that residents participated erwas expected R29 was ased off his interest and aformation. p.m., nursing assistant (NA)-F stants were responsible for the activities posted on the m and the activity coordinators offer the resident specific their interests. NA-F stated end activities on the calendar				
	On 4/9/24 at 12:30 (DON) stated resid offered activities be to each resident an staff were expected of his preferences. The facility Activity indicated: 1. The activities presented activities of the facility Activities presented activities activities activities activities presented activities act	p.m., the director of nursing ents were expected to be ased of interests and specific at the DON confirmed activities to offer R29 activities based and activity assessment. Programs policy dated 6/18, sidents and to encourage both				

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F 679	2. Activities offered comprehensive restand the preference 3. The activities prefacility-organized gracility-organized gracility-organized gracility-organized gracility-organized gracility-organized gracility-organized gracility-organized gracility-organized gracility-organized and routine ADL's participates, that is her sense of well-beenhance physical, 5. Our activity programs are geared toward 6. Activities are schand residents are gracility conducting, clean uprograms. 9. All activities are medical record 12. Individualized a provided that: a. reflect the schenical free and residents, including weekends; c. reflect the cubobies, life experiments of their endocrates of th	community interaction. I are based on the sident-centered assessment is each resident. Ogram is ongoing and includes roup activities, independent and assisted individual onsidered any endeavor, other in which the resident intended to enhance his or reing and to promote or cognitive or emotional health. rams are designed to am individual participation and the individual resident's needs. The individual resident's needs are deven days a week given an opportunity to anning preparation, up and critique of the documented in the resident's and group activities are chedules, choices and rights of at hours convenient to the gevenings, holidays and altural and religious interests, ences, and personal	F 67	9		
F 684 SS=D	Quality of Care CFR(s): 483.25		F 68	34		5/17/24

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F 684	applies to all treatmer facility residents. Be assessment of a resthat residents received accordance with proportice, the compressive plan, and the This REQUIREMENT by: Based on observative review the facility factordinated with the resident (R52) reviews ervices. Findings include: R52's significant che (MDS) dated 3/21/2 maximum staff assed aily living except shygiene. R52's Bri (BIMS), indicated in understands and is R52's facility care put the resident is at the utilizing hospice secondinate care with services. R52's (local hospic dated 3/28/24, indicated 3/28/24, indic	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure we treatment and care in ofessional standards of rehensive person-centered residents' choices. NT is not met as evidenced tion, interview and document ailed to ensure services were to hospice agency for 1 of 1 ewed who received hospice and oral stance with all activities of set up assist for eating and oral ref Interview for Mental Status intact cognition and	F 6	Ecumen Pathstone Living hat the deficiency related to F684 R52 has an updated and cur indicating the scheduled visit RN and HHA from Hospice. Is placed in R52 s room and binder. Additionally, R52 s oplan of care has been update the resident's preference to be any changes to the hospice wia personal cell phone. Residents receiving hospice have the potential to be affect alleged deficient practice. The and/or designee has complete all hospice residents to ensure were coordinated with hospice all hospice residents to ensure the potential to be affect alleged deficient practice. To prevent recurrence and endomination of the process of the potential to be affect alleged deficient practice. To prevent recurrence and endomination of the process of the process and committed the process and co	the hospice of the look to include the hospice of the hospice of the hospice of the look ted by the he look ted audits of the services of the services of the services of the look ted audits of the look te	

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F 684	the nurses station, (but dates written windicating when the coming to visit R54 completed through were present. The 3/29, 4/2 and 4/8. During interview and 12:42 p.m. R52 was within reach and a R52 indicated last is supposed to come showed up and not the HHA then show R52 it was a sched would come on Friedday missed. R52 son 4/5/24 so she can out what happened R52 stated she ask didn't call the facility she told them this is things up for the state indicated the hospic tried but couldn't ge scheduler is responsible tried but couldn't g	y's hospice binder, located at ncluded a March/April 2023 ere current for 2024) calendar RN and HHA would be. The calendar was 4/8/24 but no further dates HHA visits included 3/28, d observation on 4/8/24, at s lying in her bed with call light cell phone on bedside table. Monday (4/1/24), the HHA was to give a bath but never one told R52 why. R52 stated ed up on Wednesday and told uled holiday off of work, but lay (4/5/24) to make up the tated the HHA didn't show up alled hospice services to find and was told HHA was sick. ed hospice services why they or let her know. R52 stated is "very rude and messes aff at the facility." R52 be agency initially stated they a hold of her, then said the sible, but then they claimed facility and no one answered. on 4/9/24, at 9:51 a.m., R52 h HHA and nurse not letting of are coming. R52 stated "I and no one ever calls to let me a coming. They just show up". a lack of communication from and it isn't fair for staff to	F 68	expectations on 5/13-5/14/2 the IDON designee. On 5/8 IDON designee met with the team to review communicat collaboration, and best prace in a clearly defined list of ex- responsibilities for both hos nursing facility staff. The DON and/or designee or residents receiving hospice weekly for four weeks, then two months, to ensure that calendars are maintained in resident's hospice binder an As part of Ecumen Pathston ongoing commitment to qua any identified concerns will through the community's Qu the IDON and/or designee.	/2024, the e Hospice tion, ctices, resulting pectations and pice and will audit all services monthly for up-to-date hoth the nd their room. The Living sality assurance be reported	g d

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001	1 0 17	
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F 684	be doing them. R52 baths from the facily have to do hospice has told the hospice advanced notice and didn't want advanced. During interview on with local hospice Fastated previously shappior to visits. RN-Fanotify the staff in addin her chart." RN-Fathe unit staff to know	cares when hospice should 2 indicated she has refused ity staff because they shouldn't s work. R52 indicated she staff before she wants id denied every saying she		584		
	from hospice agend would know it was a following Easter, but HHA indicated she know in advance of was out ill Friday 4/2	visits. 4/10/24 at 10:15 a.m., HHA-G by stated she thought R54 a holiday on the Monday at "I guess I didn't tell her." does not let the facility or R54 her visits. HHA indicated she 5/24 and notification to R54 is nembers to let the resident				
	director of nursing (communication is la and the facility and	4/10/24 at 2:37 p.m., the (DON) confirmed acking with the hospice agency R54 should know in advance taff are coming to the facility.				
F 688 SS=D	none received.	services was requested and ecrease in ROM/Mobility 1)-(3)	F 6	588		5/17/24

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING) COM	(X3) DATE SURVEY COMPLETED	
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F 688	resident who enters range of motion do range of motion un condition demonstro of motion is unavoid §483.25(c)(2) A resmotion receives apservices to increas prevent further deceives appropriate assistance to main the maximum practicution in mobility. This REQUIREME by: Based on observating the facility failed to program for upper wrist brace was apglove was on for 1 limited range of motions. Findings include: R14's face sheet program for the body) and hem side of the body) for (central nervous systems).	facility must ensure that a sthe facility without limited es not experience reduction in less the resident's clinical rates that a reduction in range	F 6	In continuing compliance we Ecumen Pathstone Living of deficiency by obtaining an occupational therapy (OT) threat Resident 14 (R14) on services were initiated on 4 occupational therapist triale splints for R14 and ordered on 5/7/2024, which is pendificationally, R14's platform replaced with a wheelchair Range of Motion (PROM), of coordination were added of care and Group Daily Shand required documentation to the electronic Medication Record (eMAR) and point of	corrected the order for to evaluate and 4/16/2024. OT 1/18/2024. The ed several new a new splinting arrival. It trough was table. Passive splint use, and ed to R14's planet. PROM neet. PROM neet added Administration		
	R14's quarterly Mir	nimum Data Set (MDS) dated					

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F 688	dependent on staff personal hygiene, a (ROM) on one side R14's provider order apply resting hand and at bedtime. Do edema glove during Document refusals R14's plan of care limited physical more hemiplegia/hemiparemain free of combine including contracture formation, skin-breathrough the next resincluded R54 to we and off at bedtime. Wheelchair and at a rand off at bedtime. Wheelchair and at a rand and off at bedtime. Wheelchair and at a rand and off at bedtime. Wheelchair and at a rand off at bedtime. Wheelchair and at a rand and wrist, elbow a week as resident to R14's Occupational Plan of Treatment of the staff of the s	R14 had intact cognition, for transfers, dressing, and and limited range of motion and limited range of motion, and limited range of motion (PROM) to left and shoulder three times per	F 6	Residents with limited ROM mobility have the potential to by the alleged deficient pra IDON and/or designee has audits of these residents to are receiving appropriate trequipment and assistance. residents were found affect alleged deficient practice. Mandatory staff education of mobility and range of motion Nursing Assistants (CNAs) was completed on 5/13-5/1 who did not attend will be review the education mater will submit therapy recommincluding restorative and Revia TEAMS to the nurse manurse manager and/or desiresponsible for updating the plan, Group Daily Sheet, and The restorative binder will the documentation purposes, and and the nurse manager and/or desiresponsible for updating the plan, Group Daily Sheet, and The restorative binder will the documentation purposes, and the nurse manager and/or desired the shift change reports.	to be affected ctice. The completed ensure they eatment, No other ted by the on resident on for Certified and nurses 4/2024. Staff equired to rials. Therapy nendations, OM programs, anager. The ignee will be e resident care and eMAR tasks. See updated for and CNAs and dupdated by designee at		
	with nurse manage maintain strength a A Group Daily Shee R14 should wear his but did not include	er regarding program to help and reduce risk of contractures. et, used by the NA's included is hand/wrist brace at bedtime PROM or edema glove.		designee will complete aud weeks and monthly for 2 mensure residents are received ROM/mobility treatment. Reare cognitively intact with a for Mental Status (BIMS) so will be interviewed regarding	lits weekly for 4 onths to ring appropriate esidents who Brief Interview core of 13-15 ag the		
	R14's medication a	dministration record or task		implementation and execut	ion of range of		

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F 688	Continued From pa	ge 21	F 688	3			
	list in the electronic PROM. During interview an 3:49 p.m., R14 was splint and edema glower palm of hand fingers were curled R14 stated my hand move my hand. R1 range of motion on before his hand is pR14 added staff are don't put on the braplace. Arm brace who board with 3 Velcroup his arm with his loose enough it modules arm with the splint was on honger in the palm of mid lower arm to pale edema glove and phand and placed or indicated staff forgothe arm of the chair R14's left arm fell of two minutes and he place back on the arm., R14 was in the place back on the arm., R14 was in the place back on the arm.	d observation on 4/8/24 at slying in his bed with hand love on his left hand from the to below the elbow. R14's left into the palm of his hand. It is really curved and I can't added no one has done hand but would like them to be rmanently "stuck this way". It is always in such a hurry they always in such a hurry they are right and it doesn't stay in was observed to be a flat blue straps and when R14 picked right hand, the splint was wed further towards his elbow. It dobservation 4/8/24 at 5:41 to do be a flat blue straps and when R14 picked right hand, the splint was wed further towards his elbow. It do be a flat blue straps and when R14 picked right hand, the splint was wed further towards his elbow. It do be a flat blue straps and when R14 picked right hand, the splint was not his hand and extended from ast his elbow. R14 had on his icked up his left arm with right in the arm of the chair. R14 of to put the platform trough on to hold his arm in place. If the arm of the chair within that to pick up his hand and		motion and mobility programs. As Ecumen Pathstone Living's ongoin commitment to quality assurance, DON and/or designee will report in concerns through the community's Assurance (QA) process.	ng the dentified		
	glove on. The hand	R14 did not have his edema d splint was present on his left nid arm and attached with 3					

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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 718 MOUND AVENUE MANKATO, MN 56001	<u> </u>	
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F 688	Continued From pa	ge 22	F 6	688		
	Velcro straps. R14	's fingers were curled over the ard towards the under side of				
	indicated she has to past and he should hand splint, have at wheelchair and be on his left hand, arrowided was for his elbow and should be outwards and not compliant. OT-F indicate PROM should be or the past and should be or t	4/9/24 at 12:32 p.m., OT-F, reated R14's left hand in the wear an edema glove, resting n arm support trough on his receiving restorative exercises n, elbow and shoulder to OT-F stated the splint that was a hand and not his wrist or be placed on with fingers held urved around the end of the ted instructions for R14's n his closet in his room as previously to the nurse				
	12:52 p.m., nursing ROM is ordered the closet in resident's	and interview on 4/9/24 at assistant (NA)-D indicated if ere are instructions on the room with instructions on how OT and activities does the				
	indicated she does left hand. NA-E inc	4/9/24 at 1:00 p.m., NA-E not perform PROM on R14's licated he has a lot of tempting to complete it.				
	1:08 p.m., NA-B incomposited on the close exercises were presuringly incontinence instructions were presented instructions.	d observation on 4/9/24 at dicated R14 does some range ercises himself, which is et. On R14's closet, ROM sent for hip abductions and for exercises but no ROM resent for his left arm, hand, NA-B indicated she has never				

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F 688	During interview on was lying in his bed fingers were curled R14 stated he would because he doesn't his hand and finger and he has shootin move his fingers. During interview an 8:28 a.m., R14 was evaluated the splint and should extend and not curled under splint is for his finger and the way the splint is for his finger and the way the splint is for his finger and the way the splint is for his finger and the way the splint is for his finger and the way the splint is for his finger and the way the splint is for his finger and the way the splint is for his fingers. OTform, as it was a beautiful beaut	4/10/24 at 7:39 a.m., R14 with his arm splint on but under at the end of the splint. Id allow staff to perform ROM twant to lose the flexibility in s. R14 indicated it is painful g pains in his hand when they dobservation on 4/10/24 at sin the dining room. OT-F and placement. OT-F was not in the correct position to keep his fingers straight out er the splint. OT-F stated the ers and not his hand or wrist lint was placed on R14 was to prevent contractures of F stated the splint had lost its endable splint, and should not OT-F added the splint was ds. R14 was not wearing his F went to R14's room and got wash cloth. OT-F attempted to and stated his fingers are ble to straighten his fingers sition. OT-F placed edema ds with difficulty taking hinutes to place on his left OT-F bent the splint to get into	F 68			
	washcloth under Raneed some continu	OT-F then placed a rolled 14's fingers and stated he will ed therapy to get his hand to wearing a hand splint again.				

