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	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pathstone Living	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)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49616 Based on interview and document review, the facility failed to comprehensively assess, implement interventions, and provide timely notification for change in condition to a provider for 1 of 1 resident (R1) who was found unresponsive which delayed care resulting in death from acute respiratory distress. The facility's failures resulted in an immediate jeopardy for R1. The immediate jeopardy (IJ) began on 3/3/24, when licensed nursing staff failed to comprehensively assess and monitor R1 after being notified by several nursing assistants of R1's change in condition which included decreased appetite, facial pallor, blue lips, increased fatigue, lethargy, and decreased responsiveness. The Administrator and Director of Nursing were notified of the IJ on 3/7/24 at 5:25 p.m. The immediate jeopardy was removed on 3/8/24 at 2:40 p.m. but noncompliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include R1's quarterly Minimum Data Set (MDS) dated [DATE], identified R1 had diagnoses that included Parkinson's Disease, renal insufficiency, neurogenic bladder, seizure disorder or epilepsy, and muscle weakness. The MDS indicated R1 did not have cognitive impairment. R1 required substantial to maximum assistance with dressing upper body and toileting, dependent on staff for lower body, and use of a wheelchair for mobility. No oxygen use. R1's activities of daily living (ADL) care plan dated 11/8/23, directed staff to monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Further focus on dehydration directed staff to monitor/document/record signs and symptoms that included but not limited to decreased or no urine output, concentrated urine, new onset confusion, dizziness on sitting/standing, fatigue/weakness, and dizziness. R1's urinary indwelling catheter focus dated 11/6/23, directed staff to monitor/document/report signs and symptoms of infection that included but was not limited to monitor/record/report blood-tinged urine, change in behavior, change in eating patterns. (continued on next page)

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.

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Progress note dated 3/4/24 at 6:51 a.m., indicated that during rounds at 11:00 p.m. on 3/3/24, R1 was having labored breathing, cyanosis (blue) lips and hard to arouse. Vitals signs were way off blood pressure (BP)-81/47 (normal BP 120/80), P (pulse)-49 (normal pulse 60-100), T (temperature)-97.7 (normal temp 97-100), R-9, O2 (blood oxygen saturation)-78% (Normal O2 95-100%). The ambulance was called, and they left the building at 12:53 a.m. after unsuccessful attempt to raise R1's 02 above 89%. In review of R1's record, the last recorded set of vitals prior to 3/4/24 was documented on 2/6/24, almost one month ago. Her vitals were BP 110/70, P 85, T 97.6, R 18, and 02 93%. No other progress notes entries were made on 3/3/24 pertaining to R3's change of condition. During an interview on 3/6/24 at 10:29 a.m., nursing assistant (NA)-A stated she saw R1 in the dining room for lunch 3/2/24 and thought R1 looked good and had not noticed any changes. Emergency Medical Services (EMS) run report from 3/4/24 12:18 a.m. 1:25 a.m., indicated upon EMS arrival R1's O2 was in the low 20's on room air, R1 was unresponsive, was lying in a mid-upright position on the bed. Oxygen was applied at 12:33 a.m., high flow 02 per non-rebreather and an oropharyngeal airway placed. The patient is having periods of apnea, A strong sternal rub would get breathing started again. R1's emergency department summary dated 3/4/24, indicated R1 arrived in severe respiratory distress after being found around 12:30 a.m. in an altered state for level of consciousness. R1 had labs completed with a carbon dioxide (CO2) level of 81 mm (normal range 35-45). R1's Minnesota Documentation of Death worksheet identified the final disease or condition resulting in death was ACUTE RESPIRATORY FAILURE with the secondary significant condition contributing to death but not resulting in the underlying cause was listed as PARKINSON'S DISEASE, SEIZURE DISORDER. During a phone interview on 3/7/24 at 4:30 p.m., R1's family members (FM)-A, FM-B, and FM-C indicated they brought dinner to the facility to eat with R1 on 3/3/24. FM-C indicated that R1's sclera (white of eye) had been red and glossy and R1 looked dazed and drugged up. FM-A indicated that R1 had difficulty holding a cookie and took one bite of it. FM-A indicated that R1 did not seem like herself Sunday (3/3/24) and R1 usually enjoyed sweets, family meals and staying up late. R1 requested to go to bed and she usually sat in the recliner until 10:00 p.m. FM-A and FM-C indicated they had seen R1 hunched over to one side while on the toilet before R1 went to bed. FM-B indicated that FM-C had to point out to RN-A of the catheter having [NAME] (bright red) cherry blood and sediment in it. FM-B stated that RN-A said, it's ok. During a phone interview on 3/7/24 at 8:30 a.m., NA-C indicated on 3/3/24 she worked the day shift and around 7:00 a.m. R1 had very little urine in her collection bag. NA-C did not think the urine was super dark at that time and did not notice any other changes. During an interview on 3/6/24 at 10:35 a.m., unit assistant (UA)-A stated on she worked the day shift on 3/3/24. UA-A explained R1 looked tired. R1 had told UA-A she did not feel good in general. R1 did not eat lunch but drank half a container of Ensure (vitamin enriched drink supplement). UA-A stated she told someone of R1's condition but could not recall if she told a nursing assistant or a nurse that R1 did not eat and was tired. