Protecting, Maintaining and Improving the Health of All Minnesotans

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

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

Protecting, Maintaining and Improving the Health of All Minnesotans

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/8/24-4/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/8/24-4/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was IN NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H53902668C (MN00099237) H53902743C (MN00091448) H53902744C (MN00097558) H53902745C (MN00098060) H53902746C (MN00099410) H53907949C (MN00087616) The following complaint was reviewed and in compliance, however a related deficiency was cited. H53903054C (MN00102383) with a deficiency cited at (F609) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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

Electronically 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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified	F 609		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 2 appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an allegation of misappropriation of property was reported to the state agency (SA) within 24 hours, in accordance with established policies and procedures, for 1 of 1 resident (R1) reviewed for allegation of money theft. Findings include: R1's facesheet printed on 4/11/24, included diagnoses of macular degeneration (an eye disease that causes vision loss) and cognitive communication deficit. R1's quarterly Minimum Data Set (MDS) dated 3/27/24, indicated R1 was cognitively intact, had adequate vision and hearing, clear speech, was understood and able to understand. R1 was independent with most activities of daily living. R1's care plan initiated on 8/18/23, indicated R1 had a behavior problem of paranoia related to dementia and would have fewer episodes of paranoia. During an interview on 4/8/24 at 1:20 p.m., R1 stated he had cash stolen from his room a couple weeks ago, approximately $70 in a pouch. R1 stated the facility was aware of the missing cash and a police officer had talked to him about it over the phone. According to R1, as of today (4/8/24), the money had not been found. A progress note dated 3/12/24 at 11:11 a.m., indicated R1 reported to staff money had been	F 609	In continuing compliance with F609, Reporting of Alleged Violations, Ecumen Pathstone Living corrected the deficiency by educating R1 and their family about storing valuables in a locked drawer provided in the room. R1's care plan and care sheet were updated to reflect this practice. Staff are instructed to document and notify the administrator and/or designee if R1 and/or their family refuse to use the provided lock box as directed. A Vulnerable Adult report was filed for R1 by the facility on 4/10/24, and it was confirmed and documented that R1 had identified and found the alleged missing items on 4/4/24. To correct the deficiency and to ensure the problem does not recur, CNAs and nurses were educated on the missing items policy, the Vulnerable Adult Reporting Process and documentation of grievances and incidents on 5/13-5/14/24 by the IDON and/or designee. Grievance forms and incident reports will be reviewed during daily IDT stand-up meetings to determine the next steps and whether there is a need for escalation to state officials. The IDON and/or designee will complete audits of grievance forms and incident reports weekly for four weeks and bi-weekly for an additional two weeks to ensure that all alleged violations are reported according to standards. This	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 3 stolen from his room. The note indicated R1 informed staff all his dollars and change were taken but was unsure of the exact amount. Writer reported this to nurse manager and social worker. A progress note dated 3/14/24 at 10:23 a.m., indicated SW (social worker) contacted the local police department to report R1's allegation of missing cash. A grievance report hand-written by LSW-A and dated 3/12/24, indicated the following: R1 was missing money - a purse and money clip. It happened over the course of about a week; three different times. R1 had not suspected a specific person or time when it may have occurred. R1 was interviewed and also FM-A to verify the objects existed and validity of the report. R1's room was searched and did not find a purse or money clip. The first time it occurred, the $20's and $10's went missing and two dollars were folded and put in the money clip. The second time, the five-dollar bills were gone and the last time, the change was gone. Each happened about two days a part. Filed a police report with R1 speaking on the phone. Police filed a MAARC report. R1 had a functioning key and lock in which to put his belongings. During an interview on 4/9/24 at 2:32 p.m., licensed social worker (LSW)-A stated she was aware of R1's allegation of missing cash and when informed of it, searched R1's room and had not found it. LSW-A stated law enforcement had been notified and a police report filed. LSW-A stated a report had not been filed with the SA because law enforcement informed her they would file a MAARC (Minnesota Adult Abuse Reporting Center) report. According to LSW-A,	F 609	comprehensive approach aims to maintain compliance with F609 and prevent the recurrence of similar deficiencies, ensuring a safe and secure environment for all residents.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 4 on 4/4/24, at care conference, R1 reported he found the cash in his underwear drawer. LSW-A stated R1's family member (FM)-A brought the pouch of cash to the care conference that day and then took the pouch home. LSW-A stated they had questioned whether the cash was ever really missing since R1 tended to fabricate stories. During an interview on 4/11/24 at 1:45 p.m., regional nurse consultant (RNC)-B stated LSW-A had informed her of the allegation, including not reporting it to the SA. RNC-B stated she would have expected the missing money to be reported to SA within the required time frame indicated in the facility policy. The facility Investigating Incident of Theft and/or Misappropriation of Resident Property with revised date of April 2021, indicated all reports of exploitation, theft or misappropriation of resident property were promptly and thoroughly investigated. Residents had the right to be free from exploitation, theft and/or misappropriation of personal property. If an alleged or suspected case of theft, exploitation or misappropriation of resident property was reported, the administrator or his/her designee notified the following persons or agencies within 24 hours of such incident as appropriate: state licensing and certification agency, ombudsman, resident representative, adult protective services, law enforcement.	F 609		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 2 of 2 resident (R52, R21) reviewed for hospice and pressure ulcers. Findings include: R52's Face Sheet indicated admission date was 2/7/24, and diagnoses of malignant neoplasm (uncontrolled growth and division of abnormal 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.	F 641	R52 MDS was modified to reflect Hospice status. R 21 MDS was unlocked and corrected prior to export to reflect that resident has pressure ulcers. Audit all current residents on hospice status to ensure MDS is coded correctly. Audit all residents who currently have wounds to ensure MDS is coded correctly. Remind and educate MDS team members re: skin assessments must match MDS skin condition coding, resident's Hospice status must match on the MDS that resident is receiving hospice care. Audit 10% of each MDS submitted to ensure accurate coding for hospice and wound care weekly x4 and bi-weekly x2. Results reviewed at QAPI to determine further auditing needs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 6 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 tissue injury was also answered no. PU or injury care included application of ointments/medications other than to feet. R21's Skin Assessment dated 4/4/24, indicated small open shallow area on left buttock, and pressure ulcer on left heel measuring 2 cm x 3 cm, closed with peeling edges. During interview on 4/11/24 at 12:13 p.m., RN-B, also identified as MDS coordinator, confirmed the quarterly MDS was incorrect as R21 does have pressure ulcer present and injury cares and treatment. RN-B confirmed she would not have looked at the MDS again and would have submitted it incorrectly. During interview on 4/10/24 at 2:37 p.m., the director of nursing stated the MDS should have been completed accurately. The facility MDS Assessment Coordinator policy and procedure dated 11/2019, included an RN shall be responsible for conducting and coordinating the development and completion of the resident assessment. Each individual who completes a portion of the assessment must	F 641		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 7 certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed.	F 641		
F 655 SS=D	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 (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the	F 655		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 8 resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer/provide a summary of the baseline care plan to the resident and/or resident representative for 3 of 3 residents (R29, R57, R112) reviewed who were newly admitted. Findings include: R112's Admission Record identified an admission date of 3/22/24, with diagnoses of displaced fracture of head of right radius (bone of forearm) and fracture (break) around internal prosthetic right hip joint (hip replacement). R112's admission Minimum Data Set (MDS) dated 3/28/24, identified R112 as having a brief interview for mental status (BIMS) score of 15 indicating the resident was cognitively intact. R112's activities of daily living MDS section was not completed. R112's baseline care plan indicated R112 required staff will assist with dressing grooming with extensive to limited assistance as R112 is non weight bearing on right leg. Comments included use pivot disc and assist of two from	F 655	In continuing compliance with F655, Baseline Care Plans, Ecumen Pathstone Living corrected the deficiency by completing ADL MDS section for R112 and provided a copy of baseline care plan to R112, R29 and R57. Baseline care plans were provided to short term care residents 4/11/2024. A completed Baseline Care Plan was provided to all current residents as of 4/22/2024. To correct the deficiency and to ensure the problem does not recur all staff were educated on 4/22/24 on baseline care plan policy and expectations by IDON. Nursing, social worker, dietary, and activities will have their portion of the baseline care plan completed with 48 hours of admission. At that time, the nurse manager will provide a copy of the baseline care plan to the resident. The DON and/or designee will audit all new admissions, weekly x4 weeks, then bi-weekly x2, to ensure baseline care plans have been completed and a copy presented to resident and/or resident	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 9 wheelchair to bed or recliner. When interviewed on 4/8/24 at 4:15 p.m., R112 stated she never received a copy of her plan of care and would like to have one. During interview on 4/9/24 at 2:55 p.m., R112 indicated she did have a care conference and some things about her care were discussed but was never was offered or received a copy of her plan of care. When interviewed on 4/10/24, at 12:41 p.m., social worker (SW)-A indicated they bring a copy of the care plan with to the care conference and pass it around, but do not give a copy to the resident or family member. SW-A stated "We only give copies if one is requested." When interviewed 4/10/24 at 2:39 p.m., the director of nursing (DON) confirmed a copy of the baseline care plan was not being offered to the resident or a family member. R29's admission MDS dated 3/11/24, indicated R29 was admitted to the facility 3/5/24, had moderately intact cognition, dependent on staff for toileting and transfers, required substantial/maximal assistance with shower/bathe and dressing, required supervision with eating and oral hygiene, and diagnoses included pneumonia, urinary tract infection, and mild cognitive impairment . R29's baseline care plan indicated effective date of 3/5/24. On 4/11/24 at 12:30 p.m., during a interview family member (FM)-H stated she did not recall	F 655	representative 48 hours after admission. As part of Ecumen Pathstone Living's ongoing commitment to quality assurance, the IDON and/or designee will report identified concerns through the community's QA Process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 10 the facility providing a copy of the baseline care plan. R57's admission MDS dated 3/21/24, indicated R57 was admitted the facility 3/14/24, had severe cognitive impairment, required supervision with personal hygiene, sit to stand, chair transfer, and walking and diagnoses included aphasia (ability to understand or express speech), hemiplegia following cerebral infract (paralysis of partial or total body function on one side of the body after a stroke) affecting right side, tobacco use, muscle weakness, anxiety disorder, depression, and diabetes. R57's baseline care plan indicated effective date of 3/14/24. On 4/11/24 at 9:49 a.m., registered nurse (RN)-C, known as the regional nurse coordinator, stated it was not current facility practice to provide the resident or resident representative a copy of the baseline care plan. The facility Care Plans-Baseline policy and procedure dated 3/2022, included: - A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within 48 hours of admission. - The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes but is not limited to the following: - The stated goals and objectives of the resident; -A summary of the resident's medications and dietary instructions; -Any services and treatments to be	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 11 administered by the facility and personnel acting on behalf of the facility; -Any updated information based on the details of the comprehensive care plan, as necessary. -Provision of the summary to the resident and or resident representative is documented in the medical record.	