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F 688	indicated she is aw of his hand. RN-B aren't comfortable want to hurt him so confirmed there is a care plan indicates completed 3 times staff should completed they need wasn't done and with the instructions for restorative book. During interview on director of nursing should be done by hand splint should nurses are responsite treatment is getting. The facility Resider Motion policy and princluded: -Residents will not reduction in range expected. Resident with limit treatment and server a further decreaseResidents with limit appropriate services.	a 4/10/24 at 8:49 a.m., RN-B are that R14 has contractures indicated moving his fingers for him and some staff don't do the best they can. RN-B an order for PROM and the he should have ROM per week. RN-B confirmed at the PROM and if not ed to let the nurse know it my. RN-B was unable to locate PROM in the room or 4/10/24 at 2:25 p.m., the stated if PROM is ordered it the nursing assistants and the be applied correctly. The sible to ensure the care and done. at Mobility and Range of procedure dated 7/2017 experience an avoidable of motion (ROM). ed range of motion will receive ices to increase and/or prevent in ROM. ited mobility will receive es, equipment and assistance ove mobility unless reduction	F 68	38		
	interdisciplinary tea comprehensive ass as needed.	be developed by the m based on the sessment and will be revised the residents progress toward				

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F 688	Continued From page 25		F 68	8		
	the goals and objectives identified in the plan of care will include attempts to address any changes or decline in the residents condition or needs.					
	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)		F 68	9	5/15/24	
	supervision and assaccidents.	resident receives adequate sistance devices to prevent				
	review, the facility	tion, interview and document ailed to properly assess tes for 1 of 1 resident (R57) ng.		The alleged deficiencies for resident have been corrected. A cigarette receptacle was acquired and R57 was educated on proper butt disposal. The IDON was responsible for implementing	S e	
	Findings include:			the corrections.		
	(MDS) dated 3/21/2 cognitive impairment personal hygiene, so walking and diagnoto understand or exfollowing cerebral in	inimum Data Assessment 24, indicated R57 had severe nt, required supervision with sit to stand, chair transfer, and ses included aphasia (ability press speech), hemiplegia nfract (paralysis of partial or on one side of the body after a		Residents that smoke have the potent to be affected by the alleged deficient practice. The IDON has completed at of residents that smoke cigarettes to ensure no other residents were affect by the alleged deficient practice. The following measures and systemic	udits	
	stroke) affecting right side, tobacco use, muscle weakness, anxiety disorder, depression, and diabetes.			changes have been made to ensure to alleged deficient practice will not recunsive to and communicate to team if facility is	he re: itify	
	would like to smoke	ised 4/8/24, indicated R57 while residing at this care ered smoking cessation		accepting a referral who is an active tobacco user. Facility will continue to remain a smoke-free campus but will		

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F 689	when first admitted stopped d/t being in smoke unless direct family/responsible poly:resident determine independently per stores resident's liguidassessed quarterly, safety, will be offered quarterly, will smoke will dress appropriate smoking risks and locessation aids that facility policy on smoking risks and locessation aids that facility policy on smoking risks and locessation aids that facility policy on smoking, resident policy, observe clot cigarette burns, regramily/friend/staff with the stood behind resided observed to cross the behind wheelchair and intested to cross the behind wheelchair and intested to cross the behind wheelchair and intested to cross the behind wheelchair and cigarette as hon the finished smoking, Fand put out the cigarette as hon the finished smoking, Fand put out the cigarette details and put out the cigarette details and put out the cigarette details.	ed, (was on nicotine patch, requested for them to be deffective for him), will not etly supervised by carty/staff as evidenced and unsafe to smoke smoking assessment, facility hter and cigarettes, will be (PRN (as needed) for smoking ed smoking cessation options e in designated areas only and ately for weather, instruct about a hazards and about smoking are available, instruct about oking: locations, times, safety arge nurse immediately if it is has violated facility smoking hing and skin for signs of quires supervision by while smoking. a.m., alarm was heard at front R57 was observed seated in a sim director of nursing (IDON) ent's wheelchair and R57 was he street and IDON was and assisted R57 across the served to smoke a cigarette of the street and IDON stood as on the side of the street observed R57 ash and flick his estreet. When R57 was R57 bent over in his wheelchair arette on the curb of the street. R57's wheelchair, and R57 ross the street with the R57 and IDON entered the		provide education to new resmoking off campus ground "Smoking Policy-Residents' reviewed and updated as of Education provided 5/13-5/CNA's and nurses regarding processes noted above. Ecumen Pathstone Living was performance to make sure noted above are sustained. designee will complete wee weeks and then monthly x2 proper cigarette butt disposongoing compliance, results presented to the QAPI common committee will review and precommendations regarding frequency and content of further and new interventions as incommon to the common to the commo	ds. Policy "has been f 5/15/24. 14/2024 for g policies and vill monitor its corrections The IDON or ekly audits x4 months on eal. To ensure s will be mittee. The provide g the arther audits	

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F 689	wheelchair and obset by IDON, and where was disposed of, ID hands up and said stated, "I know noth know R57 brought facility. R57 was as IDON and exited R where the cigarette he was not sure, where the cigarette but whe said he could not asked to retrace the IDON was observed entrance to the right garbage located in and no cigarette but practical nurse (LP) came in through the room. IDON stated directions through observed and exite asked if they entered and walked by the with a plastic trash cigarette butt was for the facility with remember who three remember where he on 4/10/24 at 9:16 (DON) stated the facility stated the facility with remember where he on 4/10/24 at 9:16 (DON) stated the facility stated the facilit	a.m., R57 was seated in a erved pushed in the hallway asked where the cigarette DON and R57 both put their I don't know. R57 further ning". IDON stated he did not the cigarette butt back into the sisted back to his room by 57's room. IDON was asked butt was disposed, and said nen asked if R57 showed him hen they entered the facility, of remember. IDON was a steps coming into the facility of and walked from the at and into the dining room, a the dining room was observed the still got confused without the facility. IDON was dethe bathrooms by the dining he still got confused without the facility. IDON was do the dining room and was and the dining room and was and the dining room and was and the bathrooms by the dining and the dining room and was are the bathrooms by the dining and the dining room and was and the dining room and was are the bathrooms by the dining and the dining room and was are the bathrooms by the dining and the dining room and was are the bathrooms by the dining and the din not garbage. a.m., R57 was lying in bed by it away and could not ever it away and could not ev		589		

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F 689	Continued From pa	ge 28	F 6	89		
	have a receptacle, R57 to dispose of he the cigarette was not brought in the build. On 4/10/24 at 9:30 to supervise R57 at R57 while he smoke to light his cigarette on the side the cigarette on the side the cigarette on the side the cigarette out. ID back across the strestated he thought Fether the street, and confirmed the facility receptacle for R57, a non smoking carried smoke off facility proposed in the cigarette. ID safety concern for Fein the trash at the facility outside. IDON state out the cigarette on facility. The IDON state out the cigarette on facility. The IDON state out the cigarette on facility. The IDON state out the cigarette on facility and still gets. Observation on 4/1 facility entrance doctray or receptacle in the trash at the facility and still gets.	sed of and the facility did not a plan or designated area for his cigarette. The DON stated of expected to have been ing. a.m., IDON stated staff were cross the street and attend to ed, IDON stated R57 was able himself, ashed on the ground he observed R57 scrape the e of the curb and street to put DON stated he assisted R57 eet into the building. IDON R57 left the cigarette butt on firmed a cigarette butt should k in the facility. IDON by did not have a smoking IDON stated the facility was appus, however allowed R57 to roperty and further stated it ht out" plan about R57 not aware of a plan to dispose ON stated it would be a fire R57 disposing cigarette butts acility and not a receptacle ed he watched R57 fully put the street prior to entering the stated he was recently hired as ed approximately 5 days last ys the week before at the lost in the building. 0/24 at 9:45 a.m., outside the ors confirmed no cigarette ash ocated near R57's smoking eet or near the entrance of the				

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		245390	B. WING	ì	04/	C 11/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 718 MOUND AVENUE MANKATO, MN 56001	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		IOULD BE	(X5) COMPLETION DATE
F 880	the area across the multiple cigarette be where R57 common why R57 brought the today and would prothe resident regards. The facility Smoking indicated The facility has estates resident smoking protection. Prior to, and upon informed of the facility can or non-smoking protection. Smoking is only president smoking are outside of the building 4. Metal containers devices, are available Infection Prevention CFR(s): 483.80(a) (1) §483.80 Infection CFR(s): 483.80(a) (2) §483.80(a) Infection program. The facility must estimate the facility must estimate and infection program. The facility must estimate and infection program.	12:38 p.m., the DON stated street was observed and utts found on the ground only smoked and was unsure the cigarette back in the facility ovide education to nursing and lang disposal of the cigarette. If Policy-Residents dated 8/22, ablished and maintains safe ractices. In admission, residents are lity smoking policy, including grareas, and the extent to a naccommodate their smoking efferences. In permitted in designated reas, which are located ing. If with self closing cover to be in smoking areas. If & Control (1)(2)(4)(e)(f) If control (1)(2)(4)(e)(f) If control (1)(2)(4)(e)(f) If with and maintain and and control program as as as as as as and the prevent the transmission of communicable of the communication of th		880		5/15/24

