



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 14, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: December 21, 2021

Dear Administrator:

On February 11, 2022, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 24, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

RE: CCN: 245390
Cycle Start Date: December 21, 2021

Dear Administrator:

On December 21, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

**Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593**

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 21, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

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January 24, 2022
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In addition, if substantial compliance with the regulations is not verified by June 21, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.
Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245390	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/21/2021
NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 12/21/21, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be NOT in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5390035C (MN79360), with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:	F 684		2/2/22	

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

TITLE

(X6) DATE
02/02/2022

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

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F 684	<p>Continued From page 1</p> <p>Based on interview and document review, the facility failed to ensure repeated episodes of diarrhea was comprehensively assessed and interventions developed to provide comfort and reduce the risk of complications for 1 of 1 resident (R1) and to prevent the spread of an infectious agent, reviewed for Clostridioides difficile (C-diff) (a bacteria that causes infection of the large intestine, causing diarrhea).</p> <p>Findings include:</p> <p>Review of a VA report dated 12/15/21, indicated R1 had been admitted to the hospital on 12/14/21, for a hardware implant surgery to the right hip. The report indicated R1 complained of having loose stools intermittently for 2 weeks, prior to the surgical procedure. The provider ordered a lab test for C-diff at that time, which came back positive. The report indicated R1's surgical procedure was then canceled, until fully treated for C-diff. (approximately 6 weeks). R1 was started on an antibiotic for treatment. The hospital nurse indicated she contacted the facility director of nursing (DON) to inform her of R1 being positive for C-diff.</p> <p>R1 was admitted on 10/14/21, to the facility. R1's diagnosis located on the admission face sheet, in the medical record included: infection of the right hip, osteomyelitis (inflammation of the bone), constipation, sepsis (body's response to an infection), muscle weakness, atherosclerotic heart disease (ASHD) (hardening and narrowing of the arteries).</p> <p>R1's admission minimum data set (MDS), dated 12/9/21, identified R1 as having a brief interview for mental status (BIMS) of "15" (meaning</p>	F 684	<p>Plan of correction for F684-Quality of life.</p> <ol style="list-style-type: none"> 1. This was an isolated incident. No other resident's impacted at this time. See #4 for further measures to ensure others are not impacted by deficient practices. 2. All resident had the potential to be affected if not initiating proper precautions. Education provided to all care staff to identify change in condition and initiation of precautions when indicated from assessment findings. 3. Reviewed Transmission based precautions and when to initiate precautions. Reviewed Infectious Disease Policy. Reviewed Interagency Transfer form and completed Case Scenarios with quiz to ensure education was provided to prevent further or future deficient practices. 4. Weekly audits will be completed on residents receiving antibiotics for 2 or more weeks. 5. Education provided to CNA's, nurses, and TMA's on 1/19/2022. See attached meeting agenda, and topics covered to ensure quality of care as related to tag F684. <p>Updated POC</p> <p>-Individual was discharged from the facility prior to MDH site visit. Facility has put interventions into place to prevent any future incidents to current and/or future residents.</p> <p>-Infection control nurse will do audits on any residents with orders for antibiotics. Any residents receiving antibiotics for 14</p>		

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F 684	<p>Continued From page 2</p> <p>cognitively intact). The MDS indicated R1 required extensive assistance of 2 staff with mobility and toileting. The MDS indicated R1 was frequently incontinent of bowel and bladder.</p> <p>Review of a baseline care plan dated 10/14/21, indicated R1 required staff assistance with activities of daily living (ADL's) that included mobility, dressing and toileting. The care plan identified R1 as being incontinent of bowel and bladder. The care plan included interventions: monitor incontinence, record bowel movements and describe amount and consistency of stools.</p> <p>Review of a bowel tracking log from 12/12/21 to 12/14/21, indicated R1 had 3 large loose stools on 12/12/21, 5 large loose stools on 12/13/21 and 1 large loose stool on 12/14/21, prior to discharging to the hospital for a planned hip surgery.</p> <p>Review of a progress note dated 12/12/21, indicated R1 had a "few" loose stools today, and has been on the call light 14 times requesting the bedpan and the toilet.</p> <p>Review of the physician orders dated 10/6/21 to 11/27/21, indicated R1 received antibiotic intravenous (IV) therapy throughout this time for a sepsis infection of the right hip.</p> <p>Review of a physician standing order dated 12/12/21 and 12/13/21, indicated R1 received Lopermide (medication for loose stools). The medication was administered on 12/12/21, at 2:00 pm and on 12/13/21, at 11:28 a.m. There was 1 entry on 12/13/21, at 2:33 a.m. stating the medication was effective. There was no documentation on 12/13/21, after the medication</p>	F 684	<p>days or more will have an assessment completed, upon findings of those assessments interventions will be placed as indicated by assessment findings in conjunction with infection control nurse and nurse manager. These audits/assessments will be ongoing to ensure any further harm is avoided to current residents or future residents. This process will be discussed/monitored in the monthly quality meetings for the next 6 months and then yearly to ensure stainability.</p>		