F 655		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 1 resident (R29) reviewed for activities. Findings include: R29's admission Minimum Data Set (MDS) dated 3/11/24, indicated R29 was admitted to the facility 3/5/24, had moderately intact cognition, dependent on staff for toileting and transfers, required substantial/maximal assistance with shower/bathe and dressing, required supervision with eating and oral hygiene, identified it was very	F 679	In continuing compliance with F679, Ecumen Pathstone Living corrected the deficiency by updating Resident 29's (R29) care plan to include R29's activities, interests, and interventions related to activities. R29's care plan was updated to include daily invites and orientation to activities offered each day, including invites when R29 has family and/or visitors present. R29's eMAR and point of care tasks were updated to include documentation of invites to activities and documentation of refusals. R29's activity preferences will be reviewed and updated	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 12 important to do his favorite activities, keep up with the news, participate in religious services, and go outside to get fresh air, and somewhat important to have reading material, listen to music, and do things with groups of people and diagnoses included pneumonia, urinary tract infection, and mild cognitive impairment, . R29's care plan dated 3/5/24, did not include R29's activities, interests or interventions related to activities. R29's baseline care plan dated 3/5/24, activities coordinator (AC)-A indicated R29 will independently choose activity of choice with both in-room and scheduled events, enjoys watching sporting events, reads the daily newspapers, playing cards, listening to music, may decline activities to attend therapy sessions and rest. Activities/Initial review document dated 3/11/24, indicated R29 wished to participate in activities, wished to participate in group activities, does not wish to participate in 1:1 with staff, and liked independent activities, expressed interest in attending activities as tolerated once acclimated to facility, enjoyed playing cards in the past (sheep's head and buck euchre), independently watched TV in room, especially sporting events, wife visits daily, assistance should be provided to get resident to to the activity. On 4/8/24 at 7:15 p.m., R29 was observed in his room seated in a wheelchair, television on, and family member (FM)-H present. R29 was interviewed about what, if any, activities he attended or was offered . R29 stated he could not recall being offered to attend activities and stated he could not recall any activities attended while at	F 679	at quarterly care conferences and upon R29's request. To correct the deficiency and ensure the problem does not recur, mandatory staff education on Activity Programs and associated staff expectations for CNAs and nurses was completed on 5/13-5/14/2024. Mandatory education for the Activity Director was completed by the Community Life Director on 4/19/2024, and mandatory education for the entire Life Enrichment team regarding Activity Program expectations and policy was completed on 5/8/2024. Staff who did not attend will be required to review the education materials. The Life Enrichment Supervisor will complete comprehensive care plans. Life enrichment staff and/or designee will attend quarterly resident council meetings per council request to gather feedback from residents in attendance. The Community Life Director and/or designee will complete audits for individualized care plans, once weekly for 4 weeks, then bi-weekly for 2 weeks. The Community Life Director and/or designee will ensure that residents who have been in the facility for more than 20 days have an individualized comprehensive care plan. Audits will also be completed to ensure residents are invited to activities, once weekly for 4 weeks, then bi-weekly for 2 weeks. As part of Ecumen Pathstone Living's ongoing commitment	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 13 the facility, but expressed he would like participate in activities, if offered. R29 stated he enjoyed playing card games and listening to music. FM-H stated she was at the facility most days and stayed all day, and stated she had not observed staff offer R29 any activities. FM-H stated staff have offered him to take naps. On 4/9/24 at 9:52 a.m., R29 was seated in a wheelchair in his room and FM-H was present. R29 stated his activities of choice would include anything with games, cards, music, and stated he would attend activities if the facility had something. FM-H stated R29 had gone to church one time that she was aware of. A activity calendar was posted in R29's room and R29 stated he had not been offered to attend the activities listed. On 4/9/24 at 7:49 a.m., the AC-A stated she completed R29's admission activities interests and activities preferences to find out what activities R29 enjoyed. AC-C stated the assessment is used for the activity coordinators to offer those activities to residents. AC-A stated the activity assessment indicated R29 loved playing card games, interested in sports and stated the assessment indicated once he was acclimated to the facility he would participate in more activities. AC-C stated activity staff were expected to offer R29 activities based of the assessment which would include cards and music. AC-C stated she wondered if staff assumed since he had company he would not want to participate in activities and stated staff were not expected to ask a resident if they wanted to participate in an activity when company was present in the room. AC-C stated if the wife was always present would expect activities staff	F 679	to quality assurance, the IDON and/or designee will report identified concerns through the community's QA process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 14 to ask resident to participate and would expect staff to ask resident to play cards based of his interest. AC-C stated in the medical record she was not able to find documentation R29 had participated in activities at the facility. On 4/9/24 at 9:00 a.m., AC-B confirmed she had not offered R29 to participate in any activities and was not sure if other staff had offered R29 activities. AC-B stated R29 was on short term care and AC-A completed the intakes and activities for short term care residents. On 4/9/24 at 9:30 a.m., AC-A stated she was responsible to ensure that residents participated in activities and she was expected R29 was offered activities based off his interest and admission intake information. On 4/9/24 at 12:24 p.m., nursing assistant (NA)-F stated nursing assistants were responsible for offering residents the activities posted on the calendar in the room and the activity coordinators were expected to offer the resident specific activities based on their interests. NA-F stated she has offered R29 activities on the calendar and R29 did not want to participate. On 4/9/24 at 12:30 p.m., the director of nursing (DON) stated residents were expected to be offered activities based of interests and specific to each resident and the DON confirmed activities staff were expected to offer R29 activities based of his preferences and activity assessment. The facility Activity Programs policy dated 6/18, indicated: 1. The activities program is provided to support the well-being of residents and to encourage both	F 679		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 15 independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent individual activities and assisted individual activities. 4. "Activities" are considered any endeavor, other than routine ADL's in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. 5. Our activity programs are designed to encourage maximum individual participation and are geared toward the individual resident's needs. 6. Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning preparation, conducting, clean up and critique of the programs. 9. All activities are documented in the resident's medical record 12. Individualized and group activities are provided that: a. reflect the schedules, choices and rights of the residents b. are offered at hours convenient to the residents, including evenings, holidays and weekends; c. reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of their residents; e. incorporate family, visitor and resident ideas of the desired appropriate activities	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25	F 684		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 16 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R52) reviewed who received hospice services. Findings include: R52's significant change Minimum Data Set (MDS) dated 3/21/24, required substantial to maximum staff assistance with all activities of daily living except set up assist for eating and oral hygiene. R52's Brief Interview for Mental Status (BIMS), indicated intact cognition and understands and is understood. R52's facility care plan, dated 3/21/24, included the resident is at the end stage of life and is utilizing hospice services. Intervention included coordinate care with hospice and other end of life services. R52's (local hospice agency) current plan of care, dated 3/28/24, indicated a registered nurse (RN) would provide services 1-2 times times a week (1-2 x/wk) and the home health aide (HHA) 2 times per week. The care plan indicated R52 is her own person, and does not need calls prior to	F 684	Ecumen Pathstone Living has addressed the deficiency related to F684 by ensuring R52 has an updated and current calendar indicating the scheduled visits from the RN and HHA from Hospice. This calendar is placed in R52□s room and the hospice binder. Additionally, R52□s collaborative plan of care has been updated to include the resident's preference to be notified of any changes to the hospice visit schedule via personal cell phone. Residents receiving hospice services have the potential to be affected by the alleged deficient practice. The IDON and/or designee has completed audits of all hospice residents to ensure services were coordinated with hospice agency. This includes up-to-date calendars are maintained in both the resident's hospice binder and their room. No other residents were found affected by the alleged deficient practice. To prevent recurrence and ensure consistent communication, CNA and nursing staff received education on hospice services and communication	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 visits. Review of the facility's hospice binder, located at the nurses station, included a March/April 2023 (but dates written were current for 2024) calendar indicating when the RN and HHA would be coming to visit R54. The calendar was completed through 4/8/24 but no further dates were present. The HHA visits included 3/28, 3/29, 4/2 and 4/8. During interview and observation on 4/8/24, at 12:42 p.m. R52 was lying in her bed with call light within reach and a cell phone on bedside table. R52 indicated last Monday (4/1/24), the HHA was supposed to come to give a bath but never showed up and no one told R52 why. R52 stated the HHA then showed up on Wednesday and told R52 it was a scheduled holiday off of work, but would come on Friday (4/5/24) to make up the day missed. R52 stated the HHA didn't show up on 4/5/24 so she called hospice services to find out what happened and was told HHA was sick. R52 stated she asked hospice services why they didn't call the facility or let her know. R52 stated she told them this is "very rude and messes things up for the staff at the facility." R52 indicated the hospice agency initially stated they tried but couldn't get a hold of her, then said the scheduler is responsible, but then they claimed they tried to call the facility and no one answered. When interviewed on 4/9/24, at 9:51 a.m., R52 stated concerns with HHA and nurse not letting her know when they are coming. R52 stated "I have no calendar, and no one ever calls to let me know when they are coming. They just show up". R52 stated there is a lack of communication from the hospice agency and it isn't fair for staff to	F 684	expectations on 5/13-5/14/24, provided by the IDON designee. On 5/8/2024, the IDON designee met with the Hospice team to review communication, collaboration, and best practices, resulting in a clearly defined list of expectations and responsibilities for both hospice and nursing facility staff. The DON and/or designee will audit all residents receiving hospice services weekly for four weeks, then monthly for two months, to ensure that up-to-date calendars are maintained in both the resident's hospice binder and their room. As part of Ecumen Pathstone Living□s ongoing commitment to quality assurance, any identified concerns will be reported through the community's QA process by the IDON and/or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 18 have to provide her cares when hospice should be doing them. R52 indicated she has refused baths from the facility staff because they shouldn't have to do hospice's work. R52 indicated she has told the hospice staff before she wants advanced notice and denied every saying she didn't want advanced notice. During interview on 4/10/24 at 9:47 a.m., spoke with local hospice RN-F who indicated R52 had stated previously she did not want to be notified prior to visits. RN-F stated "we do not routinely notify the staff in advance but do keep a calendar in her chart." RN-F confirmed it is challenging for the unit staff to know if they should provide personal cares or not if they aren't aware of the HHA's schedule for visits. During interview on 4/10/24 at 10:15 a.m., HHA-G from hospice agency stated she thought R54 would know it was a holiday on the Monday following Easter, but "I guess I didn't tell her." HHA indicated she does not let the facility or R54 know in advance of her visits. HHA indicated she was out ill Friday 4/5/24 and notification to R54 is on the office staff members to let the resident know. During interview on 4/10/24 at 2:37 p.m., the director of nursing (DON) confirmed communication is lacking with the hospice agency and the facility and R54 should know in advance when the hospice staff are coming to the facility. A policy on hospice services was requested and none received.