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	IPLE CONSTRUCTION NG	COMPLETED		
		245390	B. WING _		O4/11/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001		
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F 880	reporting, investigate and communicable staff, volunteers, viproviding services arrangement based conducted accordinaccepted national services arrangement based conducted accordinaccepted national services arrangement based conducted accordinaccepted national services for the but are not limited (i) A system of survices possible communicable diservices in the facil (ii) When and to whom the facil (iii) When and to whom the facil (iii) Standard and the followed to provide (iv) When and how resident; including (A) The type and depending upon the involved, and (B) A requirement to least restrictive possible contact with reside contact with reside contact with reside contact will transmit (vi) The hand hygien	stem for preventing, identifying, ating, and controlling infections ediseases for all residents, sitors, and other individuals under a contractual dupon the facility assessmenting to §483.70(e) and following standards; ten standards, policies, and program, which must include, to: veillance designed to identify cable diseases or ney can spread to other lity; nom possible incidents of ease or infections should be ransmission-based precautions revent spread of infections; isolation should be used for a but not limited to: uration of the isolation, e infectious agent or organism that the isolation should be the esible for the resident under the ces under which the facility oyees with a communicable I skin lesions from direct nts or their food, if direct				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245390	B. WING _		04/11/2024		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001	1 0-17		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 31	F 88	30			
	identified under the corrective actions to \$483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual i	ndle, store, process, and as to prevent the spread of review.					
	IPCP and update the	duct an annual review of its neir program, as necessary. NT is not met as evidenced					
	Based on interview review the facility facontrol program incorrectly for the facility facontrol program in the facility and analyst doffed (removed) program incorrectly for the facility incorrectly for the facility. Based on interview review the facility facility. Based on interview review facility facilit	v, observation, and document ailed to ensure the infection cluded ongoing surveillance, ais of resident infections, staff personal protective equipment or 1 of 1 resident (R16), failed a stored in a manner to prevent eteria when PPE was observed ne floor for 18 of 18 residents R3, R20, R36, R41, R10, R27, R17, R57, R46, R21, and anhanced barrier precautions placed a meal tray on the dent (R27). This had the II 56 residents who resided in		The alleged deficiencies for resid R12, R52, R218, R3, R20, R36, R10, R27, R15, R16, R6, R8, R17 R46, R21, and R219 have been corrected. Isolation carts/enhance precaution carts have been placed outside the applicable rooms, stock with the necessary PPE. Additional trash receptacles for disposal have positioned directly inside the entral each resident's room. Immediate education provided to NA-D, NA-C RN-G on donning and doffing PPE Enhanced Barrier Precautions polyprocedure. NA-C received educating infection control practices, specific emphasizing the importance of no meal trays on the floor and the proof the meal tray delivery cart. The and/or designee was responsible	A1, R57, d barrier cked ally, e been nce of C, NA-B, E, and icy and ion on cally of placing oper use IDON		
	Enhanced Barrier Precautions Facility document titled Enhanced Barrier Precautions printed 4/10/24, indicated the following residents had Enhanced Barrier			implementing the corrections. All residents have the potential to affected by the alleged deficient p The IDON and/or designee complements.	be ractice.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG	l \	(X3) DATE SURVEY COMPLETED	
		245390	B. WING			C 11/2024	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	11/2024	
				718 MOUND AVENUE			
PATHST	ONE LIVING			MANKATO, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	Continued From pa	ge 32	F 88	30			
	,	R12, R52, R218, R3, R20, 7, R15, R16, R6, R8, R17, d R219.		audits on 4/12/24 for all resider transmission-based and enhand precautions. The audit ensured was stored outside resident rooms.	ced barrier I that PPE		
	on 4/9/24 at 8:46 a. R52, R218, R3, R2	ion of private resident rooms m., through 9:33 a.m., R12, 0, R36, R41, R16, R6, R8, 1, R219 room door signage		manner that prevents the trans bacteria and that appropriate d options for used PPE were pro- directly inside each resident's r	mission of isposal vided		
	indicated the residence residents identified located directly insidence.	ents were on EBP. The on EBP had plastic gowns de the resident's room on the		audit was completed to ensure tray delivery cart is utilized whe delivering meals to resident room	the meal en oms, where		
	plastic gowns prior	not a place to dispose of the to leaving the resident's room. have PPE located near or		applicable. This process confirm no other residents were affected alleged deficient practice. The following measures and systems.	ed by the		
	During observations 4/9/24 at 9:10 a.m.	s of private resident rooms on observed PPE directly on the		changes have been made to enable alleged deficient practice will not Policy Enhanced Barrier Preca	nsure the ot recure:¿		
	identified by signag EBP:	e on their doors as being in a box of plastic gowns was		Donning and Doffing education/competency, Surveil Infections policy, and Infection and Control Program policy has	Prevention		
	a plastic dishpan or	- a box of plastic gowns was in the floor inside the door		reviewed. Education for Certified Nursing (CNAs) and nurses was compl			
	a plastic dishpan or	- a box of plastic gowns was in the floor inside the doorm., occupational therapy		5/13-5/14/2024 regarding the aforementioned policies and preducation for the ADON and the was completed by 5/15/2024.	erapy staff		
	assistant (OTA)-A sign on the door an	tated residents on EBP had a d staff were expected to wear		training on the proper use of the delivery cart, with a specific for	e meal tray cus on the		
	care. OTA-A stated resident bathrooms	when providing hands on the PPE was located in the , and confirmed PPE was entered EBP resident rooms.		process for residents in isolatic provided. PRN and casual staff working during this period will be receive this education prior to	f not be required		
	On 4/9/24 at 8:55 a	.m., nursing assistant (NA)-D		to receive this education prior to scheduled workday. ¿ IDON me ADON/IP to create process to	et with ensure		
		n and stated it would be easier s and gloves were mounted on		ongoing surveillance, tracking, and analysis of resident infection	•		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245390	B. WING			C 11/2024
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F 880	the resident floors get the gloves. NA inside resident's resident's resident's resident's resident's resident's resident's resident's resident (ADON), wherevention nurse, splaced on EBP has and confirmed the EBP R12, R52, R27, R15, R16, R6, R219. The ADON medical devices, when providing can would expect staff inside the resident was still trying to whe location for the PP ADON stated the expected on the flowould expect glove confirmed the glow bathrooms. On 4/9/24 at 2:40 director of nursing the plastic gowns in on the floor inside the floor inside the floor inside the glow bathrooms.	id not have to get the gowns off and go into the bathroom to -D confirmed PPE was donned		Education and confirmation tracking program complete and ADON/IP to utilize for infection surveillance, tremanalysis. Ecumen Pathstone Living performance to make sure noted above are sustained designee will audit x4 wee monthly x2. Audits will included and doffing and auditing prisolation carts, trash receptor of meal tray delivery cart. Week will be completed. Prand doffing audit will included observation of 3 staff mem EBP isolation cart audit with on all residents on EBP. To ongoing compliance, result presented to the QAPI concommittee will review and recommendations regarding frequency and content of for and new interventions as in the supplementation of the supplementation o	ed with IDON ongoing ding and will monitor its corrections. I. IDON and/or ks and then ude donning roper location of tacles, and use Three audits per PE/ donning de the abers per audit. Il be conducted to ensure ts will be mittee. The provide and the further audits	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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F 880		ige 34 k. The ADON confirmed there or place to dispose of the	F 88	D			
	plastic gowns readi	ly available next to the door for ior to exiting resident rooms					
	Infection Surveillan	ce					
	the DON and the A infection prevention started the position. The ADON stated hinfection surveilland the infections was not aware whe surveillance had on had training last we tracking, and trending stated discussions residents who were and on antibiotics. facility used electrostaff for possible infinformation. The D surveillance had no incidence of infection and the infection coimprovement. The prevention was donstated daily during residents on antibior residents were not trending's or pattern currently tracking the verified a monthly a infections were import patterns, and into the prevention was donstated as a monthly a infections were important patterns, and into the prevention was donstated as a monthly a infections were important patterns, and into the prevention was donstated as a monthly a infections were important patterns, and into the prevention was donstated as a monthly a patterns, and into the prevention was donstated as a monthly a patterns, and into the prevention were important.	p.m. during an interview with DON, who was identified as nist, the ADON stated he in January of this year [2024]. The was responsible for the end confirmed tracking of the currently taking place, and the last infection surveillance, and of the data. The DON were held at daily meetings of the DON also explained the nic communication among fection concerns and the program had room for ADON verified infection an informal basis and staff meeting he discussed of the facility staff; however, tracked or compared for the infection data. The ADON analysis of the illnesses and cortant to rule out any trending the erventions could be initiated to so infections including staff.					

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
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F 880	NA-C was observed floor outside R27's order to don (put or room. During an interview stated she did not obseach to set a mea food and beverages off the bottom of the R27's overbed table. Doffing During an observat observed signage owas in transmission Covid-19. A progrest tested positive for Con 4/9/24. An isolat observed outside Rindicated: 1. 7 - 14 DAY QUA through 4/19/24. 2. Droplet Precautic Gown, Gloves. Institution direct care: doff leaving the room. Day CDC Enhance Bay CD	ion on 4/8/24 at 5:48 p.m., d setting a meal tray on the room who was in EBP, in h) PPE prior to entering the consider it an infection control al tray on the floor since the swere covered and she wiped e meal tray before setting it on e. ion on 4/10/24 at 6:35 a.m., on R16's door indicating he h-based precautions for ss note indicated he had covid-19 late in the afternoon ion cart/organizer was at 6's room. Signage on door aRANTINE - start date 4/9/24 cons: N95 Mask, Face Shield, ructions for staff providing gown and glovesprior to coff N-95 outside of room. arrier Precaution sign	F 8	380			
	(N-95 mask) after e	exiting the room.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG) COM	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER ONE LIVING			STREET ADDRESS, CITY, STATE, ZIP COI 718 MOUND AVENUE MANKATO, MN 56001	<u> </u>	11/2024
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F 880	Continued From pa	ige 36	F 88	80		
	7:39 a.m., observed all PPE already dof sign on the door, N after exiting the root the doffing sign on remove all PPE in rexiting the room. R this [donning and dothe sequence. During an observed full PPE on. NA-B soutside the door - g shield, setting it all NA-B then picked to across the hall to the stated she did not he training yet and stated she did not he training yet and stated for transmissed Covid-19, staff were residents room except face shield - which the room. The ADC had donning and do ADON acknowledge proper procedure for ADON was informed setting R27's meal room while she dorn meal tray should not acknowledged there.	ion and interview on 4/10/24 at d RN-G exit R16's room with fed. According to the doffing 95 mask should be doffed om. Together with RN-G, read the door which indicated to room (except N95), before N-G stated she hadn't done offing] for a while and forgot ion and interview on 4/10/24 at d NA-B exit R16's room with stood and doffed the PPE gloves, gown, mask and face on the floor outside the room. Up the PPE and carried it he dirty utility room. NA-B have donning and doffing ted she didn't see the sign on ing. If on 4/10/24 at 2:50 p.m., so the infection preventionist sion-based precautions for the to doff all PPE inside the sept for the N-95 mask and should be doffed after exiting on stated staff should have offing training upon hire. The ed staff had not followed or doffing. In addition, the ed of observation of NA-C tray on the floor outside his need PPE. The ADON stated a lever be set on the floor and the were no surfaces for staff to y donned/doffed PPE to				

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F 880	Documentation of defor RN-G and NA-B and indicated RN-G competency on 3/8/donning and doffing on 3/22/24. The facility Enhanced dated 8/22, indicated Enhanced barrier per to prevent the spread of the prevent the spread of the	onning and doffing education was provided by the ADON had received education with 24, and NA-B had received education with competency education with competency education with competency education with competency educations (EBPs) are utilized educations (EBPs) are utilized educations (EBPs) are used ion and control intervention to of multi-drug resistant educations (EBPs) are used ion and control intervention to of multi-drug resistant educations (EBPs) are used ion and control intervention to end to the education and glove use resident care activities when do not otherwise apply. However, applied prior to contact resident care activity or entering the room). It ective equipment (PPE) is ingument for another resident. On may be used if there is a or spray. In contact resident care the use of gown and gloves for evering the room and gloves for every every expensive the received education with and received education with a r		80			

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F 880	dressing. 9. staff are trained EBPs 11. PPE is available rooms. The facility Surveille 9/17, indicated: That infection prevents are infections that have potential resident of transmission based preventative intervents in the current standard and the current standard a	any skin opening requiring a prior to caring for residents on a outside of the resident ance for Infections policy dated entionist will conduct ongoing althcare associated infections oidemiologically significant a substantial impact on autcome and that may require a precautions and other entions. This surveillance of infections is vidual cases and trends of ignificant organisms and ated infections to guide nations and to prevent future auch infections are based on a definitions of infections. If transmissibility in a ment rocesses and procedures that he spread of infection gnificant morbidity or mortality ection (e.g pneumonia, UTIs, associated with serious any be considered in				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	DING	· /	ATE SURVEY DMPLETED
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F 880	infection control per gathering and interprintection control concommittee may be data 2. if surveillance shall of the following in possible indicators a. laboratory in b. skin care shall of the following in possible indicators a. laboratory in b. skin care shall culture shall cu	ention strategies nce Data ntionist are designated rsonnel is responsible for oreting surveillance data. The mmittee and or QAPI involved in interpretation of ould include a review of any or information to help identify of infection: records heets ontrol rounds or interviews orts from staff infection ords e logs records eview l/summaries s are used to identify relevant owing findings merit further and cultures altures that do not just colonization ne cultures with corresponding as that suggest infection autum culture		880		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
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F 880	criteria for definition collect the following identifying informatidate of onset of infer pathogens invasive pertinent remarks, precautions. Calculating infection Interpreting Surveill 1. Analyze the data The facility Infection Program policy data Infection prevent coand maintained to promote the comfortable environd development and tradiseases and infect 11. Prevention of Infection 5. educating states	Recording h infections that meet the of infection for surveillance data as appropriate: fon, diagnosis, admission date ection, infection site, procedures are risk factors, treatment measures and a rates fance Data factor to identify trends on Prevention and Control ed 10/18, indicated ontrol program is established provide safe sanitary and ment to help prevent the ransmission of communicable tions.	F 88	30		
F 881 SS=E	program. The facility must est and control program a minimum, the following \$483.80(a)(3) An articles.	n prevention and control tablish an infection prevention n (IPCP) that must include, at	F 88	31		5/17/24