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 3/7/24 at 11:21 a.m., NA-D indicated on 3/3/24 she worked the day shift and R1 did not look herself. R1 was pale, had a sore throat, did not talk, did not eat breakfast, and drank only half a container of Ensure. NA-D stated she told licensed practical nurse (LPN)-A of R1's symptoms. NA-D indicated (UA)-A sat with R1 for lunch, R1 did not eat anything then either and only consumed half of her Ensure. NA-D indicated when she emptied R1's catheter bag it only had 100-150 cc's of very dark, like an orange-brown color urine in it for the entire shift (normal 30 cc' s' per hour). NA-D stated she had notified LPN-A of her concerns for R1 at least three times that day. NA-D was aware LPN-A gave R1 a Covid test, however was unaware if LPN-A assessed R1 beyond the Covid test. During a phone interview on 3/7/24 at 1:52 p.m., LPN-A stated on 3/3/24 she worked the day shift. LPN-A stated NA-D felt that R1 was little slower to respond when completing tasks. R1 seemed fine when LPN-A gave R1 her scheduled medications in the morning. LPN-A attributed R1's slow response time to a newly scheduled pain medication (tramadol). LPN-A explained in response to NA-D concerns, she gave R1 a Covid test which showed negative results, however, did not complete any further assessments and did not take R1's vital signs. LPN-A stated she did not document NA's reported concern(s) and the negative Covid test results. During a phone interview on 3/7/24 at 10:34 a.m., Family member (FM)-A indicated that family was at the facility visiting R1 at 5:00 p.m. on 3/3/24 and R1 had one bite of bread for dinner. FM-A indicated R1's eyes were glazed over and R1 looked worse than normal. FM-A stated R1 was brought back to the room at 6:30 p. m., she wanted to lay in bed. FM-A stated RN-A was notified of R1's red and clotty urine and RN-A stated they would follow-up the next day. During a phone interview on 3/7/24 at 11:11 a.m., NA-E indicated on 3/3/24, she worked the evening shift. NA-E stated during shift report NA-D reported R1 did not seem like herself, her eyes were red. R1 had stated she was not doing good. NA-E had checked on R1 at the beginning of her shift a little after 2:00 p.m. NA-E indicated at that time R1's lips were a darker purplish color and were like that throughout the entire shift. NA-E also explained when R1 talked she could barely hear her, and she wanted to go to bed early which was not normal. NA-E indicated that R1's urine output had been 150 cc' s' and was a really, really dark brown and looked like blood clots were in there. NA-E stated after dinner sometime and when R1 was in bed (could not recall time) it seemed like things had gotten progressively worse. as R1 had bloodshot eyes, was pale, and could not really move her eyes or talk. NA-E stated she immediately called registered nurse (RN)-A and RN-B to evaluate R1. NA-E indicated RN-A and RN-B came to R1's room, she did not see any vital signs taken, but the nurses told her they were normal. NA-E indicated she felt R1 should have gone to the hospital. During a phone interview on 3/7/24 at 12:21 p.m., RN-B indicated on 3/3/24 she worked the evening shift. RN-B stated a nursing assistant reported concerns about R1 so she went to R1's room; the room was dark during the assessment but she could see R1 had dark urine and red eyes. RN-B indicated RN-A took R1's vital signs and they looked stable. RN-B indicated they concluded R1 was fine aside from the dark urine and R1 did not need to be sent to the hospital. RN-B could not recall any of the vital sign values and did not document them and/or write a progress note. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 3/7/24 at 10:26 a.m., RN-A indicated on 3/3/24 he worked the evening shift. RN-A stated R1's family was at the facility around supper. R1's family had notified him they were concerned about the color of R1's urine and R1 was in pain. RN-A stated he explained to family R1 could not have any more pain medication until bedtime and he would have the concerns with the urine followed up tomorrow during the day (3/4/24). RN-A indicated he had checked R1's vital signs after R1 went to bed and they seemed normal and would pass it [concerns] on to the next shift to monitor. RN-A had also asked RN-B to evaluate R1. RN-A could not recall the time he took R1's vital signs, could not remember any of the vital sign values, and did not document and/or write a progress note about R1's condition. RN-A gave shift report to RN-C and stated, I shared what the family had said and told him [RN-C] as of now we are not concerned of anything and to just watch her. During a phone interview on 3/7/24 at 9:50 a.m., NA-F indicated he worked the overnight shift on 3/3/24. NA-F stated NA-E gave her shift report at 10:15 p.m. which included R1 was less responsive than normal, lethargic and urine was cola brown. NA-F did not go to R1's room until after 11:30 p.m. NA-F stated, immediately when I went to her room, I could tell she was in crisis. R1 had