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 19 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper extremities was implemented, wrist brace was applied correctly, and edema glove was on for 1 of 2 residents (R14) who had limited range of motion to prevent contractures. Findings include: R14's face sheet printed 4/10/24, included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness one on side of the body) following cerebral infarction (central nervous system injury) affecting left non-dominate side, osteoarthritis, and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated	F 688	In continuing compliance with F688, Ecumen Pathstone Living corrected the deficiency by obtaining an order for occupational therapy (OT) to evaluate and treat Resident 14 (R14) on 4/16/2024. OT services were initiated on 4/18/2024. The occupational therapist trialed several new splints for R14 and ordered a new splint on 5/7/2024, which is pending arrival. Additionally, R14's platform trough was replaced with a wheelchair table. Passive Range of Motion (PROM), splint use, and OT coordination were added to R14's plan of care and Group Daily Sheet. PROM and required documentation were added to the electronic Medication Administration Record (eMAR) and point of care tasks.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 20 3/22/24, indicated R14 had intact cognition, dependent on staff for transfers, dressing, and personal hygiene, and limited range of motion (ROM) on one side. R14's provider orders dated 5/7/21, included apply resting hand splint on when in wheelchair and at bedtime. Document refusals. Apply edema glove during the day and off at bedtime. Document refusals. R14's plan of care last revised 10/17/23, included limited physical mobility related to stroke with hemiplegia/hemiparesis. A goal included R14 will remain free of complications related to immobility, including contractures, thrombus (blood clot) formation, skin-breakdown, fall related injury through the next review date. Interventions included R54 to wear edema glove during the day and off at bedtime. Resting hand split when up in wheelchair and at night as resident tolerates. The plan of care also included an activities of daily living self-care deficit. Interventions included passive range of motion (PROM) to left hand, wrist, elbow and shoulder three times per week as resident tolerates. R14's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 10/13/21, indicated R14 was discharged from program with PROM and splint use for left upper extremity; collaborated with nurse manager regarding program to help maintain strength and reduce risk of contractures. A Group Daily Sheet, used by the NA's included R14 should wear his hand/wrist brace at bedtime but did not include PROM or edema glove. R14's medication administration record or task	F 688	Residents with limited ROM and/or limited mobility have the potential to be affected by the alleged deficient practice. The IDON and/or designee has completed audits of these residents to ensure they are receiving appropriate treatment, equipment and assistance. No other residents were found affected by the alleged deficient practice. Mandatory staff education on resident mobility and range of motion for Certified Nursing Assistants (CNAs) and nurses was completed on 5/13-5/14/2024. Staff who did not attend will be required to review the education materials. Therapy will submit therapy recommendations, including restorative and ROM programs, via TEAMS to the nurse manager. The nurse manager and/or designee will be responsible for updating the resident care plan, Group Daily Sheet, and eMAR tasks. The restorative binder will be updated for documentation purposes, and CNAs and nurses will be educated and updated by the nurse manager and/or designee at shift change reports. The Director of Nursing (DON) and/or designee will complete audits weekly for 4 weeks and monthly for 2 months to ensure residents are receiving appropriate ROM/mobility treatment. Residents who are cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13-15 will be interviewed regarding the implementation and execution of range of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 21 list in the electronic medical record did not identify PROM. During interview and observation on 4/8/24 at 3:49 p.m., R14 was lying in his bed with hand splint and edema glove on his left hand from the lower palm of hand to below the elbow. R14's left fingers were curled into the palm of his hand. R14 stated my hand is really curved and I can't move my hand. R14 added no one has done range of motion on hand but would like them to before his hand is permanently "stuck this way". R14 added staff are always in such a hurry they don't put on the brace right and it doesn't stay in place. Arm brace was observed to be a flat blue board with 3 Velcro straps and when R14 picked up his arm with his right hand, the splint was loose enough it moved further towards his elbow. During interview and observation 4/8/24 at 5:41 p.m., R14 was in the dining room in a wheelchair. The splint was on his left lower arm and was no longer in the palm of his hand and extended from mid lower arm to past his elbow. R14 had on his edema glove and picked up his left arm with right hand and placed on the arm of the chair. R14 indicated staff forgot to put the platform trough on the arm of the chair to hold his arm in place. R14's left arm fell off the arm of the chair within two minutes and he had to pick up his hand and place back on the armrest. During observation and interview 4/9/24 at 8:23 a.m., R14 was in the dining room having breakfast in his wheelchair. Arm trough was present attached to the left arm of the wheelchair with 3 Velcro straps. R14 did not have his edema glove on. The hand splint was present on his left palm extending to mid arm and attached with 3	F 688	motion and mobility programs. As part of Ecumen Pathstone Living's ongoing commitment to quality assurance, the DON and/or designee will report identified concerns through the community's Quality Assurance (QA) process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 22	F 688		

Velcro straps. R14's fingers were curled over the end of the splint board towards the under side of 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 the closet in resident's room with 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 23 done PROM to R14's left hand, elbow, wrist or shoulder. During interview on 4/10/24 at 7:39 a.m., R14 was lying in his bed with his arm splint on but fingers were curled under at the end of the splint. R14 stated he would allow staff to perform ROM because he doesn't want to lose the flexibility in his hand and fingers. R14 indicated it is painful and he has shooting pains in his hand when they move his fingers. During interview and observation on 4/10/24 at 8:28 a.m., R14 was in the dining room. OT-F evaluated the splint and placement. OT-F indicated the splint was not in the correct position and should extend to keep his fingers straight out and not curled under the splint. OT-F stated the splint is for his fingers and not his hand or wrist and the way the splint was placed on R14 was not doing anything to prevent contractures of R14's fingers. OT-F stated the splint had lost its form, as it was a bendable splint, and should not be straight like it is. OT-F added the splint was placed on backwards. R14 was not wearing his edema glove. OT-F went to R14's room and got edema glove and wash cloth. OT-F attempted to move R14's fingers and stated his fingers are "tight" and was unable to straighten his fingers from the curled position. OT-F placed edema glove on R14's hands with difficulty taking approximately 10 minutes to place on his left hand and fingers. OT-F bent the splint to get into a better position for his hand but was unsuccessful in getting R14's fingers extended for the splint to work. OT-F then placed a rolled washcloth under R14's fingers and stated he will need some continued therapy to get his hand more flexible prior to wearing a hand splint again.	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 24 During interview on 4/10/24 at 8:49 a.m., RN-B indicated she is aware that R14 has contractures of his hand. RN-B indicated moving his fingers aren't comfortable for him and some staff don't want to hurt him so do the best they can. RN-B confirmed there is an order for PROM and the care plan indicates he should have ROM completed 3 times per week. RN-B confirmed staff should complete the PROM and if not completed they need to let the nurse know it wasn't done and why. RN-B was unable to locate the instructions for PROM in the room or restorative book. During interview on 4/10/24 at 2:25 p.m., the director of nursing stated if PROM is ordered it should be done by the nursing assistants and the hand splint should be applied correctly. The nurses are responsible to ensure the care and treatment is getting done. The facility Resident Mobility and Range of Motion policy and procedure dated 7/2017 included: -Residents will not experience an avoidable reduction in range of motion (ROM). -Resident with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. -Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. - The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. -Documentation of the residents progress toward	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 25 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.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess disposing of cigarettes for 1 of 1 resident (R57) reviewed for smoking. Findings include: R57's admission Minimum Data Assessment (MDS) dated 3/21/24, indicated R57 had severe cognitive impairment, required supervision with personal hygiene, sit to stand, chair transfer, and walking and diagnoses included aphasia (ability to understand or express speech), hemiplegia following cerebral infract (paralysis of partial or total body function on one side of the body after a stroke) affecting right side, tobacco use, muscle weakness, anxiety disorder, depression, and diabetes. R57's care plan revised 4/8/24, indicated R57 would like to smoke while residing at this care community, was offered smoking cessation	F 689	The alleged deficiencies for resident R57 have been corrected. A cigarette receptacle was acquired and R57 was educated on proper butt disposal. The IDON was responsible for implementing the corrections. Residents that smoke have the potential to be affected by the alleged deficient practice. The IDON has completed audits of residents that smoke cigarettes to ensure no other residents were affected by the alleged deficient practice. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recure: Admissions team will continue to identify and communicate to team if facility is accepting a referral who is an active tobacco user. Facility will continue to remain a smoke-free campus but will	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26 options and declined, (was on nicotine patch when first admitted, requested for them to be stopped d/t being ineffective for him), will not smoke unless directly supervised by family/responsible party/staff as evidenced by:resident determined unsafe to smoke independently per smoking assessment, facility stores resident's lighter and cigarettes, will be assessed quarterly/PRN (as needed) for smoking safety, will be offered smoking cessation options quarterly, will smoke in designated areas only and will dress appropriately for weather, instruct about smoking risks and hazards and about smoking cessation aids that are available, instruct about facility policy on smoking: locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, observe clothing and skin for signs of cigarette burns, requires supervision by family/friend/staff while smoking. On 4/10/24 at 8:38 a.m., alarm was heard at front entrance door and R57 was observed seated in a wheelchair and interim director of nursing (IDON) stood behind resident's wheelchair and R57 was observed to cross the street and IDON was behind wheelchair and assisted R57 across the street. R57 was observed to smoke a cigarette while near the curb of the street and IDON stood next to R57. R57 was on the side of the street near the curb and observed R57 ash and flick his cigarette ash on the street. When R57 was finished smoking, R57 bent over in his wheelchair and put out the cigarette on the curb of the street. IDON stood behind R57's wheelchair, and R57 wheeled himself across the street with the supervision of IDON. R57 and IDON entered the facility through the front doors.	