NAME OF PROVIDER OR SUPPLIER		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	· /	E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG							С
PATHSTONE LIVING (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 881 Continued From page 41 system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 56 residents who had infections requiring antibiotic use. Findings include: Findings include: During interview on 4/10/24, 1:13 p.m., with the director of nursing (DON) and assistant director of nursing (ADON), who was the infection prevention nurse. The DON stated the nurses completed monitoring of symptoms if resident had a possible infection and report that information to the providers. The provider identified potential infections and order testing and review the cultures. The DON further stated To ensure continued compliance with PR81, Antibiotic Stewardship Program, Ecumen Pathstone Living has implemented a comprehensive process for antibiotic review. This process involves evaluating the appropriateness of antibiotic indications, dosages, durations, and tracking trends in antibiotic use and resistance. A detailed tracking sheet has been created to consolidate all relevant data, including infection details, lab results, x-rays, identified organisms, prescribing clinicians, and antibiotic therapies. This tool also tracks whether appropriate follow-up communication with residents and/or prescribing clinicians has occurred.			245390	B. WING _		04/	11/2024
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 881 Continued From page 41 system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 56 residents who had infections requiring antibiotic use. During interview on 4/10/24, 1:13 p.m., with the director of nursing (DON) and assistant director of nursing (DON), who was the infection prevention nurse. The DON stated the nurses completed monitoring of symptoms if resident had a possible infection and report that information to the providers. The poon further stated FR81 F 881 F 881 To ensure continued compliance with F881, Antibiotic Stewardship Program, Ecumen Pathstone Living has implemented a comprehensive process for antibiotic review. This process involves evaluating the appropriateness of antibiotic indications, dosages, durations, and tracking the appropriateness of antibiotic indications, dosages, durations, and tracking the appropriateness of antibiotic indications, dosages, durations, and tracking the appropriateness of antibiotic indications, dosages, durations, and tracking the appropriateness of antibiotic indications, dosages, durations, and tracking the appropriateness of antibiotic indications, dosages, durations, and tracking the appropriateness of antibiotic indications, dosages, durations, and tracking sheet has been created to consolidate all relevant data, including infection details, lab results, x-rays, identified organisms, prescribing clinicians, and antibiotic therapeses. This tool also tracks whether appropriate follow-up communication with residents and/or prescribing clinicians has occurred. The tracking sheet will be managed by the					718 MOUND AVENUE		
system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any of the 56 residents who had infections requiring antibiotic use. Findings include: During interview on 4/10/24, 1:13 p.m., with the director of nursing (DON) and assistant director of nursing (ADON), who was the infection prevention nurse. The DON stated the nurses completed monitoring of symptoms if resident had a possible infection and report that information to the providers. The provider identified potential infections and order testing and review the cultures. The DON further stated To ensure continued compliance with F881, Antibiotic Stewardship Program, Ecumen Pathstone Living has implemented a comprehensive process for antibiotic review. This process involves evaluating the appropriateness of antibiotic indications, dosages, durations, and tracking trends in antibiotic use and resistance. A detailed tracking sheet has been created to consolidate all relevant data, including infection details, lab results, x-rays, identified organisms, prescribing clinicians, and antibiotic therapies. This tool also tracks whether appropriate follow-up communication with residents and/or prescribing clinicians has occurred.	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
the nursing staff also were responsible to review lab and culture results to ensure resident is taking proper antibiotic. The ADON stated he was the infection prevention nurse and was responsible for the infection control program, including antibiotic stewardship. The ADON confirmed education completion of infection control/prevention and antibiotic stewardship program and received specific facility training last week for tracking infections and antibiotics and stated he planned to implement the training next week for antibiotic tracking. The ADON stated awareness of any resident infections, new symptoms or residents placed on antibiotics was discussed during daily stand-up meetings to keep up with resident status. The ADON confirmed the	F 881	system to monitor at This REQUIREMENT by: Based on interview facility failed to impreview in order to dindications, dosage use and resistance affect any of the 56 requiring antibiotic frindings include: During interview on director of nursing (ADON), prevention nurse. To completed monitoring had a possible inferinformation to the proper antibiotic for the nursing staff also lab and culture resurroper antibiotic. To infection prevention for the infection completed control/prevention appropriate ducation completed control/prevention approgram and received week for tracking in stated he planned to week for antibiotic tracking in symptoms or resided discussed during data.	antibiotic use. NT is not met as evidenced and document review, the lement a process for antibiotic etermine appropriate , duration, trends of antibiotic . This had the potential to residents who had infections use. 4/10/24, 1:13 p.m., with the (DON) and assistant director who was the infection the DON stated the nurses ng of symptoms if resident ction and report that croviders. The provider infections and order testing ures. The DON further stated so were responsible to review alts to ensure resident is taking the ADON stated he was the in nurse and was responsible introl program, including inp. The ADON confirmed on of infection and antibiotic stewardship a	F 8	To ensure continued compliant F881, Antibiotic Stewardship P Ecumen Pathstone Living has implemented a comprehensive for antibiotic review. This proceevaluating the appropriateness antibiotic indications, dosages, and tracking trends in antibiotic resistance. A detailed tracking been created to consolidate all data, including infection details results, x-rays, identified organ prescribing clinicians, and antitherapies. This tool also tracks appropriate follow-up commun residents and/or prescribing clinical coccurred. The tracking sheet will be man Infection Prevention Nurse and designee and will be accessibl staff for collaboration via the T This system ensures thorough and promotes effective community within the clinical team to supple antibiotic use and resistance management. To correct the deficiency and to the problem does not recur, Clinurses were educated on the Procedure and the Antibiotic Times Stewardship Program, The 'Times Procedure and the Antibiotic Times Sheet Process and Expectation	rogram, e process ess involves of durations, c use and sheet has relevant s, lab hisms, biotic whether ication with inicians has aged by the dor their e to clinical EAMS app. monitoring unication ort optimal ort optimal ort optimal	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245390	B. WING _		O4/11/2024	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 921	stated the facility use for staff to track reseantibiotic and if cultivated the health unculture results via fastaff and the nurse culture result indicated was needed. The Diffacility did not have to include the required stewardship and continued the required stewardship and continued the required stewardship and continued the results to entracked for culture r	I on an antibiotic The DON seed electronic communication idents who were on an ures were received. The DON sit coordinator received the ax, would alert the nursing would contact the doctor if the ted a change in the antibiotic ON and ADON verified the a formal process or tracking rements for Antibiotic onfirmed the antibiotics were ures, source, location of swhen placed on antibiotic. The does not review or track is ure proper antibiotics were a tracking log. Ion and Control Program indicated on antibiotic safe sanitary and ament to help prevent the ansmission of communicable ions. Irdship ts sensitivity data and iews are included in	F 92	The IDON and/or designee will con audits weekly x4 weeks and then mx2 months. Audit will include complof antibiotic timeout for residents cutaking antibiotics. As part of Ecume Pathstone Living's ongoing commit to quality assurance, the IDON and designee will report identified concentrough the community's QA Proce	nonthly letion urrently en ment l/or erns	
	§483.90(i) Other En	vironmental Conditions				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUM					E SURVEY IPLETED
		245390	B. WING		O4/11/2024	
	PROVIDER OR SUPPLIER ONE LIVING			STREET ADDRESS, CITY, STATE, ZIP C 718 MOUND AVENUE MANKATO, MN 56001	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 921	sanitary, and comforesidents, staff and This REQUIREMED by: Based on observational failed to provide a skitchen serving foo pots/pans area. The 56 residents current Findings include: On 4/8/24 at 12:00 kitchen, a vent with fuzzy material on the pots and pans dish and pans were left area, 3 plugs were extended down appropriate appropriate covered in gray, fuzzy debris pextended from ceilic covered in gray, fuzzy debris along printer cord. Cook staff clean the vent responsible for cleat the ceiling. C-A cocovered in debris at During observation 11:35 a.m., mainteresponsible for cleat the ceiling. C-A cocovered in debris at During observation 11:35 a.m., mainteresponsible for cleat the ceiling. C-A cocovered in debris at During observation 11:35 a.m., mainteresponsible for cleat the ceiling. C-A cocovered in debris at During observation 11:35 a.m., mainteresponsible for cleat the ceiling. C-A cocovered in debris at During observation 11:35 a.m., mainteresponsible for cleat the ceiling. C-A cocovered in debris at During observation 11:35 a.m., mainteresponsible for cleat the ceiling.	provide a safe, functional, ortable environment for a the public. NT is not met as evidenced tion and interview, the facility sanitary environment in the dipreparation area and drying is had the potential to affect all only residing in the facility. p.m., during initial tour of the a 2 rungs present had dark the top rung. This was over the washing area and where pots to dry. Above the food serving present in a wire mesh that proximately 5-6 inches that had resent. A white flat printer cording to the printer and was azzy debris. These cords were clean plates and near the in the left and next to a food		Ecumen Pathstone Living the deficiency related to F9 thoroughly cleaning the item the kitchen area (i.e., vents exhaust hoods, drainage pi etc.). These items have now included in the facility's kitch audit. Any additional items attention will be entered into addressed promptly as they To prevent recurrence and ongoing compliance, all die environmental staff received culinary sanitation expectate cleaning schedules, monitod cleaning tasks, and the TEL 5/15/24 and 5/21/24. This transfer conducted by the Culinary In the Culinary Director and/or conduct monthly audits to incleanliness of ceiling vents, cords, and exhaust hoods. As part of Ecumen Pathstoongoing commitment to quarter IDON and/or designee widentified concerns through community's QA process.	21 by ms identified in a ceiling cords, pes, carpeting, when seen then sanitation requiring of TELS to be a rise. ensure stary and a deducation on tions, including or all LS process, on raining was Director. or designee will a spect the pect the pect the pect ical in the ceiling assurance, will report any	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		245390	B. WING		(C 04/11/2024
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 718 MOUND AVENUE MANKATO, MN 56001	<u> </u>	
(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 CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOWS CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION OF CORRECTIVE	HOULD BE	(X5) COMPLETION DATE
F 921	was covered in in d be cleaned. On interview 4/10/2 director (CD) indica dirt or debris on the	ust and debris and needed to 4 at 9:43 a.m., the culinary ted there should not be any cords, or wires holding the re the food serving or clean	F 9	21		

F5390033

PRINTED: 05/13/2024 FORM APPROVED OMB NO. 0938-0391

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING			DATE SURVEY COMPLETED
		245390	B. WING _				04/09/2024
	ROVIDER OR SUPPLIER			718 MC	T ADDRESS, CITY, STATE, ZIP CODE OUND AVENUE (ATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	K 0	000			
	FIRE SAFETY						
	conducted by the M Public Safety, State 04/09/2024. At the Living was found no requirements for part Medicare/Medicaid 483.70(a), Life Safe edition of National F (NFPA) 101, Life Safe Existing Health Care ALLEGATION OF CONDUCTED TO NOTITE OF CONDUCTED TO NOTITE REVISIT CONDUCTE	at 42 CFR, Subpart ty from Fire, and the 2012 fire Protection Association afety Code (LSC), Chapter 19 and the 2012 edition of are Facilities Code. OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR E BOTTOM OF THE FIRST 6-2567 FORM WILL BE ATION OF COMPLIANCE. F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE S BEEN ATTAINED IN TH YOUR VERIFICATION. THE PLAN OF R THE FIRE SAFETY TAGS) TO: IN THE E-POC PROCESS, A THE PLAN OF CORRECTION					
_ABORATORY	DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIVE'S SIGNATUR	RE		TITLE		(X6) DATE
Electroni	cally Signed						05/10/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION - MAIN BUILDING	1 ' '	(X3) DATE SURVEY COMPLETED	
		245390	B. WING		0	4/09/2024	
	ROVIDER OR SUPPLIER		718	REET ADDRESS, CITY, STATE, ZIP COD MOUND AVENUE NKATO, MN 56001	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
K 000	Healthcare Fire Inspectate Fire Marshal E 445 Minnesota St., St. Paul, MN 55101. By email to: FM.HC.Inspections@THE PLAN OF COFDEFICIENCY MUSTFOLLOWING INFO@1. A detailed describation and monitor and monitor and monitor and monitor sustained. 4. Identify who is actions and monitor and monitor 5. The actual or pathe remedy. BUILDING 01 Building 01 was build basement, is fully fire determined to be of the 2008 addition is basement, is fully fire was determined to be of the 2008 addition is basement, is fully fire was determined to be of the 2008 addition is basement, is fully fire was determined to be of the 2008 addition is basement, is fully fire was determined to be of the 2008 addition is basement, is fully fire was determined to be actual or pathernal and the second addition is basement, is fully fire was determined to be actual or pathernal and the second addition is basement, is fully fire was determined to be actual or pathernal and the second addition is basement, is fully fire was determined to be actual or pathernal and the second and the secon	Division Suite 145 -5145, OR Distate.mn.us RECTION FOR EACH FINCLUDE ALL OF THE RMATION: ription of the corrective action correct the deficiency. Passures that will be put in deficiency does not reoccur. The facility plans to monitor to ensure solutions are responsible for the corrective ting of compliance. Troposed date for completion of It in 1992, is one-story, has no the sprinkler protected and was Type II(111) construction; The two-stories, has a partial the sprinkler protected, and the of Type II(111) construction. The pacity of 69 beds and had a	K 000				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING		` '	ATE SURVEY OMPLETED
		245390	B. WING			04/09/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	Continued From page	e 2	K 0	00		
	The requirement at 42 NOT MET as evidence	2 CFR, Subpart 483.70(a) is ed by:				
K 923 SS=D		nder and Container Storag	K 9	23		5/15/24
	Storage locations are ventilated in accordary 5.1.3.3.3. >300 but <3,000 cubic Storage locations are within an enclosed in limited- combustible of gates outdoors) that of gases are not stored separated from combustible consumption or enclose noncombustible consumption or enclose noncombustible consumption or equal to linear available for care areas with an agoing or equal to 300 cubic stored in an enclosure handled with precauting a precautionary sign each door or gate of a where the sign includes minimum "CAUTION: STORED WITHIN NO STORED WITHIN WITHI	designed, constructed, and nee with 5.1.3.3.2 and c feet coutdoors in an enclosure or derior space of non- or construction, with door (or can be secured. Oxidizing with flammables, and are custibles by 20 feet (5 feet if sed in a cabinet of truction having a minimum rating. 300 cubic feet mpartment, individual r immediate use in patient agregate volume of less than feet are not required to be ence. Cylinders must be sons as specified in 11.6.2. The readable from 5 feet is on a cylinder storage room, the wording as a coxidizing GAS(ES) of SMOKING." To cylinders are used in order derived from the supplier.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION 11 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED		
245390			B. WING		04/	09/2024
	ROVIDER OR SUPPLIER		7	TREET ADDRESS, CITY, STATE, ZIP CODE 18 MOUND AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
K 923	considered empty is a are marked to avoid of in the open are proted 11.3.1, 11.3.2, 11.3.3, This REQUIREMENT by: Based on observation facility failed to store 699 (2012 edition), Head section 11.6.5.2 and 6 finding could have an residents within the face of	established. Empty cylinders confusion. Cylinders stored cted from weather. 11.3.4, 11.6.5 (NFPA 99) is not met as evidenced and staff interview, the exygen cylinders per NFPA alth Care Facilities Code, 11.6.5.3. This deficient isolated impact on the acility. AM, it was revealed by exygen storage room had exygen cylinders being stored and was not segregated. Maintenance Director	K 923	Signage was added on 5/9/24 to oxyg storage rooms to indicate which tanks full and which tanks are empty. Education was provided to the maintenance staff on 5/7/24, and adde the following verbiage to the weekly building tour task in TELS. Full and empty cylinders are not comingled. Partially used tanks are to stored with empty cylinders. Signage and tags for "full" and "empty" tanks in place. Cylinders are in storage rack Weekly TELS building tour to make suitems are compliant. Weekly audits x4 and then monthly x2 months. TELS task will clearly state what to loo for and check for proper signage and storage.	d be	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	CONSTRUCTION (X3) DATE COMF		SURVEY LETED
	00036	B. WING		04/1	; 1/2024
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING	718 MOU	DRESS, CITY, S ND AVENUE O, MN 56001	STATE, ZIP CODE		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000 Initial Comments		2 000			
****ATTE	NTION*****				
NH LICENSING	CORRECTION ORDER				
144A.10, this correpursuant to a surve found that the deficient herein are not corrected shall with a schedule of the Minnesota Deputermination of water corrected requires requirements of the number and MN Rule with a rule contains comply with any of lack of compliance re-inspection with a result in the assess	Minnesota Statute, section ction order has been issued by. If, upon reinspection, it is being or deficiencies cited ected, a fine for each violation be assessed in accordance fines promulgated by rule of artment of Health. The hether a violation has been compliance with all e rule provided at the tagule number indicated below. In several items, failure to the items will be considered any item of multi-part rule will sment of a fine even if the item uring the initial inspection was				
that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to thin 15 days of receipt of a ent for non-compliance.				
conducted at your facility was NOT in Licensure and the issued. Please indi	TS: a licensing survey was facility by surveyors from the nent of Health (MDH). Your compliance with the MN State following correction orders are cate in your electronic plan of a reviewed these orders and				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