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F 684	<p>Continued From page 3</p> <p>was given, although the bowel tracker indicated R1 had a large loose stool at 12:30 p.m. and 10:06 p.m. and on 12/14/21, at 12:49 a.m.</p> <p>Review of a discharge note dated 12/14/21, indicated R1 was having right hip replacement surgery that day, R1 had a septic infection on 10/4/21. The hardware from the previous hip surgery needed to be removed from the hip after all the infection was gone. New hardware for the hip is scheduled to be replaced for this surgery. The note indicated R1 received antibiotics throughout her stay, from a peripherally inserted catheter (PICC) line (a tube inserted in a vein and used for long term antibiotic therapy). The note further indicated R1's husband decided to hold R1's bed at the facility and discharge. The plan was for R1 to recover in a hospital swing bed for 6 weeks, and then R 1 would be strong enough for the husband to take care of her at home. Although, because of the C-diff, R1 remains in the hospital. .</p> <p>Interview on 12/21/21, at 9:15 a.m. with hospital social worker (SW)-A indicated R1 was admitted to the hospital on 12/14/21, for a scheduled hip surgery. SW-A indicated R1 had her hip hardware removed in October 2021, related to an infection in the hip. SW-A further indicated R1 was having her hip hardware replaced that morning, after receiving long term antibiotic therapy. SW-A stated when R1 arrived to the hospital, she reported to the staff she had been having loose stools for 2 weeks. SW-A indicated she talked with registered nurse (RN)-A at the NH, who confirmed R1 had been having loose stools for the past couple of days. RN-A indicated she thought it may have been because R1 was nervous, about her upcoming surgery. SW-A</p>	F 684			

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F 684	<p>Continued From page 4</p> <p>informed RN-A R1 had tested positive for C-diff, and surgery would be canceled for roughly 6 weeks until after treatment. RN-A informed SW-A that R1 would not be able to return to the facility, because there was a waiting list for admissions. SW-A indicated R1 currently remained in the hospital, until placement could be found. SW-A stated R1 had planned on having hip surgery that included the placement of new hardware, recovery in swing bed for 6 weeks and then discharge to home. SW-A indicated now that R1's surgery had been postponed for 6 weeks due to C-diff, she is unable to discharge home.</p> <p>Interview on 12/21/21, at 10:30 a.m. the DON stated she had received a phone call on 12/14/21, from hospital SW-A. The DON stated SW-A inquired about R1 having loose stools prior to hospitalization. The DON indicated she had confirmed R1 had been having loose stools 2 days prior to R1's hospitalization. The DON also indicated R1 received Lopermide for control of the loose stools.</p> <p>Interview on 12/21/21, at 10:45 a.m. registered nurse (RN)-A confirmed R1 had received intravenous (IV) antibiotics through a PICC line from 10/6/21 to 11/27/21, RN-A indicated she had been aware of R1 having loose stools prior to hospitalization. RN-A did not consider R1 may have C-diff, because the stools were not odorous. RN-A did not consider the long term use of antibiotics R1 had been given over the past couple of months. RN-A indicated she was unsure if the hospital had been informed of the loose stools prior to hospitalization. RN-A indicated she had been aware of R1's discharge plans after surgery that included; swing bed for 6 weeks and then discharge home.</p>	F 684			