F 689	provide education to new residents on smoking off campus grounds. Policy “Smoking Policy-Residents" has been reviewed and updated as of 5/15/24. Education provided 5/13-5/14/2024 for CNA’s and nurses regarding policies and processes noted above. Ecumen Pathstone Living will monitor its performance to make sure corrections noted above are sustained. The IDON or designee will complete weekly audits x4 weeks and then monthly x2 months on proper cigarette butt disposal. To ensure ongoing compliance, results will be presented to the QAPI committee. The committee will review and provide recommendations regarding the frequency and content of further audits and new interventions as indicated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 On 4/10/24 at 8:41 a.m., R57 was seated in a wheelchair and observed pushed in the hallway by IDON, and when asked where the cigarette was disposed of, IDON and R57 both put their hands up and said I don't know. R57 further stated, "I know nothing". IDON stated he did not know R57 brought the cigarette butt back into the facility. R57 was assisted back to his room by IDON and exited R57's room. IDON was asked where the cigarette butt was disposed, and said he was not sure, when asked if R57 showed him the cigarette butt when they entered the facility, he said he could not remember. IDON was asked to retrace the steps coming into the facility. IDON was observed and walked from the entrance to the right and into the dining room, a garbage located in the dining room was observed and no cigarette butt was found. Licensed practical nurse (LPN)-A stated to IDON that he came in through the other entrance of the dining room. IDON stated he still got confused with directions throughout the facility. IDON was observed and exited the dining room and was asked if they entered the bathrooms by the dining room and stated he did not, IDON was observed and walked by the chapel and a trash can lined with a plastic trash bag was was observed and a cigarette butt was found in the garbage. On 4/10/24 at 9:06 a.m., R57 was lying in bed and confirmed he brought the cigarette butt back into the facility with him and stated he did not remember who threw it away and could not remember where he disposed the cigarette butt. On 4/10/24 at 9:16 a.m., the director of nursing (DON) stated the facility did not have a receptacle for R57 to dispose of the cigarette, stated the staff assisting R57 was responsible to ensure the	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 cigarette was disposed of and the facility did not have a receptacle, a plan or designated area for R57 to dispose of his cigarette. The DON stated the cigarette was not expected to have been brought in the building. On 4/10/24 at 9:30 a.m., IDON stated staff were to supervise R57 across the street and attend to R57 while he smoked, IDON stated R57 was able to light his cigarette himself, ashed on the ground on the street, and he observed R57 scrape the cigarette on the side of the curb and street to put the cigarette out. IDON stated he assisted R57 back across the street into the building. IDON stated he thought R57 left the cigarette butt on the street, and confirmed a cigarette butt should not be brought back in the facility. IDON confirmed the facility did not have a smoking receptacle for R57. IDON stated the facility was a non smoking campus, however allowed R57 to smoke off facility property and further stated it was "not well thought out" plan about R57 smoking and was not aware of a plan to dispose of the cigarette. IDON stated it would be a fire safety concern for R57 disposing cigarette butts in the trash at the facility and not a receptacle outside. IDON stated he watched R57 fully put out the cigarette on the street prior to entering the facility. The IDON stated he was recently hired as the IDON and worked approximately 5 days last week, and three days the week before at the facility and still gets lost in the building. Observation on 4/10/24 at 9:45 a.m., outside the facility entrance doors confirmed no cigarette ash tray or receptacle located near R57's smoking area across the street or near the entrance of the facility.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29 On 4/10/24 p.m. at 12:38 p.m., the DON stated the area across the street was observed and multiple cigarette butts found on the ground where R57 commonly smoked and was unsure why R57 brought the cigarette back in the facility today and would provide education to nursing and the resident regarding disposal of the cigarette. The facility Smoking Policy-Residents dated 8/22, indicated The facility has established and maintains safe resident smoking practices. 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 4. Metal containers, with self closing cover devices, are available in smoking areas.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at	F 880		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30 a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31 §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections, staff doffed (removed) personal protective equipment (PPE) incorrectly for 1 of 1 resident (R16), failed to ensure PPE was stored in a manner to prevent transmission of bacteria when PPE was observed stored directly on the floor for 18 of 18 residents (R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219) placed on enhanced barrier precautions (EBP) and the staff placed a meal tray on the floor for 1 of 1 resident (R27). This had the potential to affect all 56 residents who resided in the facility. Finding include: Enhanced Barrier Precautions Facility document titled Enhanced Barrier Precautions printed 4/10/24, indicated the following residents had Enhanced Barrier	F 880	The alleged deficiencies for residents R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219 have been corrected. Isolation carts/enhanced barrier precaution carts have been placed outside the applicable rooms, stocked with the necessary PPE. Additionally, trash receptacles for disposal have been positioned directly inside the entrance of each resident's room. Immediate education provided to NA-D, NA-C, NA-B, RN-G on donning and doffing PPE, and Enhanced Barrier Precautions policy and procedure. NA-C received education on infection control practices, specifically emphasizing the importance of not placing meal trays on the floor and the proper use of the meal tray delivery cart. The IDON and/or designee was responsible for implementing the corrections. All residents have the potential to be affected by the alleged deficient practice. The IDON and/or designee completed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32 Precautions (EBP) R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. During an observation of private resident rooms on 4/9/24 at 8:46 a.m., through 9:33 a.m., R12, R52, R218, R3, R20, R36, R41, R16, R6, R8, R17, R19, R46, R21, R219 room door signage indicated the residents were on EBP. The residents identified on EBP had plastic gowns located directly inside the resident's room on the floor and there was not a place to dispose of the plastic gowns prior to leaving the resident's room. The facility failed to have PPE located near or outside of resident rooms. During observations of private resident rooms on 4/9/24 at 9:10 a.m., observed PPE directly on the floor in the following rooms of residents who were identified by signage on their doors as being in EBP: -- R15, room 3101 - a box of plastic gowns was on the floor inside the door -- R27, room 3105 - a box of plastic gowns was in a plastic dishpan on the floor inside the door -- R10, room 3113 - a box of plastic gowns was in a plastic dishpan on the floor inside the door. On 4/9/24 at 7:41 a.m., occupational therapy assistant (OTA)-A stated residents on EBP had a sign on the door and staff were expected to wear a gown and gloves when providing hands on care. OTA-A stated the PPE was located in the resident bathrooms, and confirmed PPE was donned when staff entered EBP resident rooms. On 4/9/24 at 8:55 a.m., nursing assistant (NA)-D entered R17's room and stated it would be easier for staff if the gowns and gloves were mounted on	F 880	audits on 4/12/24 for all residents on transmission-based and enhanced barrier precautions. The audit ensured that PPE was stored outside resident rooms in a manner that prevents the transmission of bacteria and that appropriate disposal options for used PPE were provided directly inside each resident's room. An audit was completed to ensure the meal tray delivery cart is utilized when delivering meals to resident rooms, where applicable. This process confirmed that no other residents were affected by the alleged deficient practice. The following measures and systemic changes have been made to ensure the alleged deficient practice will not recure:¿ Policy Enhanced Barrier Precautions, Donning and Doffing education/competency, Surveillance for Infections policy, and Infection Prevention and Control Program policy have been reviewed. Education for Certified Nursing Assistants (CNAs) and nurses was completed on 5/13-5/14/2024 regarding the aforementioned policies and processes. Education for the ADON and therapy staff was completed by 5/15/2024. Additional training on the proper use of the meal tray delivery cart, with a specific focus on the process for residents in isolation, was also provided. PRN and casual staff not working during this period will be required to receive this education prior to their scheduled workday.¿ IDON met with ADON/IP to create process to ensure ongoing surveillance, tracking, trending and analysis of resident infections.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33 the wall and she did not have to get the gowns off the resident floors and go into the bathroom to get the gloves. NA-D confirmed PPE was donned inside resident's room on EBP. On 4/9/24 at 2:35 p.m., assistant director of nursing (ADON), who is the facility infection prevention nurse, stated residents who are placed on EBP had signs posted on their door and confirmed the following residents were on EBP R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. The ADON stated residents with indwelling medical devices, wounds, or those colonized by or infected with a multi-drug resistant organism the staff were expected to wear gloves, gowns, when providing cares for residents with EBP and would expect staff to donn PPE immediately inside the resident door. RN-A stated the facility was still trying to work through the placement and location for the PPE for residents with EBP. The ADON stated the box of plastic gowns was not expected on the floor of resident rooms and would expect gloves readily available. The ADON confirmed the gloves were kept in residents bathrooms. On 4/9/24 at 2:40 p.m., during an interview the 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	F 880	Education and confirmation of use of tracking program completed with IDON and ADON/IP to utilize for ongoing infection surveillance, trending and analysis. Ecumen Pathstone Living will monitor its performance to make sure corrections noted above are sustained. IDON and/or designee will audit x4 weeks and then monthly x2. Audits will include donning and doffing and auditing proper location of isolation carts, trash receptacles, and use of meal tray delivery cart. Three audits per week will be completed. PPE/ donning and doffing audit will include the observation of 3 staff members per audit. EBP isolation cart audit will be conducted on all residents on EBP. To ensure ongoing compliance, results will be presented to the QAPI committee. The committee will review and provide recommendations regarding the frequency and content of further audits and new interventions as indicated.¿¿	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34	F 880		