TITLE

05/10/24

If continuation sheet 1 of 36

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00036	B. WING		1	C 1 1/2024
	PROVIDER OR SUPPLIER	718 MOUN	DRESS, CITY, S ND AVENUE D, MN 56001	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	The following composite survey and NO H53902668C (MNO H53902745C (MNO H53902746C (MNO H53907949C (MNO H53903054C (MNO H53903054C (MNO Minnesota Department the State Licensing federal software. Tale assigned to Minnesota Department the State Licensing federal software. Tale assigned to Minnesota Department the State Licensing federal software. Tale assigned to Minnesota Department the State Licensing federal software. Tale assigned to Minnesota Department the State Licensing federal software. Tale assigned to Minnesota Department the State Licensing federal software in the far leading to the finding which a statute after the state as evidence by." For are the Suggested I Time period for Control of the State Licensing federal software in the far leading which as the state of the Suggested I Time period for Control of the Suggested I Time period for Control of the State Licensing federal software.	en they will be completed. laints were reviewed during licensing orders were issued.: 0099237) 0091448) 0098060) 0099410) 0087616) 0102383) lent of Health is documenting Correction Orders using a numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of the state tement, "This Rule is not met following the surveyors findings Method of Correction and rection.	2 000			
	receipt of State lice the Minnesota Department on all Bullet on/infobulletins/ib14 orders are delineated	in state.mn.us/facilities/regulati _1.html> The State licensing ed on the attached Minnesota				
	you electronically. It is necessary for Statement of the word "corrected text. You must then	Although no plan of correction the Statutes/Rules, please ected" in the box available for indicate in the electronic cess, under the heading				

Minnesota Department of Health

STATE FORM YJLJ11 If continuation sheet 2 of 36

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING		1	C 11/2024
NIANAE OE I				NTATE ZID OODE	1 04/	11/2024
NAME OF I	PROVIDER OR SUPPLIER		ND AVENUE	STATE, ZIP CODE		
PATHST	ONE LIVING		DAVENUE D, MN 56001	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	completion date, the corrected prior to el Minnesota Departmental enrolled in ePOC ar	e date your orders will be ectronically submitting to the ent of Health. The facility is not therefore a signature is not of the first page of state				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEAL IS NO REQUIREME CORRECTION FOR	N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE. THERE ENT TO SUBMIT A PLAN OF				
2 550	MN Rule 4658.0400 Resident Assessme	Subp. 4 Comprehensive ent; Review	2 550			5/15/24
	home must examine quarterly and must comprehensive ass	assessments. A nursing e each resident at least revise the resident's essment to ensure the of the assessment.				
	by: Based on observation review, the facility facurately identified the second	ent is not met as evidenced on, interview and document ailed to ensure resident status itified in the Minimum Data nent for 2 of 2 resident (R52, lospice and pressure ulcers.		corrected		
	Findings include:					
	2/7/24, and diagnos	ndicated admission date was ses of malignant neoplasm h and division of abnormal				

Minnesota Department of Health

STATE FORM YJLJ11 If continuation sheet 3 of 36

Minnesota Department of Health

AND BLAN OF CORRECTION INTERCATION NUMBER:	2) MULTIPLE CONSTRUCTION BUILDING:	(X3) DATE SURVEY COMPLETED
00036 B. V	WING	C 04/11/2024
NAME OF PROVIDER OR SUPPLIER 718 MOUND A MANKATO, M		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF OPERING (EACH CORRECTIVE ACT TAG CROSS-REFERENCED TO TOTAL DEFICIENCY	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
cells) of upper lobe of lung, malignant neoplasm of bone and heart failure. R52's admission significant change, Minimum Data Set (MDS) dated 3/21/24, section O, K1 under special treatments and programs, did not include hospice care services. Section J 1400 Prognosis: conditions or chronic diseases that may result in a life expectancy of less than 6 months was marked as yes. R52's provider order dated 2/29/24, indicated hospice was to evaluate. During interview on 4/8/24 at 12:42 p.m., R52 indicated she is receiving hospice services but was not sure who the hospice agency was. During interview on 4/9/24 at 8:56 a.m., registered nurse (RN)-A, also identified as MDS coordinator, indicated R52 is currently receiving hospice services. Upon review of the significant change MDS, RN- A confirmed section 0 was not coded correctly as R52 is receiving hospice services. R21's Face Sheet included diagnoses of hemiplegia and hemiparesis (mild or partial weakness to severe or complete loss of strength or paralysis on one side of body) following cerebral infarction (area of dead tissue in the brain resulting from brain bleed or blood clot) affecting left dominant side, and diabetes mellitus type 2. R21's quarterly MDS dated 4/9/24, listed as ready for export and locked, indicated R21 was at risk for pressure ulcer (PU) injury but has none. Deep	550	

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			D MINIO			
		00036	B. WING		04/1	1/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTO	ONE LIVING		ND AVENUE			
24.0.15			D, MN 56001		TON	0.45
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 4	2 550			
	ointments/medication	ons other than to feet.				
	small open shallow	nent dated 4/4/24, indicated area on left buttock, and eft heel measuring 2 cm x 3 eling edges.				
	also identified as M quarterly MDS was pressure ulcer prestreatment. RN-B co	4/11/24 at 12:13 p.m., RN-B, DS coordinator, confirmed the incorrect as R21 does have ent and injury cares and onfirmed she would not have again and would have ctly.				
	<u> </u>	4/10/24 at 2:37 p.m., the stated the MDS should have curately.				
	and procedure date shall be responsible coordinating the det the resident assess completes a portion certify the accuracy assessment by dati	sessment Coordinator policy of 11/2019, included an RN of the assessment must of that portion of the and signing the entifying each section				
	director of nursing (coordinator could repolicies and proced coding of the MDS.	HOD OF CORRECTION: The (DON) or designee or RAI eview the RAI manual, review lures to ensure accurate The DON, designee or RAI nen perform audits to ensure				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00036	B. WING		04/1) 1/2024
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING	718 MOUN	DRESS, CITY, S ND AVENUE D, MN 5600			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the custodial care, and individual needs and the comprehensive plan of care as des written order from the custodial care, and individual needs and the comprehensive plan of care as des written order from the custodial care, and individual needs and the custodial care, and the custodia	general. A resident must and treatment, personal and supervision based on depretences as identified in resident assessment and scribed in parts 4658.0400 and and home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			5/15/24
by: Based on observation review, the facility facility facility facility facility facility for the facility facility of the facility facility of the facility facility of the facility facility for the facility facility for the facility fa	nimum Data Assessment 4, indicated R57 had severe nt, required supervision with it to stand, chair transfer, and ses included aphasia (ability press speech), hemiplegia ifract (paralysis of partial or on one side of the body after a ht side, tobacco use, muscle disorder, depression, and		Corrected		
R57's care plan rev	ised 4/8/24, indicated R57				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING		04/1) 1/2024
	PROVIDER OR SUPPLIER	718 MOUN	DRESS, CITY, S ND AVENUE D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	community, was off options and decline when first admitted, stopped d/t being in smoke unless direct family/responsible propersident determined independently per stores resident's liguraterly, will be offered quarterly, will smoke will dress appropriates smoking risks and because the cessation aids that facility policy on smoking risks and because the burns, required family/friend/staff with the concerns, notify characterity, observe clothed cigarette burns, required family/friend/staff with the concerns and interest of the concerns and interest of the curb and interest to R57 was observed to cross the concerns and interest to R57. R57 with the curb and of cigarette as and put out the cigarette as and put out the cigarette and put out t	e while residing at this care fered smoking cessation d, (was on nicotine patch requested for them to be reffective for him), will not stly supervised by party/staff as evidenced ned unsafe to smoke smoking assessment, facility hter and cigarettes, will be (PRN (as needed) for smoking ed smoking cessation options in designated areas only and tely for weather, instruct about nazards and about smoking are available, instruct about oking: locations, times, safety arge nurse immediately if it is has violated facility smoking hing and skin for signs of uires supervision by hile smoking. a.m., alarm was heard at front R57 was observed seated in a rim director of nursing (IDON) ent's wheelchair and R57 was he street and IDON was and assisted R57 across the served to smoke a cigarette of the street and IDON stood as on the side of the street of the street and IDON stood as on the side of the street. R57 was estreet with the street with the R57 and IDON entered the R57 and IDON entered the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l `´	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BOILDING.			_
	00036	B. WING			1/2024
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTONE LIVING	718 MOUI	ND AVENUE			
		D, MN 56001			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830 Continued From pa	ge 7	2 830			
wheelchair and obset by IDON, and where was disposed of, ID hands up and said stated, "I know noth know R57 brought facility. R57 was as IDON and exited Rewhere the cigarette he was not sure, where the cigarette but whe said he could not asked to retrace the IDON was observed entrance to the right garbage located in and no cigarette but practical nurse (LPI came in through the room. IDON stated directions through observed and exite asked if they entered asked if they entered asked by the cwith a plastic trash cigarette butt was for and confirmed he be into the facility with remember who three remember where he con 4/10/24 at 9:16 (DON) stated the facility st	a.m., R57 was seated in a erved pushed in the hallway asked where the cigarette DON and R57 both put their I don't know. R57 further ning". IDON stated he did not the cigarette butt back into the sisted back to his room by 57's room. IDON was asked butt was disposed, and said nen asked if R57 showed him hen they entered the facility, of remember. IDON was esteps coming into the facility. It and walked from the at and into the dining room, a the dining room was observed the was found. Licensed N)-A stated to IDON that he estill got confused with ut the facility. IDON was dethe bathrooms by the dining he still got confused with ut the facility. IDON was do the bathrooms by the dining and in the garbage. a.m., R57 was lying in bed brought the cigarette butt back him and stated he did not even it away and could not endisposed the cigarette butt. a.m., the director of nursing acility did not have a receptacle of the cigarette, stated the was responsible to ensure the				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ´	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:	A. BUILDING:		
		00036	B. WING		04/1	<i>1</i> /2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHST	ONE LIVING	718 MOUI	ND AVENUE			
		MANKATO	D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	Continued From page	ge 8	2 830			
	have a receptacle, a R57 to dispose of h	sed of and the facility did not a plan or designated area for is cigarette. The DON stated of expected to have been ing.				
	to supervise R57 ac R57 while he smoke to light his cigarette on the side the cigarette on the side the cigarette on the side the cigarette out. ID back across the strestated he thought R the street, and confirmed the facility receptacle for R57. a non smoking came smoke off facility provides "not well though smoking and was not the cigarette. ID safety concern for F in the trash at the facility. The IDON state out the cigarette on facility. The IDON state out the cigarette on facility and still gets. Observation on 4/10 facility entrance door tray or receptacle loarea across the street.	a.m., IDON stated staff were cross the street and attend to ed, IDON stated R57 was able himself, ashed on the ground e observed R57 scrape the e of the curb and street to put iON stated he assisted R57 eet into the building. IDON immed a cigarette butt on irmed a cigarette butt should in the facility. IDON y did not have a smoking IDON stated the facility was ipus, however allowed R57 to operty and further stated it hit out" plan about R57 ot aware of a plan to dispose ON stated it would be a fire R57 disposing cigarette butts acility and not a receptacle of the watched R57 fully put the street prior to entering the stated he was recently hired as ed approximately 5 days last yes the week before at the lost in the building. D/24 at 9:45 a.m., outside the ors confirmed no cigarette ash ocated near R57's smoking eet or near the entrance of the				
	facility. On 4/10/24 p.m. at	12:38 p.m., the DON stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		ΈY Ο
				С	
	00036	B. WING		04/11/20	24
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTONE LIVING		ND AVENUE D, MN 56001			
(X4) ID SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE CON	MPLETE DATE
2 830 Continued From page	age 9	2 830			
the area across the multiple cigarette to where R57 common why R57 brought to today and would puthe resident regard. The facility Smoking indicated The facility has est resident smoking puther to an across the facility can be accompanied of the facility can be accompanied to the facility can be	e street was observed and outts found on the ground only smoked and was unsure he cigarette back in the facility rovide education to nursing and ling disposal of the cigarette. In Policy-Residents dated 8/22, ablished and maintains safe practices. In admission, residents are illity smoking policy, including a greas, and the extent to an accommodate their smoking references. In permitted in designated areas, which are located ling. In with self closing cover ble in smoking areas. I HOD OF CORRECTION: I sing (DON) or designee, could resident supervision to resident supervision to resident supervision to resident supervision to resident and interventions are and recodures. A system for resident supervision to results of these audits being ity's Quality Assurance rew.				
(21) days.	R CORRECTION: Twenty-one				