shallow breaths and R1's respirations were intermittent, and about 9 breaths per minute. R1 was unresponsive and not able to be aroused. She had virtually no urine in the collection bag. NA-F stated he took a full set of vital signs; R1's oxygen saturations were in the 70's (normal is 95-100%) and pulse was in the 40's (normal is 60-100 beats per minute). NA-F indicated that R1's head of bed had been elevated between 30 and 60 degrees. NA-F indicated he ran and told RN-C to call an ambulance. NA-F requested NA-G to sit with R1 and wait for the ambulance. NA-F indicated he completed vital signs only one time on R1 and was unaware if RN-C completed vital signs or an assessment. NA-F stated RN-C did not put oxygen on R1 and he gave emergency medical services (EMS) the medical history on R1. During a phone interview on 3/7/24 at 12:26 p.m., NA-G indicated she worked on the evening shift on 3/3/24. NA-G stated NA-F asked if she would sit with R1 or do rounds on the other residents. NA-G chose to sit with R1. NA-G stated when she got to the room R1 was unresponsive. NA-F had taken R1's vital signs, NA-F remembered R1's blood pressure was 81/47. R1 had the oximeter on her finger, it was not reading right. NA-G was concerned because R1's fingernails were blue. R1 did not have oxygen on, and no oxygen had ever been brought into the room. While they were waiting for the ambulance it seemed like R1 had hiccup things now and again. When EMS arrived, they put the oximeter on R1's ear and then NA-F switched places with her because NA-F said he knew R1 better. During a phone interview on 3/7/24 at 9:29 a.m., RN-C indicated he worked the overnight shift on 3/3/24. RN-C stated RN-A had only reported off R1 had coffee brown colored urine and low output but R1 had issues with urine output and catheter for some time. RN-C indicated he was notified of the change in R1 when NA-F was doing rounds. RN-C stated when he went into R1's room around 11:00 p.m., R1 was breathing differently and was not able to be aroused. RN-C stated he tried to arouse R1, but could not. RN-C called the on-call medical doctor, family, and EMS with update on R1. RN-C documented VS: blood pressure 81/47, pulse 49, respirations 9, oxygen 78%. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a phone interview on 3/6/24 at 12:10 p.m., EMS stated they received a call on 3/4/24 for respiratory distress on a resident at the facility. EMS stated when they arrived in R1's room, R1 did not have any oxygen on, and did not have the head of bed elevated more than 20-30 degrees. It didn't look like they had propped it up for anyone that couldn't breathe. EMS indicated initially a staff member was in the room but was unable to answer questions [NA-G] and then another nursing assistant [NA-F] came to the room that provided answers. EMS stated R1's nursing assistant reported to EMS that the evening shift reported that R1 had not been acting like herself, had blue lips, and was sleepier. EMS state We had to bag (ambu bag-a technique used for encountering patients in respiratory distress using a bag, valve, and mask) her a few times and she was very agonal breathing (desperate gasping for air). A male nurse [RN-C] came to the room and produced paperwork for EMS and provided a secondary oxygen tank. EMS questioned and stated, if this would have been caught earlier would the outcome have been different? and nothing was mitigated to help the situation between calling the ambulance and us getting there. During an interview on 3/7/24 at 11:51 a.m., RN-D indicated that R1's oxygen saturations were scheduled to be checked weekly. RN-D indicated if oxygen saturations dropped below 90% on room air, they would initiate oxygen via the facility standing orders. Nurses were expected to start oxygen if the saturation was below 90% on room air. RN-D had an expectation that a full set of VS, lung sounds, and documentation would be done for any change of condition. During a phone interview on 3/7/24 at 1:36 p.m., medical director (MD)-A indicated nursing should follow the standing orders for oxygen if saturations are below normal. MD-A expected vital signs and assessments completed for any change of condition and a physician notified of the change. During an interview on 3/7/24 at 1:54 p.m., Administrator and Director of Nursing (DON) identified the facility had a standing order for oxygen. DON indicated being notified of R1 hospital transfer at 1:27 a.m. on 3/4/24. Administrator and DON expected a comprehensive assessment be completed and documented with any change of condition and the physician be notified. The facility Change in a Resident's Condition or Status policy revised February 2021 directed: -Our facility promptly notifies the resident, attending physician and resident representative of changes in the residents medical/mental condition and/or status. -significant change in resident's physical/emotional/mental condition 2. A significant change of condition is a major decline or improvement in the resident's status that: -will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions -impacts more than one area of the resident's health status -requires interdisciplinary review and /or review on to the care plan; and -ultimately is based on the judgement of the clinical staff and the guidelines outlined in the Resident Assessment Instrument. (continued on next page)

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