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 had occurred. The ADON stated he had training last week for 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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 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 through 4/19/24. 2. Droplet Precautions: N95 Mask, Face Shield, Gown, Gloves. Instructions for staff providing direct care: .... doff gown and gloves...prior to leaving the room. Doff N-95 outside of room. 3. CDC Enhance Barrier Precaution sign 4. Donning sign 5. Doffing sign which directed staff to remove gloves and gown in the resident's room prior to exiting and to remove face shield and respirator (N-95 mask) after exiting the room.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36 During an observation and interview on 4/10/24 at 7:39 a.m., observed RN-G exit R16's room with all PPE already doffed. According to the doffing sign on the door, N95 mask should be doffed after exiting the room. Together with RN-G, read the doffing sign on the door which indicated to remove all PPE in room (except N95), before exiting the room. RN-G stated she hadn't done this [donning and doffing] for a while and forgot the sequence. During an observation and interview on 4/10/24 at 7:40 a.m., observed NA-B exit R16's room with full PPE on. NA-B stood and doffed the PPE outside the door - gloves, gown, mask and face shield, setting it all on the floor outside the room. NA-B then picked up the PPE and carried it across the hall to the dirty utility room. NA-B stated she did not have donning and doffing training yet and stated she didn't see the sign on the door about doffing. During an interview on 4/10/24 at 2:50 p.m., ADON who was also the infection preventionist stated for transmission-based precautions for Covid-19, staff were to doff all PPE inside the residents room except for the N-95 mask and face shield - which should be doffed after exiting the room. The ADON stated staff should have had donning and doffing training upon hire. The 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37 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 3/22/24. 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 activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing. b. bathing/showering c. transferring d. providing hygiene e. changing linens. f. changing briefs or assisting with toileting g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator,	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 38 etc.) h. wound care any skin opening requiring a dressing. 9. staff are trained prior to caring for residents on EBPs 11. PPE is available outside of the resident rooms. The facility Surveillance for Infections policy dated 9/17, indicated : That infection preventionist will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions. 1. The purpose of this surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and health care associated infections to guide appropriate interventions and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment b. available processes and procedures that prevent or reduce the spread of infection c. clinically significant morbidity or mortality associated with infection (e.g pneumonia, UTIs, C. difficile; d. Pathogens associated with serious outbreaks 4. Infections that may be considered in surveillance include those with limited transmissibility and health care environment	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 39 and/or limited prevention strategies Gathering Surveillance Data 1. Correction preventionist are designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and or QAPI committee may be involved in interpretation of data 2. if surveillance should include a review of any or all of the following information to help identify possible indicators of infection: a. laboratory records b. skin care sheets c. infection control rounds or interviews d. verbal reports from staff infection documentation records e. temperature logs f. pharmacy records g. antibiotic review h. transfer log/summaries 3. laboratory reports are used to identify relevant information the following findings merit further evaluation: a. positive blood cultures b. positive cultures that do not just represent surface colonization c. positive urine cultures with corresponding signs and symptoms that suggest infection d. positive sputum culture e. other positive cultures f. all cultures positive for Group A streptococcus 4. In addition to collecting data on the incidence of infections the surveillance system is designed to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted for example focus surveillance data may be gathered for residents with high risk for infection or those with their	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 40 recent hospital stay. Data Collection and Recording 1. For residents with infections that meet the criteria for definition of infection for surveillance collect the following data as appropriate: identifying information, diagnosis, admission date date of onset of infection, infection site, pathogens invasive procedures are risk factors, pertinent remarks, treatment measures and precautions. Calculating infection rates Interpreting Surveillance Data 1. Analyze the data to identify trends The facility Infection Prevention and Control Program policy dated 10/18, indicated Infection prevent control program is established and maintained to provide safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. 11. Prevention of Infection 3. educating staff and ensuring that they adhere to proper techniques and procedures. .	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a	F 881		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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: 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 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 facility was not tracking and monitoring process	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 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. The tracking sheet will be managed by the Infection Prevention Nurse and/or their designee and will be accessible to clinical staff for collaboration via the TEAMS app. This system ensures thorough monitoring and promotes effective communication within the clinical team to support optimal antibiotic use and resistance management. To correct the deficiency and to ensure the problem does not recur, CNAs and nurses were educated on the Antibiotic Stewardship Program, The ‘Timeout’ Procedure and the Antibiotic Tracking Sheet Process and Expectations on 5/13-5/14/24 by the IDON and/or designee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 881	Continued From page 42 for residents placed on an antibiotic The DON stated the facility used electronic communication for staff to track residents who were on an antibiotic and if cultures were received. The DON stated the health unit coordinator received the culture results via fax, would alert the nursing staff and the nurse would contact the doctor if the culture result indicated a change in the antibiotic was needed. The DON and ADON verified the facility did not have a formal process or tracking to include the requirements for Antibiotic Stewardship and confirmed the antibiotics were not tracked for cultures, source, location of infection, symptoms when placed on antibiotic. The ADON stated he does not review or track culture results to ensure proper antibiotics were prescribed or have a tracking log. The facility Prevention and Control Program policy dated 10/18, indicated Infection prevent control program is established and maintained to provide safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. 8. Antibiotics stewardship a. Culture reports sensitivity data and antibiotic usage reviews are included in surveillance activities. b. Medical criteria and standard definitions are of infections are used to help recognize and manage infections. c. Antibiotic usage is evaluated and practitioners are provided feedback on reviews	F 881	The IDON and/or designee will complete audits weekly x4 weeks and then monthly x2 months. Audit will include completion of antibiotic timeout for residents currently taking antibiotics. As part of Ecumen Pathstone Living's ongoing commitment to quality assurance, the IDON and/or designee will report identified concerns through the community's QA Process.	
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions	F 921		5/17/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 43 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a sanitary environment in the kitchen serving food preparation area and drying pots/pans area. This had the potential to affect all 56 residents currently residing in the facility. Findings include: On 4/8/24 at 12:00 p.m., during initial tour of the kitchen, a vent with 2 rungs present had dark fuzzy material on the top rung. This was over the pots and pans dishwashing area and where pots and pans were left to dry. Above the food serving area, 3 plugs were present in a wire mesh that extended down approximately 5-6 inches that had gray fuzzy debris present. A white flat printer cord extended from ceiling to the printer and was covered in gray, fuzzy debris. These cords were located above the clean plates and near the steam table area on the left and next to a food prep area on the right. During observation and interview on 4/9/24 at 11:33 a.m., the vent remained covered in dark fuzzy debris along with the wire mesh and white printer cord. Cook (C)-A indicated the dietary staff clean the vents but maintenance would be responsible for cleaning the cords extending from the ceiling. C-A confirmed they were dirty and covered in debris and needed to be cleaned. During observation and interview on 4/9/24 at 11:35 a.m., maintenance director (MD)-A confirmed the 3 plugs wire mesh and printer cord	F 921	Ecumen Pathstone Living has addressed the deficiency related to F921 by thoroughly cleaning the items identified in the kitchen area (i.e., vents, ceiling cords, exhaust hoods, drainage pipes, carpeting, etc.). These items have now been included in the facility's kitchen sanitation audit. Any additional items requiring attention will be entered into TELS to be addressed promptly as they arise. To prevent recurrence and ensure ongoing compliance, all dietary and environmental staff received education on culinary sanitation expectations, including cleaning schedules, monitoring of all cleaning tasks, and the TELS process, on 5/15/24 and 5/21/24. This training was conducted by the Culinary Director. The Culinary Director and/or designee will conduct monthly audits to inspect the cleanliness of ceiling vents, electrical cords, and exhaust hoods. As part of Ecumen Pathstone Living's ongoing commitment to quality assurance, the IDON and/or designee will report any identified concerns through the community's QA process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921	Continued From page 44 was covered in in dust and debris and needed to be cleaned. On interview 4/10/24 at 9:43 a.m., the culinary director (CD) indicated there should not be any dirt or debris on the cords, or wires holding the cords or vents above the food serving or clean areas in the kitchen.	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 04/09/2024. At the time of this survey, Pathstone Living was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically 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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. BUILDING 01 Building 01 was built in 1992, is one-story, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2008 addition is two-stories, has a partial basement, is fully fire sprinkler protected, and was determined to be of Type II(111) construction. The facility has a capacity of 69 beds and had a census of 56 at the time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure	K 923		5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245390	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/09/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 3 considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to store oxygen cylinders per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2 and 11.6.5.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 04/09/2024 at 10AM, it was revealed by observation that the oxygen storage room had both full and empty oxygen cylinders being stored in the same location and was not segregated. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Signage was added on 5/9/24 to oxygen storage rooms to indicate which tanks are full and which tanks are empty. Education was provided to the maintenance staff on 5/7/24, and added the following verbiage to the weekly building tour task in TELS. Full and empty cylinders are not comingled. Partially used tanks are to be 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 sure items are compliant. Weekly audits x4 and then monthly x2 months. TELS task will clearly state what to look for and check for proper signage and storage.