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00036	B. WING		O4/11/	/2024
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
PATHST	ONE LIVING		ND AVENUE D, MN 56001	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 10	2 890			
2 890	MN Rule 4658.0525 Motion	Subp. 2 A Rehab - Range of	2 890		5	5/15/24
	that is directed towarthrough positioning implemented and more comprehensive resident of nursing services development of a nursing services development of a nursing services. A. a resident when without a limited range experience reduction	motion. A supportive program and prevention of deformities and range of motion must be naintained. Based on the dent assessment, the director must coordinate the ursing care plan which ho enters the nursing home age of motion does not on in range of motion unless all condition demonstrates range of motion is				
	by: Based on observation the facility failed to open program for upper expression with the facility failed to open program for upper expression for 1 open	ent is not met as evidenced on, interview and document ensure a range of motion extremities was implemented, plied correctly, and edema of 2 residents (R14) who had tion to prevent contractures.		corrected		
	Findings include:					
	diagnoses of hemip the body) and hemi side of the body) fol (central nervous sys	inted 4/10/24, included legia (paralysis of one side of paresis (weakness one on llowing cerebral infarction stem injury) affecting left osteoarthritis, and muscle				
	R14's quarterly Min	imum Data Set (MDS) dated				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		С	
		00036	B. WING		1	1/2024
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTO	NE LIVING		ND AVENUE			
0(4) 15	CLIMMA DV CTA		D, MN 56001		ON.	()/(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 890	Continued From page	ge 11	2 890			
	dependent on staff	R14 had intact cognition, for transfers, dressing, and and limited range of motion				
	apply resting hand sand and at bedtime. Do	ers dated 5/7/21, included splint on when in wheelchair cument refusals. Apply the day and off at bedtime.				
	limited physical mole hemiplegia/hemipar remain free of comp including contractur formation, skin-brea through the next rev included R54 to wea and off at bedtime. wheelchair and at n The plan of care also daily living self-care included passive rai	ast revised 10/17/23, included bility related to stroke with resis. A goal included R14 will blications related to immobility, res, thrombus (blood clot) akdown, fall related injury riew date. Interventions ar edema glove during the day Resting hand split when up in ight as resident tolerates. So included an activities of deficit. Interventions ange of motion (PROM) to left and shoulder three times per lerates.				
	Plan of Treatment d was discharged from splint use for left up with nurse manager	Therapy (OT) Evaluation and lated 10/13/21, indicated R14 m program with PROM and per extremity; collaborated regarding program to help and reduce risk of contractures.				
	R14 should wear his	et, used by the NA's included s hand/wrist brace at bedtime PROM or edema glove.				
		dministration record or task medical record did not identify				

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STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.			2
		00036	B. WING		1	1/2024
NAME OF PROVIDER OR SU	PPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTONE LIVING			ND AVENUE			
			D, MN 56001			
PREFIX (EACH DEF	FICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION (PROVIDENCY)	OULD BE	(X5) COMPLETE DATE
2 890 Continued Fi	rom pa	ge 12	2 890			
PROM.						
3:49 p.m., Resplint and ed lower palm of fingers were R14 stated in move my had range of mot before his had R14 added stated on the place. Arm to board with 3 up his arm we loose enough	ema g f hand curled ny hand nd is p taff are the bra the bra race v Velcro ith his n it mo	d observation on 4/8/24 at slying in his bed with hand love on his left hand from the to below the elbow. R14's left into the palm of his hand. It is really curved and I can't added no one has done hand but would like them to be rmanently "stuck this way". It is always in such a hurry they always in such a hurry they are right and it doesn't stay in was observed to be a flat blue straps and when R14 picked right hand, the splint was wed further towards his elbow.				
p.m., R14 was longer in the mid lower are edema glove hand and plasmod indicated states the arm of the R14's left are two minutes place back of During observa.m., R14 was breakfast in present attack with 3 Velcroometric variations.	as in the as on he and part of the and he as in the as in the as the as the as the as in the as	e dining room in a wheelchair. his left lower arm and was no of his hand and extended from ast his elbow. R14 had on his icked up his left arm with right in the arm of the chair. R14 of to put the platform trough on to hold his arm in place. If the arm of the chair within a had to pick up his hand and armrest. and interview 4/9/24 at 8:23 the dining room having elchair. Arm trough was the left arm of the wheelchair is. R14 did not have his edema				
palm extendi Velcro straps	ng to r s. R14	d splint was present on his left nid arm and attached with 3 's fingers were curled over the ard towards the under side of				

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00036	VING	C 04/11/2024
NAME OF PROVIDER OR SUPPLIER 718 MOUND AV PATHSTONE LIVING MANKATO, MN		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PR	ID PROVIDER'S PLAN OF COR REFIX (EACH CORRECTIVE ACTION S TAG CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETE
the splint. During interview on 4/9/24 at 12:32 p.m., OT-F, indicated she has treated R14's left hand in the past and he should wear an edema glove, resting hand splint, have an arm support trough on his wheelchair and be receiving restorative exercises on his left hand, arm, elbow and shoulder to maintain mobility. OT-F stated the splint that was provided was for his hand and not his wrist or elbow and should be placed on with fingers held outwards and not curved around the end of the splint. OT-F indicated instructions for R14's PROM should be on his closet in his room as they were provided previously to the nurse manager. During observation and interview on 4/9/24 at 12:52 p.m., nursing assistant (NA)-D indicated if ROM is ordered there are instructions on how to do it. Otherwise OT and activities does the ROM. During interview on 4/9/24 at 1:00 p.m., NA-E indicated she does not perform PROM on R14's left hand. NA-E indicated he has a lot of discomfort when attempting to complete it. During interview and observation on 4/9/24 at 1:08 p.m., NA-B indicated R14 does some range of motion (ROM) exercises himself, which is posted on the closet. On R14's closet, ROM exercises were present for hip abductions and for urinary incontinence exercises but no ROM instructions were present for his left arm, hand, shoulder or elbow. NA-B indicated she has never done PROM to R14's left hand, elbow, wrist or shoulder.	390	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		A. BUILDING:	A. BUILDING:		
	00036	B. WING		1	C 1 1/2024
NAME OF PROVIDER OR SUPPLIER	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PATHSTONE LIVING		ND AVENUE			
	MANKAI	O, MN 56001			
PREFIX (EACH DEFICIEN	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 890 Continued From p	age 14	2 890			
was lying in his befingers were curled R14 stated he wo because he does his hand and fingers.	n 4/10/24 at 7:39 a.m., R14 d with his arm splint on but d under at the end of the splint. ald allow staff to perform ROM o't want to lose the flexibility in ers. R14 indicated it is painfuling pains in his hand when they				
8:28 a.m., R14 was evaluated the splin indicated the splin and should extend and not curled unsplint is for his fing and the way the sanot doing anything R14's fingers. Ofform, as it was a labe straight like it is placed on backwas edema glove. Offedema glove and move R14's finge "tight" and was unfrom the curled possible on R14's has approximately 10 hand and fingers. a better position for unsuccessful in gothe splint to work, washcloth under fineed some continumore flexible prior	nd observation on 4/10/24 at as in the dining room. OT-F and placement. OT-F twas not in the correct position I to keep his fingers straight out der the splint. OT-F stated the gers and not his hand or wrist point was placed on R14 was a to prevent contractures of F stated the splint had lost its pendable splint, and should not as. OT-F added the splint was rds. R14 was not wearing his F went to R14's room and got wash cloth. OT-F attempted to a sand stated his fingers are able to straighten his fingers estition. OT-F placed edema ands with difficulty taking minutes to place on his left. OT-F bent the splint to get into or his hand but was etting R14's fingers extended for OT-F then placed a rolled R14's fingers and stated he will used therapy to get his hand to wearing a hand splint again.				
indicated she is a	vare that R14 has contractures indicated moving his fingers				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					c	;
		00036	B. WING		04/1	1/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
PATHST	ONE LIVING		ND AVENUE			
			O, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 890	Continued From pa	ge 15	2 890			
2 090	aren't comfortable f want to hurt him so confirmed there is a care plan indicates completed 3 times p staff should comple completed they need wasn't done and what the instructions for prestorative book. During interview on director of nursing so should be done by the hand splint should is nurses are respons treatment is getting. The facility Resident Motion policy and princluded: -Residents will not extend reduction in range of -Resident with limited.	for him and some staff don't do the best they can. RN-B an order for PROM and the he should have ROM per week. RN-B confirmed the the PROM and if not ed to let the nurse know it my. RN-B was unable to locate PROM in the room or 4/10/24 at 2:25 p.m., the stated if PROM is ordered it the nursing assistants and the pe applied correctly. The ible to ensure the care and done. It Mobility and Range of rocedure dated 7/2017 Experience an avoidable				
	a further decrease i -Residents with limi appropriate services	n ROM. ted mobility will receive s, equipment and assistance				
	in mobility is unavoi - The care plan will	be developed by the				
	as needed.	essment and will be revised				
	the goals and object care will include atte	the residents progress toward tives identified in the plan of empts to address any changes idents condition or needs.				
	SUGGESTED MET	HODS OF CORRECTION:				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00036	B. WING		1	C 11/ 2024	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0-1/	11/2024	
			ND AVENUE				
PATHST	ONE LIVING	MANKATO), MN 56001				
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2 890	develop, review and procedures to ensure in range of motion in range in needs and as recondesignee could develop ensure ongoing contresults to the quality further recommends	sing (DON) or designee could don't revise policies and re all residents with limitations eceive services to maintain or otion function. Nursing staff as necessary on the ding services to residents with motion based on assessed mended. The DON or elop monitoring systems to appliance and report those y assurance committee for	2 890				
21375	Subpart 1. Infection home must establish control program destablished anitary environment. This MN Requirements by: Based on interview, review the facility factoring and analyst doffed (removed) posterior (PPE) incorrectly for to ensure PPE was transmission of bactoring and directly on the (R12, R52, R218, R218).	n control program. A nursing h and maintain an infection signed to provide a safe and nt. ent is not met as evidenced observation, and document iled to ensure the infection luded ongoing surveillance, is of resident infections, staff ersonal protective equipment r 1 of 1 resident (R16), failed stored in a manner to prevent teria when PPE was observed e floor for 18 of 18 residents R3, R20, R36, R41, R10, R27, R17, R57, R46, R21, and	21375	Corrected		5/15/24	