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F 684	Continued From page 5 Interview on 12/21/21, at 11:15 a.m. nursing assistant (NA)-A, indicated she had been providing cares for R1 during the time she was having loose stools. NA-A stated R1 was usually continent and would call for assistance when needed to use the toilet. NA-A indicated R1 had been on the call light numerous times on 12/21/21 and 12/13/21, because she was having multiple large loose stools. NA-A stated R1 did not complain of any other symptoms, other than the loose stools. NA-A further indicated it was unusual for R1 to have so many loose stools within a short period of time. NA-A indicated she had reported the loose stools to the charge nurse. NA-A confirmed isolation precautions had not been implemented, but that they utilized proper hand hygiene when taking care of R1. Interview on 12/21/21, at 11:30 a.m. nursing assistant (NA)-B, indicated she had provided cares for R1 during the time R1 was having loose stools. NA-B stated R1 occasionally was incontinent of loose stools, but would call for assistance to the toilet. NA-B indicated R1 had been on the call light numerous times on 12/13/21, and had at least 5 loose stools. NA-B stated R1 did not complain of any other symptoms other than the loose stools. NA-B further indicated this was a change in R1's bowel pattern and consistency. NA-B confirmed isolation precautions had not been implemented, but she had reported the loose stools to the charge nurse and utilized proper hand hygiene when taking care of R1 Interview on 12/21/21, at 2:00 p.m. the DON indicated she had not been aware of R1's loose stools until hospital SW-A contacted her on	F 684			

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F 684	<p>Continued From page 6</p> <p>12/14/21. The DON indicated she had talked with nurse manager (NM)-A who confirmed R1 had been having several loose stools prior to hospitalization. The DON indicated the staff had not informed the hospital of R1's loose stools prior to surgery. The DON stated the facility staff thought because R1 was nervous about the upcoming surgery, this may be causing the loose stools. The DON further indicated isolation precautions had not been implemented. The DON indicated there had been no discussion or changes made related to their processes, after they had been notified of R1's C-diff. When asked the DON what her expectations were related assessing R1's change in bowel patterns, she stated she was unsure and unable to answer what the expectations would be. The DON confirmed she was aware of R1 receiving IV antibiotics for the past couple of months, but did not think of R1 being high risk for C-diff. The DON also confirmed the facility policy for C-diff had not been followed, and could have been assessed better. The DON also verified there were no other residents with C-diff in the facility at the current time.</p> <p>Interview on 12/21/21, at 3:00 p.m. RN-B stated she had been aware of R1's loose stools prior to the scheduled surgery. RN-B indicated R1's loose stools were not odorous like C-diff usually is. RN-B further indicated she considered R1's antibiotic use, but because R1 had not received antibiotics for 2 weeks, she was not concerned.</p> <p>Interview on 12/21/21, at 3:30 p.m. NA-C indicated she had provided cares for R1, during the time she had been having loose stools. NA-C indicated the day before (12/12/21) R1 transferred to the hospital, she had 5 large watery</p>	F 684			

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F 684	<p>Continued From page 7</p> <p>loose stools on the day shift NA-C stated she reported the loose stools to the charge nurse, but thought R1 had eaten something that caused the diarrhea. NA-C did confirm the loose stools were a change in R1's bowel consistency and pattern.</p> <p>Interview on 12/21/21, at 4:00 p.m. facility nurse practitioner (NP)-A indicated she was not aware of R1's loose stools. NP-A did indicate she would have expected a provider to be notified of the change in R1's stools. NP-A further stated the provider may have then ordered a test for C-diff, due to R1 being at risk related to the long term antibiotic use. NP-A also indicated if Lopermide had been given and R1 continued to have loose stools, that would be a good indicator that something must be going on.</p> <p>Review of the facility policy Clostridium Difficile revised 7/2014, indicates C-diff is transmitted by fecal-oral route. Preventative measures will be taken to prevent the occurrence of C-diff infections among residents, and precautions will be taken while caring for residents with C-diff, to prevent transmission to others. Residents who are considered high risk of developing symptoms associated with C-diff include; those with advanced aging, antibiotic therapy or antineoplastic therapy, previous gastrointestinal illness and gastrointestinal manipulation.</p>	F 684			

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 24, 2022

Administrator
Pathstone Living
718 Mound Avenue
Mankato, MN 56001

Re: Event ID: 8V4Q11

Dear Administrator:

The above facility survey was completed on December 21, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

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

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2021
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NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 12/21/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaint was found to be</p>	2 000		

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

Electronically Signed

TITLE

(X6) DATE
02/02/22

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/21/2021
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NAME OF PROVIDER OR SUPPLIER PATHSTONE LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 718 MOUND AVENUE MANKATO, MN 56001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>SUBSTANTIATED: H5390035C (MN79360), however, NO licensing orders were issued.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		