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 4/8/24-4/11/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey and NO licensing orders were issued.: H53902668C (MN00099237) H53902743C (MN00091448) H53902745C (MN00098060) H53902746C (MN00099410) H53907949C (MN00087616) H53903054C (MN00102383) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 2 of 2 resident (R52, R21) reviewed for hospice and pressure ulcers. Findings include: R52's Face Sheet indicated admission date was 2/7/24, and diagnoses of malignant neoplasm (uncontrolled growth and division of abnormal	2 550	corrected	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 3 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 tissue injury was also answered no. PU or injury care included application of	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 550	Continued From page 4 ointments/medications other than to feet. R21's Skin Assessment dated 4/4/24, indicated small open shallow area on left buttock, and pressure ulcer on left heel measuring 2 cm x 3 cm, closed with peeling edges. During interview on 4/11/24 at 12:13 p.m., RN-B, also identified as MDS coordinator, confirmed the quarterly MDS was incorrect as R21 does have pressure ulcer present and injury cares and treatment. RN-B confirmed she would not have looked at the MDS again and would have submitted it incorrectly. During interview on 4/10/24 at 2:37 p.m., the director of nursing stated the MDS should have been completed accurately. The facility MDS Assessment Coordinator policy and procedure dated 11/2019, included an RN shall be responsible for conducting and coordinating the development and completion of the resident assessment. Each individual who completes a portion of the assessment must certify the accuracy of that portion of the assessment by dating and signing the assessment and identifying each section completed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee or RAI coordinator could review the RAI manual, review policies and procedures to ensure accurate coding of the MDS. The DON, designee or RAI coordinator could then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly assess disposing of cigarettes for 1 of 1 resident (R57) reviewed for smoking. Findings include: R57's admission Minimum Data Assessment (MDS) dated 3/21/24, indicated R57 had severe cognitive impairment, required supervision with personal hygiene, sit to stand, chair transfer, and walking and diagnoses included aphasia (ability to understand or express speech), hemiplegia following cerebral infract (paralysis of partial or total body function on one side of the body after a stroke) affecting right side, tobacco use, muscle weakness, anxiety disorder, depression, and diabetes. R57's care plan revised 4/8/24, indicated R57	2 830	Corrected	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 6 would like to smoke while residing at this care community, was offered smoking cessation options and declined, (was on nicotine patch when first admitted, requested for them to be stopped d/t being ineffective for him), will not smoke unless directly supervised by family/responsible party/staff as evidenced by:resident determined unsafe to smoke independently per smoking assessment, facility stores resident's lighter and cigarettes, will be assessed quarterly/PRN (as needed) for smoking safety, will be offered smoking cessation options quarterly, will smoke in designated areas only and will dress appropriately for weather, instruct about smoking risks and hazards and about smoking cessation aids that are available, instruct about facility policy on smoking: locations, times, safety concerns, notify charge nurse immediately if it is suspected resident has violated facility smoking policy, observe clothing and skin for signs of cigarette burns, requires supervision by family/friend/staff while smoking. On 4/10/24 at 8:38 a.m., alarm was heard at front entrance door and R57 was observed seated in a wheelchair and interim director of nursing (IDON) stood behind resident's wheelchair and R57 was observed to cross the street and IDON was behind wheelchair and assisted R57 across the street. R57 was observed to smoke a cigarette while near the curb of the street and IDON stood next to R57. R57 was on the side of the street near the curb and observed R57 ash and flick his cigarette ash on the street. When R57 was finished smoking, R57 bent over in his wheelchair and put out the cigarette on the curb of the street. IDON stood behind R57's wheelchair, and R57 wheeled himself across the street with the supervision of IDON. R57 and IDON entered the facility through the front doors.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 7 On 4/10/24 at 8:41 a.m., R57 was seated in a wheelchair and observed pushed in the hallway by IDON, and when asked where the cigarette was disposed of, IDON and R57 both put their hands up and said I don't know. R57 further stated, "I know nothing". IDON stated he did not know R57 brought the cigarette butt back into the facility. R57 was assisted back to his room by IDON and exited R57's room. IDON was asked where the cigarette butt was disposed, and said he was not sure, when asked if R57 showed him the cigarette butt when they entered the facility, he said he could not remember. IDON was asked to retrace the steps coming into the facility. IDON was observed and walked from the entrance to the right and into the dining room, a garbage located in the dining room was observed and no cigarette butt was found. Licensed practical nurse (LPN)-A stated to IDON that he came in through the other entrance of the dining room. IDON stated he still got confused with directions throughout the facility. IDON was observed and exited the dining room and was asked if they entered the bathrooms by the dining room and stated he did not, IDON was observed and walked by the chapel and a trash can lined with a plastic trash bag was was observed and a cigarette butt was found in the garbage. On 4/10/24 at 9:06 a.m., R57 was lying in bed and confirmed he brought the cigarette butt back into the facility with him and stated he did not remember who threw it away and could not remember where he disposed the cigarette butt. On 4/10/24 at 9:16 a.m., the director of nursing (DON) stated the facility did not have a receptacle for R57 to dispose of the cigarette, stated the staff assisting R57 was responsible to ensure the	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 8 cigarette was disposed of and the facility did not have a receptacle, a plan or designated area for R57 to dispose of his cigarette. The DON stated the cigarette was not expected to have been brought in the building. On 4/10/24 at 9:30 a.m., IDON stated staff were to supervise R57 across the street and attend to R57 while he smoked, IDON stated R57 was able to light his cigarette himself, ashed on the ground on the street, and he observed R57 scrape the cigarette on the side of the curb and street to put the cigarette out. IDON stated he assisted R57 back across the street into the building. IDON stated he thought R57 left the cigarette butt on the street, and confirmed a cigarette butt should not be brought back in the facility. IDON confirmed the facility did not have a smoking receptacle for R57. IDON stated the facility was a non smoking campus, however allowed R57 to smoke off facility property and further stated it was "not well thought out" plan about R57 smoking and was not aware of a plan to dispose of the cigarette. IDON stated it would be a fire safety concern for R57 disposing cigarette butts in the trash at the facility and not a receptacle outside. IDON stated he watched R57 fully put out the cigarette on the street prior to entering the facility. The IDON stated he was recently hired as the IDON and worked approximately 5 days last week, and three days the week before at the facility and still gets lost in the building. Observation on 4/10/24 at 9:45 a.m., outside the facility entrance doors confirmed no cigarette ash tray or receptacle located near R57's smoking area across the street or near the entrance of the facility. On 4/10/24 p.m. at 12:38 p.m., the DON stated	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 the area across the street was observed and multiple cigarette butts found on the ground where R57 commonly smoked and was unsure why R57 brought the cigarette back in the facility today and would provide education to nursing and the resident regarding disposal of the cigarette. The facility Smoking Policy-Residents dated 8/22, indicated The facility has established and maintains safe resident smoking practices. 1. Prior to, and upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. 2. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. 4. Metal containers, with self closing cover devices, are available in smoking areas. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review/revise policies and procedures related to smoking accidents and resident supervision to assure proper assessment and interventions are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 10	2 890		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper extremities was implemented, wrist brace was applied correctly, and edema glove was on for 1 of 2 residents (R14) who had limited range of motion to prevent contractures. Findings include: R14's face sheet printed 4/10/24, included diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (weakness one on side of the body) following cerebral infarction (central nervous system injury) affecting left non-dominate side, osteoarthritis, and muscle weakness. R14's quarterly Minimum Data Set (MDS) dated	2 890	corrected	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 11 3/22/24, indicated R14 had intact cognition, dependent on staff for transfers, dressing, and personal hygiene, and limited range of motion (ROM) on one side. R14's provider orders dated 5/7/21, included apply resting hand splint on when in wheelchair and at bedtime. Document refusals. Apply edema glove during the day and off at bedtime. Document refusals. R14's plan of care last revised 10/17/23, included limited physical mobility related to stroke with hemiplegia/hemiparesis. A goal included R14 will remain free of complications related to immobility, including contractures, thrombus (blood clot) formation, skin-breakdown, fall related injury through the next review date. Interventions included R54 to wear edema glove during the day and off at bedtime. Resting hand split when up in wheelchair and at night as resident tolerates. The plan of care also included an activities of daily living self-care deficit. Interventions included passive range of motion (PROM) to left hand, wrist, elbow and shoulder three times per week as resident tolerates. R14's Occupational Therapy (OT) Evaluation and Plan of Treatment dated 10/13/21, indicated R14 was discharged from program with PROM and splint use for left upper extremity; collaborated with nurse manager regarding program to help maintain strength and reduce risk of contractures. A Group Daily Sheet, used by the NA's included R14 should wear his hand/wrist brace at bedtime but did not include PROM or edema glove. R14's medication administration record or task list in the electronic medical record did not identify	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 12 PROM. During interview and observation on 4/8/24 at 3:49 p.m., R14 was lying in his bed with hand splint and edema glove on his left hand from the lower palm of hand to below the elbow. R14's left fingers were curled into the palm of his hand. R14 stated my hand is really curved and I can't move my hand. R14 added no one has done range of motion on hand but would like them to before his hand is permanently "stuck this way". R14 added staff are always in such a hurry they don't put on the brace right and it doesn't stay in place. Arm brace was observed to be a flat blue board with 3 Velcro straps and when R14 picked up his arm with his right hand, the splint was loose enough it moved further towards his elbow. During interview and observation 4/8/24 at 5:41 p.m., R14 was in the dining room in a wheelchair. The splint was on his left lower arm and was no longer in the palm of his hand and extended from mid lower arm to past his elbow. R14 had on his edema glove and picked up his left arm with right hand and placed on the arm of the chair. R14 indicated staff forgot to put the platform trough on the arm of the chair to hold his arm in place. R14's left arm fell off the arm of the chair within two minutes and he had to pick up his hand and place back on the armrest. During observation and interview 4/9/24 at 8:23 a.m., R14 was in the dining room having breakfast in his wheelchair. Arm trough was present attached to the left arm of the wheelchair with 3 Velcro straps. R14 did not have his edema glove on. The hand splint was present on his left palm extending to mid arm and attached with 3 Velcro straps. R14's fingers were curled over the end of the splint board towards the under side of	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 13 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 the closet in resident's room with 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.	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 14 During interview on 4/10/24 at 7:39 a.m., R14 was lying in his bed with his arm splint on but fingers were curled under at the end of the splint. R14 stated he would allow staff to perform ROM because he doesn't want to lose the flexibility in his hand and fingers. R14 indicated it is painful and he has shooting pains in his hand when they move his fingers. During interview and observation on 4/10/24 at 8:28 a.m., R14 was in the dining room. OT-F evaluated the splint and placement. OT-F indicated the splint was not in the correct position and should extend to keep his fingers straight out and not curled under the splint. OT-F stated the splint is for his fingers and not his hand or wrist and the way the splint was placed on R14 was not doing anything to prevent contractures of R14's fingers. OT-F stated the splint had lost its form, as it was a bendable splint, and should not be straight like it is. OT-F added the splint was placed on backwards. R14 was not wearing his edema glove. OT-F went to R14's room and got edema glove and wash cloth. OT-F attempted to move R14's fingers and stated his fingers are "tight" and was unable to straighten his fingers from the curled position. OT-F placed edema glove on R14's hands with difficulty taking approximately 10 minutes to place on his left hand and fingers. OT-F bent the splint to get into a better position for his hand but was unsuccessful in getting R14's fingers extended for the splint to work. OT-F then placed a rolled washcloth under R14's fingers and stated he will need some continued therapy to get his hand more flexible prior to wearing a hand splint again. During interview on 4/10/24 at 8:49 a.m., RN-B indicated she is aware that R14 has contractures of his hand. RN-B indicated moving his fingers	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 15 aren't comfortable for him and some staff don't want to hurt him so do the best they can. RN-B confirmed there is an order for PROM and the care plan indicates he should have ROM completed 3 times per week. RN-B confirmed staff should complete the PROM and if not completed they need to let the nurse know it wasn't done and why. RN-B was unable to locate the instructions for PROM in the room or restorative book. During interview on 4/10/24 at 2:25 p.m., the director of nursing stated if PROM is ordered it should be done by the nursing assistants and the hand splint should be applied correctly. The nurses are responsible to ensure the care and treatment is getting done. The facility Resident Mobility and Range of Motion policy and procedure dated 7/2017 included: -Residents will not experience an avoidable reduction in range of motion (ROM). -Resident with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM. -Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable. - The care plan will be developed by the interdisciplinary team based on the comprehensive assessment and will be revised as needed. -Documentation of the residents progress toward 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. SUGGESTED METHODS OF CORRECTION:	2 890		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 890	Continued From page 16 The director of nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure all residents with limitations in range of motion receive services to maintain or improve range of motion function. Nursing staff could be educated as necessary on the importance of providing services to residents with limitation in range in motion based on assessed needs and as recommended. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview, observation, and document review the facility failed to ensure the infection control program included ongoing surveillance, trending and analysis of resident infections, staff doffed (removed) personal protective equipment (PPE) incorrectly for 1 of 1 resident (R16), failed to ensure PPE was stored in a manner to prevent transmission of bacteria when PPE was observed stored directly on the floor for 18 of 18 residents (R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and	21375	Corrected	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 17 R219) placed on enhanced barrier precautions (EBP) and the staff placed a meal tray on the floor for 1 of 1 resident (R27). This had the potential to affect all 56 residents who resided in the facility. Finding include: Enhanced Barrier Precautions Facility document titled Enhanced Barrier Precautions printed 4/10/24, indicated the following residents had Enhanced Barrier Precautions (EBP) R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. During an observation of private resident rooms on 4/9/24 at 8:46 a.m., through 9:33 a.m., R12, R52, R218, R3, R20, R36, R41, R16, R6, R8, R17, R19, R46, R21, R219 room door signage indicated the residents were on EBP. The residents identified on EBP had plastic gowns located directly inside the resident's room on the floor and there was not a place to dispose of the plastic gowns prior to leaving the resident's room. The facility failed to have PPE located near or outside of resident rooms. During observations of private resident rooms on 4/9/24 at 9:10 a.m., observed PPE directly on the floor in the following rooms of residents who were identified by signage on their doors as being in EBP: -- R15, room 3101 - a box of plastic gowns was on the floor inside the door -- R27, room 3105 - a box of plastic gowns was in a plastic dishpan on the floor inside the door -- R10, room 3113 - a box of plastic gowns was in a plastic dishpan on the floor inside the door.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 18 On 4/9/24 at 7:41 a.m., occupational therapy assistant (OTA)-A stated residents on EBP had a sign on the door and staff were expected to wear a gown and gloves when providing hands on care. OTA-A stated the PPE was located in the resident bathrooms, and confirmed PPE was donned when staff entered EBP resident rooms. On 4/9/24 at 8:55 a.m., nursing assistant (NA)-D entered R17's room and stated it would be easier for staff if the gowns and gloves were mounted on the wall and she did not have to get the gowns off the resident floors and go into the bathroom to get the gloves. NA-D confirmed PPE was donned inside resident's room on EBP. On 4/9/24 at 2:35 p.m., assistant director of nursing (ADON), who is the facility infection prevention nurse, stated residents who are placed on EBP had signs posted on their door and confirmed the following residents were on EBP R12, R52, R218, R3, R20, R36, R41, R10, R27, R15, R16, R6, R8, R17, R57, R46, R21, and R219. The ADON stated residents with indwelling medical devices, wounds, or those colonized by or infected with a multi-drug resistant organism the staff were expected to wear gloves, gowns, when providing cares for residents with EBP and would expect staff to donn PPE immediately inside the resident door. RN-A stated the facility was still trying to work through the placement and location for the PPE for residents with EBP. The ADON stated the box of plastic gowns was not expected on the floor of resident rooms and would expect gloves readily available. The ADON confirmed the gloves were kept in residents bathrooms. On 4/9/24 at 2:40 p.m., during an interview the	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 19 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 had occurred. The ADON stated he had training last week for 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	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 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 through 4/19/24. 2. Droplet Precautions: N95 Mask, Face Shield,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 21 Gown, Gloves. Instructions for staff providing direct care: .... doff gown and gloves...prior to leaving the room. Doff N-95 outside of room. 3. CDC Enhance Barrier Precaution sign 4. Donning sign 5. Doffing sign which directed staff to remove gloves and gown in the resident's room prior to exiting and to remove face shield and respirator (N-95 mask) after exiting the room. During an observation and interview on 4/10/24 at 7:39 a.m., observed RN-G exit R16's room with all PPE already doffed. According to the doffing sign on the door, N95 mask should be doffed after exiting the room. Together with RN-G, read the doffing sign on the door which indicated to remove all PPE in room (except N95), before exiting the room. RN-G stated she hadn't done this [donning and doffing] for a while and forgot the sequence. During an observation and interview on 4/10/24 at 7:40 a.m., observed NA-B exit R16's room with full PPE on. NA-B stood and doffed the PPE outside the door - gloves, gown, mask and face shield, setting it all on the floor outside the room. NA-B then picked up the PPE and carried it across the hall to the dirty utility room. NA-B stated she did not have donning and doffing training yet and stated she didn't see the sign on the door about doffing. During an interview on 4/10/24 at 2:50 p.m., ADON who was also the infection preventionist stated for transmission-based precautions for Covid-19, staff were to doff all PPE inside the residents room except for the N-95 mask and face shield - which should be doffed after exiting the room. The ADON stated staff should have had donning and doffing training upon hire. The	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 22 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 3/22/24. 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 activity (as opposed to before entering the room). b. Personal protective equipment (PPE) is changed before caring for another resident. c. Face protection may be used if there is also a risk of splash or spray. 3. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: a. dressing.	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 23 b. bathing/showering c. transferring d. providing hygiene e. changing linens. f. changing briefs or assisting with toileting g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.) h. wound care any skin opening requiring a dressing. 9. staff are trained prior to caring for residents on EBPs 11. PPE is available outside of the resident rooms. The facility Surveillance for Infections policy dated 9/17, indicated : That infection preventionist will conduct ongoing surveillance for healthcare associated infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions. 1. The purpose of this surveillance of infections is to identify both individual cases and trends of epidemiologically significant organisms and health care associated infections to guide appropriate interventions and to prevent future infections. 2. The criteria for such infections are based on the current standard definitions of infections. 3. Infections that will be included in routine surveillance include those with: a. evidence of transmissibility in a healthcare environment b. available processes and procedures that prevent or reduce the spread of infection c. clinically significant morbidity or mortality associated with infection (e.g pneumonia, UTIs,	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 24 C. difficile; d. Pathogens associated with serious outbreaks 4. Infections that may be considered in surveillance include those with limited transmissibility and health care environment and/or limited prevention strategies Gathering Surveillance Data 1. Correction preventionist are designated infection control personnel is responsible for gathering and interpreting surveillance data. The infection control committee and or QAPI committee may be involved in interpretation of data 2. if surveillance should include a review of any or all of the following information to help identify possible indicators of infection: a. laboratory records b. skin care sheets c. infection control rounds or interviews d. verbal reports from staff infection documentation records e. temperature logs f. pharmacy records g. antibiotic review h. transfer log/summaries 3. laboratory reports are used to identify relevant information the following findings merit further evaluation: a. positive blood cultures b. positive cultures that do not just represent surface colonization c. positive urine cultures with corresponding signs and symptoms that suggest infection d. positive sputum culture e. other positive cultures f. all cultures positive for Group A streptococcus 4. In addition to collecting data on the incidence of infections the surveillance system is designed	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 25 to capture certain epidemiologically important data that may influence how the overall surveillance data is interpreted for example focus surveillance data may be gathered for residents with high risk for infection or those with their recent hospital stay. Data Collection and Recording 1. For residents with infections that meet the criteria for definition of infection for surveillance collect the following data as appropriate: identifying information, diagnosis, admission date date of onset of infection, infection site, pathogens invasive procedures are risk factors, pertinent remarks, treatment measures and precautions. Calculating infection rates Interpreting Surveillance Data 1. Analyze the data to identify trends The facility Infection Prevention and Control Program policy dated 10/18, indicated Infection prevent control program is established and maintained to provide safe sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections. 11. Prevention of Infection 3. educating staff and ensuring that they adhere to proper techniques and procedures. SUGGESTED METHOD OF CORRECTION: The DON (director of nursing) or designee could re-educate staff on proper infection control practices in general, for transmission based precautions (TBP) and enhanced barrier precautions (EBP) to ensure proper storage and use of personal protective equipment (PPE) and tracking, analysis, evaluation and interventions to prevent the spread of infection. The DON or designee could perform periodic audits to ensure	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 26 staff adherence and results of those audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committee to determine compliance and need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