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		l \ /	(X3) DATE SURVEY COMPLETED	
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21375	Continued From pa	ge 17	21375				
	(EBP) and the staff floor for 1 of 1 resid	hanced barrier precautions placed a meal tray on the ent (R27). This had the Il 56 residents who resided in					
	Finding include:						
	Enhanced Barrier P	recautions					
	Precautions printed following residents Precautions (EBP)	tled Enhanced Barrier 4/10/24, indicated the had Enhanced Barrier R12, R52, R218, R3, R20, 7, R15, R16, R6, R8, R17, d R219.					
	on 4/9/24 at 8:46 a. R52, R218, R3, R20 R17, R19, R46, R2 indicated the resideresidents identified located directly insignated floor and there was plastic gowns prior	on of private resident rooms m., through 9:33 a.m., R12, 0, R36, R41, R16, R6, R8, 1, R219 room door signage ents were on EBP. The on EBP had plastic gowns de the resident's room on the not a place to dispose of the to leaving the resident's room. have PPE located near or rooms.					
	4/9/24 at 9:10 a.m., floor in the following identified by signage EBP: R15, room 3101 on the floor inside the result of the r	of private resident rooms on observed PPE directly on the rooms of residents who were e on their doors as being in a box of plastic gowns was not the floor inside the door a box of plastic gowns was in the floor inside the door the floor inside the door.					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	IDENTIFICATION NOIVIDEN.	A. BUILDING:			
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21375	Continued From pa	ge 18	21375			
	assistant (OTA)-Assign on the door and a gown and gloves care. OTA-A stated resident bathrooms donned when staff. On 4/9/24 at 8:55 at entered R17's room for staff if the gown the wall and she did the resident floors at get the gloves. Nainside resident's room on 4/9/24 at 2:35 punursing (ADON), who prevention nurse, so placed on EBP had and confirmed the fleated on EBP R12, R52, R27, R15, R16, R6 R219. The ADON stated with a match staff were expensively when providing care would expect staff to inside the resident was still trying to we location for the PPE ADON stated the best expected on the flow ould expect glove.	.m., occupational therapy stated residents on EBP had a d staff were expected to wear when providing hands on the PPE was located in the s, and confirmed PPE was entered EBP resident rooms. .m., nursing assistant (NA)-D and stated it would be easier and gloves were mounted on d not have to get the gowns off and go into the bathroom to D confirmed PPE was donned om on EBP. .m., assistant director of the is the facility infection tated residents who are signs posted on their door following residents were on 18, R3, R20, R36, R41, R10, R8, R17, R57, R46, R21, and stated residents with indwelling ounds, or those colonized by aulti-drug resistant organism cted to wear gloves, gowns, es for residents with EBP and to donn PPE immediately door. RN-A stated the facility ork through the placement and E for residents with EBP. The pox of plastic gowns was not or of resident rooms and as readily available. The ADON as were kept in residents				
	On 4/9/24 at 2:40 p	.m., during an interview the				

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUIL	ULTIPLE CONSTRUCTION LDING:	(X3) DATE SURVEY COMPLETED	
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director of nursing (DON) stated PPE including the plastic gowns in boxes should not be placed on the floor inside the private resident room. On 4/9/24 at 3:00 p.m. through 3:20 p.m., during tour with the ADON the following rooms were observed: R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. The ADON confirmed the boxes of plastic gowns were located on the floor. The ADON stated the gowns on the floor were an infection control risk. The ADON confirmed there was not a garbage or place to dispose of the plastic gowns readily available next to the door for staff to doff PPE prior to exiting resident rooms on EBP. Infection Surveillance On 4/10/24 at 1:13 p.m. during an interview with the DON and the ADON, who was identified as infection preventionist, the ADON stated he started the position in January of this year [2024]. The ADON stated he was responsible for infection surveillance and confirmed tracking of the infections was not currently taking place, and was not aware when the last infection surveillance, tracking, and trending of the data. The DON stated discussions were held at daily meetings of residents who were showing signs of infection and on antibiotics. The DON also explained the facility used electronic communication among staff for possible infection concerns and information. The DON confirmed ongoing surveillance had not been completed with incidence of infections determined or analyzed, and the infection control program had room for improvement. The ADON verified infection			

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MANKATO, NN 56001 PREFIX (EACH DEFICIENCY MOST EN PRECEDED BY FULL TAGE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAGE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGE REGULATORY OR LSC IDENTIFYING INFORMATION) TAGE CROSS-REFERENCED TO THE APPROPRIATE CHARLES THE REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAGE CROSS-REFERENCED TO THE APPROPRIATE CHARLES THE REGULATORY OR LSC IDENTIFYING INFORMATION) 21375 Continued From page 20 prevention was done on an informal basis and stated daily during staff meeting he discussed residents on antibiotics with facility staff; however, residents were not tracked or compared for trending's or patterns and the facility was not currently tracking the infection data. The ADON verified a monthly analysis of the illnesses and infections were important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. Meal Tray on floor During an observation on 4/8/24 at 5:48 p.m., NA-C was observed setting a meal tray on the floor since the floor outside R27's room who was in EBP. in order to don (put on) PPE prior to entering the room. During an interview on 4/8/24 at 5:56 p.m., NA-C stated she did not consider it an infection control breach to set a meal tray on the floor since the food and beverages were covered and she wiped off the bottom of the meal tray before setting it on R27's overbed table. Doffing During an observation on 4/10/24 at 6:35 a.m., observed signage on R16's door indicating he was in transmission-based precautions for Covid-19. A progress note indicated he had tested positive for Covid-19 late in the afternoon on 4/9/24. An isolation cart/organizer was observed outside R16's room. Signage on door indicated: 1. 7 - 14 DAY QUARANTINE - start date 4/9/24					STATE, ZIP CODE		
PREFIX TAG RESOLATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG Continued From page 20 prevention was done on an informal basis and stated daily during staff meeting he discussed residents on antibiotics with facility staff, however, residents on antibiotics with facility staff, however, residents were not tracked or compared for trending's or patterns and the facility was not currently tracking the infection data. The ADON verified a monthly analysis of the illnesses and infections were important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. Meal Tray on floor During an observation on 4/8/24 at 5:48 p.m., NA-C was observed setting a meal tray on the floor outside R27's room who was in EBP, in order to don (put on) PPE prior to entering the room. During an interview on 4/8/24 at 5:56 p.m., NA-C stated she did not consider it an infection control breach to set a meal tray on the floor since the food and beverages were covered and she wiped off the bottom of the meal tray before setting it on R27's overhed table. Doffing During an observation on 4/10/24 at 6:35 a.m., observed signage on R16's door indicating he was in transmission-based precautions for Covid-19. A progress note indicated he had tested positive for Covid-19 late in the afternoon on 4/8/24. An isolation cart/organizer was observed outside R16's room. Signage on door indicated: 1. 7 - 14 DAY QUARANTINE - start date 4/9/24	PAIIISI	ONL LIVING	MANKATO), MN 56001			
prevention was done on an informal basis and stated daily during staff meeting he discussed residents on antibiotics with facility staff; however, residents were not tracked or compared for trending's or patterns and the facility was not currently tracking the infection data. The ADON verified a monthly analysis of the illnesses and infections were important to rule out any trending or patterns, and interventions could be initiated to help prevent illness or infections including staff education and system process review. Meal Tray on floor During an observation on 4/8/24 at 5:48 p.m., NA-C was observed setting a meal tray on the floor outside R27's room who was in EBP, in order to don (put on) PPE prior to entering the room. During an interview on 4/8/24 at 5:56 p.m., NA-C stated she did not consider it an infection control breach to set a meal tray on the floor since the food and beverages were covered and she wiped off the bottom of the meal tray before setting it on R27's overbed table. Doffing During an observation on 4/10/24 at 6:35 a.m., observed signage on R16's door indicating he was in transmission-based precautions for Covid-19. A progress note indicated he had tested positive for Covid-19 late in the afternoon on 4/9/24. An isolation cart/organizer was observed outside R16's room. Signage on door indicated: 1. 7 - 14 DAY QUARANTINE - start date 4/9/24	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
2. Droplet Precautions: N95 Mask, Face Shield,	21375	prevention was don stated daily during a residents on antibior residents were not a trending's or pattern currently tracking the verified a monthly a infections were imporpatterns, and interested prevent illness education and system. Meal Tray on floor During an observation NA-C was observed floor outside R27's order to don (put or room. During an interview stated she did not observed signage of the bottom of the R27's overbed table. Doffing During an observation observed signage of was in transmission Covid-19. A progress tested positive for Con 4/9/24. An isolation observed outside R indicated: 1. 7 - 14 DAY QUA through 4/19/24.	e on an informal basis and staff meeting he discussed dices with facility staff; however, tracked or compared for an and the facility was not be infection data. The ADON analysis of the illnesses and ortant to rule out any trending erventions could be initiated to or infections including staff em process review. Ion on 4/8/24 at 5:48 p.m., and setting a meal tray on the room who was in EBP, in any PPE prior to entering the entering the setting and she wiped and tray on the floor since the set were covered and she wiped at tray on the floor setting it on the entering the				

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21375	Continued From pa	ge 21	21375			
	direct care: doff leaving the room. Do 3. CDC Enhance Bar 4. Donning sign 5. Doffing sign which gloves and gown in exiting and to remove (N-95 mask) after extended to be a compared to the compared to t	on and interview on 4/10/24 at RN-G exit R16's room with				
	sign on the door, No after exiting the roo the doffing sign on to remove all PPE in re exiting the room. RI	red. According to the doffing 95 mask should be doffed m. Together with RN-G, read the door which indicated to com (except N95), before N-G stated she hadn't done offing] for a while and forgot				
	7:40 a.m., observed full PPE on. NA-B so outside the door - g shield, setting it all on NA-B then picked unacross the hall to the stated she did not he	on and interview on 4/10/24 at NA-B exit R16's room with tood and doffed the PPE loves, gown, mask and face on the floor outside the room. In the PPE and carried it e dirty utility room. NA-B ave donning and doffing ted she didn't see the sign on the ng.				
	ADON who was also stated for transmiss Covid-19, staff were residents room excertised as the room. The ADO	on 4/10/24 at 2:50 p.m., o the infection preventionist sion-based precautions for e to doff all PPE inside the ept for the N-95 mask and should be doffed after exiting N stated staff should have offing training upon hire. The				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) Odd B. WING B. WING B. WING PREFIX (EACH CORECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		· /	(X3) DATE SURVEY COMPLETED	
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	21375 Continued From pa	ued From page 22	21375			
ADON acknowledged staff had not followed proper procedure for doffing. In addition, the ADON was informed of observation of NA-C setting R27's meal tray on the floor outside his room while she donned PPE. The ADON stated a meal tray should never be set on the floor and acknowledged there were no surfaces for staff to set items on as they donned/doffed PPE to enter/exit the rooms of residents in EBP. Documentation of donning and doffing education for RN-G and NA-B was provided by the ADON and indicated RN-G had received education with competency on 3/8/24, and NA-B had received donning and doffing education with competency on 3/8/24, and NA-B had received donning and doffing education with competency on 3/22/24. The facility Enhanced Barrier Precautions policy dated 8/22, indicated: Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug organisms (MDROs) to residents. 1. Enhanced barrier precautions (EBPs) are used as infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. 2. EBPs employ target gown and glove use during high contact resident care activities when contact precautions do not otherwise apply, a. Gloves and gown are applied prior to performing the high contact resident care activities when contact precautions do not otherwise apply, a. Gloves and gown are applied prior to performing the high contact resident care activities when contact precautions do not otherwise apply, a. Gloves and gown are applied prior to performing the high contact resident care activities when contact precautions on on otherwise apply, a. Gloves and gown are applied prior to performing the high contact resident care activities requiring the use of gown and gloves for EBPs include:	ADON acknowledg proper procedure for ADON was informed setting R27's meal room while she dorn meal tray should not acknowledged them set items on as the enter/exit the rooms. Documentation of confor RN-G and NA-E and indicated RN-G competency on 3/8 donning and doffing on 3/22/24. The facility Enhance dated 8/22, indicated Enhanced barrier propered to prevent the spread organisms (MDROs) to reside 1. Enhanced barrier as infection prevent reduce the spread organisms (MDROs) 2. EBPs employ tare during high contact contact precautions a. Gloves and great growth of the spread of the spread organisms to the spread of the spread organisms of the spread of	acknowledged staff had not followed procedure for doffing. In addition, the was informed of observation of NA-C R27's meal tray on the floor outside his while she donned PPE. The ADON stated a ray should never be set on the floor and wledged there were no surfaces for staff to ms on as they donned/doffed PPE to exit the rooms of residents in EBP. Inentation of donning and doffing education and NA-B was provided by the ADON dicated RN-G had received education with tency on 3/8/24, and NA-B had received g and doffing education with competency 2/24. Cility Enhanced Barrier Precautions policy 3/22, indicated: ced barrier precautions (EBPs) are utilized tent the spread of multi-drug organisms Ds) to residents. annced barrier precautions (EBPs) are used the spread of multi-drug resistant sms (MDROs) to residents. Is employ target gown and glove use high contact resident care activities when the precautions do not otherwise apply. Gloves and gown are applied prior to ming the high contact resident care activity posed to before entering the room). Personal protective equipment (PPE) is end before caring for another resident. Face protection may be used if there is risk of splash or spray. Imples of high contact resident care serequiring the use of gown and gloves for the spread of high contact resident care activity of the splash or spray.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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21375 Continued From p	age 23	21375			
g. device care catheter, feeding to etc.) h. wound care dressing. 9. staff are trained EBPs 11. PPE is availab rooms.	giene				
9/17, indicated: That infection previous surveillance for he (HAIs) and other e infections that have potential resident e transmission base preventative interval. The purpose of to identify both indepidemiologically shealth care associappropriate interveinfections. 2. The criteria for sthe current standards. Infections that we surveillance includes a evidence healthcare environ b. available prevent or reduce	rentionist will conduct ongoing althcare associated infections pidemiologically significant e substantial impact on outcome and that may require d precautions and other entions. this surveillance of infections is ividual cases and trends of significant organisms and ated infections to guide entions and to prevent future such infections are based on red definitions of infections. Vill be included in routine e those with:				