21455	MN Rule 4658.0900 Subp. 5 Activity and Recreation Program;Space/Equip Subp. 5. Space, equipment, and materials. The activity and recreation program must be provided with space both within the nursing home and out-of-doors. Appropriate and adequate equipment and materials must be provided to meet the needs of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 1 resident (R29) reviewed for activities. Findings include: R29's admission Minimum Data Set (MDS) dated 3/11/24, indicated R29 was admitted to the facility 3/5/24, had moderately intact cognition, dependent on staff for toileting and transfers, required substantial/maximal assistance with shower/bathe and dressing, required supervision with eating and oral hygiene, identified it was very important to do his favorite activities, keep up with the news, participate in religious services, and go outside to get fresh air, and somewhat important	21455	Corrected	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21455	Continued From page 27 to have reading material, listen to music, and do things with groups of people and diagnoses included pneumonia, urinary tract infection, and mild cognitive impairment, . R29's care plan dated 3/5/24, did not include R29's activities, interests or interventions related to activities. R29's baseline care plan dated 3/5/24, activities coordinator (AC)-A indicated R29 will independently choose activity of choice with both in-room and scheduled events, enjoys watching sporting events, reads the daily newspapers, playing cards, listening to music, may decline activities to attend therapy sessions and rest. Activities/Initial review document dated 3/11/24, indicated R29 wished to participate in activities, wished to participate in group activities, does not wish to participate in 1:1 with staff, and liked independent activities, expressed interest in attending activities as tolerated once acclimated to facility, enjoyed playing cards in the past (sheep's head and buck euchre), independently watched TV in room, especially sporting events, wife visits daily, assistance should be provided to get resident to to the activity. On 4/8/24 at 7:15 p.m., R29 was observed in his room seated in a wheelchair, television on, and family member (FM)-H present. R29 was interviewed about what, if any, activities he attended or was offered . R29 stated he could not recall being offered to attend activities and stated he could not recall any activities attended while at the facility, but expressed he would like participate in activities, if offered. R29 stated he enjoyed playing card games and listening to music. FM-H stated she was at the facility most	21455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21455	Continued From page 28 days and stayed all day, and stated she had not observed staff offer R29 any activities. FM-H stated staff have offered him to take naps. On 4/9/24 at 9:52 a.m., R29 was seated in a wheelchair in his room and FM-H was present. R29 stated his activities of choice would include anything with games, cards, music, and stated he would attend activities if the facility had something. FM-H stated R29 had gone to church one time that she was aware of. A activity calendar was posted in R29's room and R29 stated he had not been offered to attend the activities listed. On 4/9/24 at 7:49 a.m., the AC-A stated she completed R29's admission activities interests and activities preferences to find out what activities R29 enjoyed. AC-C stated the assessment is used for the activity coordinators to offer those activities to residents. AC-A stated the activity assessment indicated R29 loved playing card games, interested in sports and stated the assessment indicated once he was acclimated to the facility he would participate in more activities. AC-C stated activity staff were expected to offer R29 activities based of the assessment which would include cards and music. AC-C stated she wondered if staff assumed since he had company he would not want to participate in activities and stated staff were not expected to ask a resident if they wanted to participate in an activity when company was present in the room. AC-C stated if the wife was always present would expect activities staff to ask resident to participate and would expect staff to ask resident to play cards based of his interest. AC-C stated in the medical record she was not able to find documentation R29 had participated in activities at the facility.	21455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21455	Continued From page 29 On 4/9/24 at 9:00 a.m., AC-B confirmed she had not offered R29 to participate in any activities and was not sure if other staff had offered R29 activities. AC-B stated R29 was on short term care and AC-A completed the intakes and activities for short term care residents. On 4/9/24 at 9:30 a.m., AC-A stated she was responsible to ensure that residents participated in activities and she was expected R29 was offered activities based off his interest and admission intake information. On 4/9/24 at 12:24 p.m., nursing assistant (NA)-F stated nursing assistants were responsible for offering residents the activities posted on the calendar in the room and the activity coordinators were expected to offer the resident specific activities based on their interests. NA-F stated she has offered R29 activities on the calendar and R29 did not want to participate. On 4/9/24 at 12:30 p.m., the director of nursing (DON) stated residents were expected to be offered activities based of interests and specific to each resident and the DON confirmed activities staff were expected to offer R29 activities based of his preferences and activity assessment. The facility Activity Programs policy dated 6/18, indicated: 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent	21455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21455	Continued From page 30 individual activities and assisted individual activities. 4. "Activities" are considered any endeavor, other than routine ADL's in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. 5. Our activity programs are designed to encourage maximum individual participation and are geared toward the individual resident's needs. 6. Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning preparation, conducting, clean up and critique of the programs. 9. All activities are documented in the resident's medical record 12. Individualized and group activities are provided that: a. reflect the schedules, choices and rights of the residents b. are offered at hours convenient to the residents, including evenings, holidays and weekends; c. reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of their residents; e. incorporate family, visitor and resident ideas of the desired appropriate activities SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing, activities director or designee, could engage the interdisciplinary team (IDT) to ensure residents in the facility were provided meaningful activities to meet their interests and include activities on evenings and weekends. Activities selected should be resident-centered. The administrator or designee could seek advice from resident council on likes and dislikes of types and kinds of	21455		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21455	Continued From page 31 activities offered in the facility. The results of those audits should be taken to QAPI to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21455		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure individualized activities were provided for 1 of 1 resident (R29) reviewed for activities. Findings include: R29's admission Minimum Data Set (MDS) dated 3/11/24, indicated R29 was admitted to the facility 3/5/24, had moderately intact cognition, dependent on staff for toileting and transfers, required substantial/maximal assistance with shower/bathe and dressing, required supervision with eating and oral hygiene, identified it was very important to do his favorite activities, keep up with the news, participate in religious services, and go outside to get fresh air, and somewhat important	21685	Corrected	5/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 32 to have reading material, listen to music, and do things with groups of people and diagnoses included pneumonia, urinary tract infection, and mild cognitive impairment, . R29's care plan dated 3/5/24, did not include R29's activities, interests or interventions related to activities. R29's baseline care plan dated 3/5/24, activities coordinator (AC)-A indicated R29 will independently choose activity of choice with both in-room and scheduled events, enjoys watching sporting events, reads the daily newspapers, playing cards, listening to music, may decline activities to attend therapy sessions and rest. Activities/Initial review document dated 3/11/24, indicated R29 wished to participate in activities, wished to participate in group activities, does not wish to participate in 1:1 with staff, and liked independent activities, expressed interest in attending activities as tolerated once acclimated to facility, enjoyed playing cards in the past (sheep's head and buck euchre), independently watched TV in room, especially sporting events, wife visits daily, assistance should be provided to get resident to to the activity. On 4/8/24 at 7:15 p.m., R29 was observed in his room seated in a wheelchair, television on, and family member (FM)-H present. R29 was interviewed about what, if any, activities he attended or was offered . R29 stated he could not recall being offered to attend activities and stated he could not recall any activities attended while at the facility, but expressed he would like participate in activities, if offered. R29 stated he enjoyed playing card games and listening to music. FM-H stated she was at the facility most	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 33 days and stayed all day, and stated she had not observed staff offer R29 any activities. FM-H stated staff have offered him to take naps. On 4/9/24 at 9:52 a.m., R29 was seated in a wheelchair in his room and FM-H was present. R29 stated his activities of choice would include anything with games, cards, music, and stated he would attend activities if the facility had something. FM-H stated R29 had gone to church one time that she was aware of. A activity calendar was posted in R29's room and R29 stated he had not been offered to attend the activities listed. On 4/9/24 at 7:49 a.m., the AC-A stated she completed R29's admission activities interests and activities preferences to find out what activities R29 enjoyed. AC-C stated the assessment is used for the activity coordinators to offer those activities to residents. AC-A stated the activity assessment indicated R29 loved playing card games, interested in sports and stated the assessment indicated once he was acclimated to the facility he would participate in more activities. AC-C stated activity staff were expected to offer R29 activities based of the assessment which would include cards and music. AC-C stated she wondered if staff assumed since he had company he would not want to participate in activities and stated staff were not expected to ask a resident if they wanted to participate in an activity when company was present in the room. AC-C stated if the wife was always present would expect activities staff to ask resident to participate and would expect staff to ask resident to play cards based of his interest. AC-C stated in the medical record she was not able to find documentation R29 had participated in activities at the facility.	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 34 On 4/9/24 at 9:00 a.m., AC-B confirmed she had not offered R29 to participate in any activities and was not sure if other staff had offered R29 activities. AC-B stated R29 was on short term care and AC-A completed the intakes and activities for short term care residents. On 4/9/24 at 9:30 a.m., AC-A stated she was responsible to ensure that residents participated in activities and she was expected R29 was offered activities based off his interest and admission intake information. On 4/9/24 at 12:24 p.m., nursing assistant (NA)-F stated nursing assistants were responsible for offering residents the activities posted on the calendar in the room and the activity coordinators were expected to offer the resident specific activities based on their interests. NA-F stated she has offered R29 activities on the calendar and R29 did not want to participate. On 4/9/24 at 12:30 p.m., the director of nursing (DON) stated residents were expected to be offered activities based of interests and specific to each resident and the DON confirmed activities staff were expected to offer R29 activities based of his preferences and activity assessment. The facility Activity Programs policy dated 6/18, indicated: 1. The activities program is provided to support the well-being of residents and to encourage both independence and community interaction. 2. Activities offered are based on the comprehensive resident-centered assessment and the preferences each resident. 3. The activities program is ongoing and includes facility-organized group activities, independent	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00036	A. BUILDING: _____ B. WING _____	C 04/11/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 35 individual activities and assisted individual activities. 4. "Activities" are considered any endeavor, other than routine ADL's in which the resident participates, that is intended to enhance his or her sense of well-being and to promote or enhance physical, cognitive or emotional health. 5. Our activity programs are designed to encourage maximum individual participation and are geared toward the individual resident's needs. 6. Activities are scheduled seven days a week and residents are given an opportunity to contribute to the planning preparation, conducting, clean up and critique of the programs. 9. All activities are documented in the resident's medical record 12. Individualized and group activities are provided that: a. reflect the schedules, choices and rights of the residents b. are offered at hours convenient to the residents, including evenings, holidays and weekends; c. reflect the cultural and religious interests, hobbies, life experiences, and personal preferences of their residents; e. incorporate family, visitor and resident ideas of the desired appropriate activities SUGGESTED METHOD OF CORRECTION: The administrator, maintenance director or designee could work with the dietary manager to develop a cleaning schedule to ensure dust, debris, and kitchenettes are cleaned to maintain a safe, clean, environment. The administrator or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance.	21685		