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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	1 ` ′	E CONSTRUCTION	COMPLETED	
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21375 Continued From pa	age 24	21375			
C. difficile; d. Pathogens outbreaks 4. Infections that m surveillance include transmissibility and and/or limited prevents of the following and interinfection control contro	ray be considered in the those with limited the alth care environment tention strategies ance Data tentionist are designated the sonnel is responsible for preting surveillance data. The immittee and or QAPI involved in interpretation of the include a review of any or information to help identify of infection: records the ets control rounds or interviews the form staff infection ords are logs records to identify relevant towing findings merit further tood cultures that do not just colonization in e cultures with corresponding that suggest infection utum culture ive cultures to Group A				
streptococcus 4. In addition to col	lecting data on the incidence rveillance system is designed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY	
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	NAME OF PROVIDER OR SUPPLIER 718 MO PATHSTONE LIVING MANKA			STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21375	data that may influe surveillance data is surveillance data m with high risk for infrecent hospital stay Data Collection and 1. For residents with criteria for definition collect the following identifying informati date of onset of inferpathogens invasive pertinent remarks, to precautions. Calculating infection Interpreting Surveill 1. Analyze the data Infection prevent confortable environd development and tradiseases and infect 11. Prevention of In 3. educating standhere to proper terms SUGGESTED MET DON (director of nure-educate staff on practices in general precautions (TBP) apprecautions (EBP) for tracking, analysis, exprevent the spread	pidemiologically important ence how the overall interpreted for example focus any be gathered for residents fection or those with their I Recording h infections that meet the of infection for surveillance data as appropriate: on, diagnosis, admission date ection, infection site, procedures are risk factors, treatment measures and are to identify trends are to identify trends are restablished ontrol program is established or ovide safe sanitary and ment to help prevent the eansmission of communicable ions.	21375			

Minnesota Department of Health

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			D 14/1510		С		
		00036	B. WING		04/1	1/2024	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
PATHST	ONE LIVING		ND AVENUE D, MN 5600 ²				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21375	Continued From pa	ge 26	21375				
	be taken to the Qua Performance Impro	d results of those audits could ality Assurance and vement (QAPI) committee to ace and need for further					
	Time Period for Cordays.	rection: Twenty-one (21)					
21455	MN Rule 4658.0900 Recreation Progran	Subp. 5 Activity and n;Space/Equip	21455			5/15/24	
	activity and recreat with space both with out-of-doors. Appro	juipment, and materials. The ion program must be provided hin the nursing home and opriate and adequate erials must be provided to the activity and recreation					
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure individualized ided for 1 of 1 resident (R29) es.		Corrected			
	Findings include:						
	3/11/24, indicated R 3/5/24, had moderal dependent on staff required substantial shower/bathe and or with eating and oral important to do his the news, participat	nimum Data Set (MDS) dated 29 was admitted to the facility tely intact cognition, for toileting and transfers, l/maximal assistance with tressing, required supervision hygiene, identified it was very favorite activities, keep up with the in religious services, and go air, and somewhat important					

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING		1	C 11/2024
	PROVIDER OR SUPPLIER	718 MOU	DRESS, CITY, S ND AVENUE O, MN 56001	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21455	things with groups of included pneumonial mild cognitive impared R29's care plan dated R29's activities, into activities. R29's baseline care coordinator (AC)-A independently choosin-room and schedus sporting events, reaplaying cards, lister activities to attend to Activities to attend to Activities to attend to participate wish to participate wish to participate wish to participate wish to participate independent activities to facility, enjoyed possible (sheep's head and watched TV in room wife visits daily, assigned resident to to the On 4/8/24 at 7:15 possible resident to the On 4/	terial, listen to music, and do of people and diagnoses a, urinary tract infection, and irment, . ded 3/5/24, did not include erests or interventions related erests or interventions related explain dated 3/5/24, activities indicated R29 will use activity of choice with both alled events, enjoys watching ads the daily newspapers, hing to music, may decline herapy sessions and rest. ew document dated 3/11/24, and to participate in activities, e in group activities, does not in 1:1 with staff, and liked es, expressed interest in as tolerated once acclimated playing cards in the past buck euchre), independently in, especially sporting events, sistance should be provided to	21455	DEFICIENCY)		
	he could not recall a the facility, but expr participate in activity enjoyed playing car	to attend activities and stated any activities attended while at essed he would like ies, if offered. R29 stated he d games and listening to I she was at the facility most				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		00000	B. WING		C
		00036	D. WING		04/11/2024
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
PATHST	ONE LIVING		ND AVENUE O, MN 56001		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON (X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
21455	Continued From pa	ge 28	21455		
	observed staff offer stated staff have of	day, and stated she had not R29 any activities. FM-H fered him to take naps.			
	wheelchair in his rock R29 stated his active anything with game would attend activities something. FM-H stone time that she was posted	m., R29 was seated in a om and FM-H was present. vities of choice would include s, cards, music, and stated he les if the facility had tated R29 had gone to church vas aware of. A activity d in R29's room and R29 een offered to attend the			

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING			C I 1/2024
	PROVIDER OR SUPPLIER	718 MOUN	DRESS, CITY, S ND AVENUE D, MN 56001	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21455	Continued From pa	ge 29	21455			
	not offered R29 to p was not sure if other activities. AC-B state care and AC-A com- activities for short to On 4/9/24 at 9:30 at responsible to ensu- in activities and she	m., AC-A stated she was re that residents participated was expected R29 was sed off his interest and				
	stated nursing assist offering residents the calendar in the room were expected to off activities based on	p.m., nursing assistant (NA)-F stants were responsible for ne activities posted on the n and the activity coordinators fer the resident specific their interests. NA-F stated 9 activities on the calendar nt to participate.				
	(DON) stated resident offered activities batto each resident and staff were expected.	p.m., the director of nursing ents were expected to be sed of interests and specific d the DON confirmed activities to offer R29 activities based and activity assessment.				
	indicated: 1. The activities protein the well-being of resindependence and 2. Activities offered comprehensive resident the preferences 3. The activities protein the preferences of the activities protein the preferences of the activities protein the activities activities protein the activities protein the activities activities protein the activities activities protein the activities	dent-centered assessment				

Minnesota Department of Health

AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMPLETED	
	00036	B. WING		C 04/1 1	1/2024
NAME OF PROVIDER OR SUPPLIER	STREET ADI	ORESS CITY S	TATE, ZIP CODE		
NAME OF TROVIDER OR SOFT LIER			TATE, ZII CODE		
PATHSTONE LIVING		ND AVENUE D, 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 SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETE DATE
21455 Continued From page	e 30	21455			
individual activities ar activities. 4. "Activities" are con than routine ADL's in participates, that is in her sense of well-being enhance physical, construction of the physical, construction of the physical of the physi	assisted individual assidered any endeavor, other which the resident atended to enhance his oring and to promote orignitive or emotional health. The are designed to an individual participation and elindividual resident's needs. It duled seven days a week en an opportunity to an ing preparation, and critique of the accumented in the resident's are dedules, choices and rights of thours convenient to the evenings, holidays and aural and religious interests, ances, and personal residents; mily, visitor and resident appropriate activities HOD OF CORRECTION: The or of nursing, activities could engage the allow (IDT) to ensure residents in ded meaningful activities to and include activities on ands. Activities selected entered. The administrator or advice from resident council				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00036	B. WING		1	C I1/2024
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 0 17	
	ONE LIVING		ND AVENUE			
РАГПОТ	JNE LIVING	MANKATO	D, MN 5600	1		,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21455	Continued From pa	ge 31	21455			
	those audits should	the facility. The results of be taken to QAPI to ce or the need for continued				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
21685	MN Rule 4658.1415 Housekeeping, Ope	Subp. 2 Plant eration, & Maintenance	21685			5/15/24
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure individualized ded for 1 of 1 resident (R29) es.		Corrected		
	Findings include:					
	3/11/24, indicated R 3/5/24, had moderal dependent on staff required substantial shower/bathe and or with eating and oral important to do his the news, participat	nimum Data Set (MDS) dated 29 was admitted to the facility tely intact cognition, for toileting and transfers, //maximal assistance with lressing, required supervision hygiene, identified it was very favorite activities, keep up with e in religious services, and go air, and somewhat important				

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING			C 11/2024
	PROVIDER OR SUPPLIER	718 MOU	DRESS, CITY, STAND AVENUE O, MN 56001	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21685	things with groups of included pneumonial mild cognitive impared R29's care plan dated R29's activities, into activities. R29's baseline care coordinator (AC)-A independently choosin-room and schedus sporting events, reaplaying cards, lister activities to attend to Activities to attend to Activities to attend to Participate wish to participate wish to participate independent activities to facility, enjoyed possible to facility and the facility and the facility attended to fa	terial, listen to music, and do of people and diagnoses a, urinary tract infection, and irment, . ed 3/5/24, did not include erests or interventions related erests or interventions related explan dated 3/5/24, activities indicated R29 will se activity of choice with both uled events, enjoys watching ads the daily newspapers, hing to music, may decline herapy sessions and rest. ew document dated 3/11/24, ed to participate in activities, e in group activities, does not in 1:1 with staff, and liked es, expressed interest in as tolerated once acclimated playing cards in the past buck euchre), independently in, especially sporting events, sistance should be provided to	21685	DEFICIENCY)		
	family member (FM interviewed about was off recall being offered he could not recall a the facility, but expression participate in activitienjoyed playing care	hat, if any, activities he ered. R29 stated he could not to attend activities and stated any activities attended while at essed he would like ies, if offered. R29 stated he d games and listening to I she was at the facility most				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING			C 11/2024
	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	•	
PAINSI	ONE LIVING	MANKATO	D, MN 56001			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPORT DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21685	Continued From pa	ae 33	21685			
	days and stayed all observed staff offer	day, and stated she had not R29 any activities. FM-H fered him to take naps.				
	wheelchair in his room R29 stated his active anything with game would attend activities something. FM-H stone time that she would alendar was posted	m., R29 was seated in a om and FM-H was present. ities of choice would include s, cards, music, and stated he es if the facility had tated R29 had gone to church as aware of. A activity d in R29's room and R29 een offered to attend the				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00036	B. WING			C I 1/2024
	PROVIDER OR SUPPLIER	718 MOUN	DRESS, CITY, S ND AVENUE D, MN 56001	STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
21685	Continued From pa	ge 34	21685			
	not offered R29 to p was not sure if other activities. AC-B state care and AC-A com- activities for short to On 4/9/24 at 9:30 at responsible to ensu- in activities and she	m., AC-A stated she was re that residents participated was expected R29 was sed off his interest and				
	stated nursing assist offering residents the calendar in the room were expected to off activities based on	p.m., nursing assistant (NA)-F stants were responsible for ne activities posted on the n and the activity coordinators fer the resident specific their interests. NA-F stated 9 activities on the calendar nt to participate.				
	(DON) stated resident offered activities batto each resident and staff were expected.	p.m., the director of nursing ents were expected to be sed of interests and specific d the DON confirmed activities to offer R29 activities based and activity assessment.				
	indicated: 1. The activities protein the well-being of resindependence and 2. Activities offered comprehensive resident the preferences 3. The activities protein the preferences of the activities protein the preferences of the activities protein the activities activities protein the activities protein the activities activities protein the activities activities protein the activities	dent-centered assessment				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00036	B. WING		C 04/11/2024	
NAME OF PROVIDER OR SUPPL		DRESS, CITY, S	STATE, ZIP CODE		
PATHSTONE LIVING	MANKAT	O, MN 56001			
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE	
activities. 4. "Activities" are than routine AD participates, that her sense of we enhance physics. 5. Our activity percourage max are geared towards are geared towards. 6. Activities are and residents a contribute to the conducting, clear programs. 9. All activities are medical record 12. Individualized provided that: a. reflect the the residents b. are offered residents, includive weekends; c. reflect the hobbies, life experiences of the preferences of the preferences of the conducting are the preferences of the conductions.	es and assisted individual considered any endeavor, other s's in which the resident tis intended to enhance his or al, being and to promote or al, cognitive or emotional health. ograms are designed to mum individual participation and rd the individual resident's needs. scheduled seven days a week e given an opportunity to planning preparation, n up and critique of the re documented in the resident's d and group activities are e schedules, choices and rights of d at hours convenient to the ing evenings, holidays and cultural and religious interests, eriences, and personal neir residents;		DEFICIENCY		
•	te family, visitor and resident ired appropriate activities				
The administrate designee could develop a clean debris, and kitch safe, clean, envious designee could the program, and and appropriate the program, and administrate designee could the program, and administrate designee could appropriate the program and administrate designees and administrate designees and administrate designees are administrated and administrate designees and administrated appropriate and administrated and	IETHOD OF CORRECTION: or, maintenance director or work with the dietary manager to ng schedule to ensure dust, enettes are cleaned to maintain a ronment. The administrator or educate all appropriate staff on d could develop monitoring re ongoing compliance.				

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STATE FORM YJLJ11 If continuation sheet 36 of 36