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	09/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pathstone Living	718 Mound Avenue Mankato, MN 56001

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 record review, the facility failed to recognize a sudden change of condition which resulted in a delay of treatment for 1 of 3 resident (R1) reviewed with change condition. As a result R1 experienced chest pain was hospitalized and died . The immediate jeopardy (IJ) began on [DATE] when licensed nursing staff failed to comprehensively assess and monitor R1 after he voiced he was having chest pain. The Administrator and Director of Nursing (DON) were notified of the IJ on [DATE] at 4:30 p.m. The IJ was removed on [DATE] but non-compliance remained at the lower scope and severity level 2 (D), which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's face sheet dated [DATE], identified R1 admitted ,d+[DATE]. R1 had diagnoses of non-st elevation myocardial infarction (heart attack that happens when part of your heart is not getting enough oxygen), atrial fibrillation (irregular heart rhythm in the heart's upper chambers), history of stroke (blood supply to part of the brain is blocked or reduced), nonrheumatic aortic stenosis (heart valve problem that affects the blood flow to the heart and body), and gastroesophageal reflux disease (GERD) (chronic condition where stomach acid flows back into the mouth from the esophagus). R1's admission Minimum Data Set (MDS) dated [DATE], identified R1 had moderate cognitive impairment. R1 had no impairments to upper or lower body and used a walker and wheelchair to move around the facility. R1 required substantial assistance to dress lower body, and supervision assistance with upper body, toileting, and transferring. R1 had an indwelling urinary catheter. R1's care plan dated [DATE], identified R1 had altered cardiovascular status and would remain free from cardiac complication. Interventions included to monitor vital signs and notify the medical doctor of significant abnormalities. R1's provider visit note dated [DATE], identified nonrheumatic aortic valve stenosis had caused recurrent chest pain, staff were to monitor for any signs of recurring chest pain, signs, or symptoms of fluid overload and to call provider if noted. During an interview on [DATE] at 10:41 a.m., licensed practical nurse (LPN)-C stated R1 was always good at telling her when something was wrong physically with him such as if he had a concern about his catheter or blood sugar readings. (continued on next page)

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 [DATE] at 8:47 p.m., identified R1 had 2+ pitting edema to bilateral lower extremities, crackles noted at base of lungs. R1 denied shortness of breath (SOB). Vital signs were blood pressure (BP) ,d+[DATE] (normal range ,d+[DATE]), temperature (T) 98.2 (normal 95XXX,d+[DATE].5), pulse (P) 71 (normal ,d+[DATE]), 95% oxygen (O2) room air (normal ,d+[DATE]%), respirations (R) 18 (normal ,d+[DATE]). On rounds to notify provider and put a message in Teams for nurse manager. R1's late entry progress note documented on [DATE] at 5:11 p.m. identified on [DATE] at 6:15 a.m., an aide reported R1 was complaining of chest pain. R1 was talking normally, did not complain of any radiating in his extremities. R1's vital signs were within normal limits (R1's record did not include recorded vital signs between 6:00 a.m. 7:00 a.m.). R1 had 2+ pitting edema to bilateral lower extremities (BLE) and wheezing in the lower lobes with a six-pound weight gain in a week and a half. Monitor R1 for increased chest pain, radiating, and difficulty breathing and address with provider when they are at the facility at 8:00 a.m. R1's late entry progress note documented on [DATE] at 5:40 p.m. for [DATE] at 7:11 a.m., identified R1 was sitting in recliner and did not appear to be distressed or anxious. R1 stated pain was in the center of his chest. R1 stated the pain was not radiating anywhere and he did not have pain anywhere else. R1 reported pain between 4-,d+[DATE]. R1 had been to the bathroom prior to nurse entering room and R1 denied SOB or increased pain with movement. R1 had increased blood sugar (BS) of 204 (normal BS range is ,d+[DATE] before meals), which was noted to be high for R1. R1 complained of nausea and nursing assistant brought yogurt for R1 and he declined Tylenol. R1's late entry progress note documented on [DATE] at 5:40 p.m. for entry from [DATE] at 7:58 a.m., identified R1 had 1,000 milligrams (mg) of Tylenol for pain. R1's family member (FM)-A was present in room and R1 appeared calm and was sitting in the recliner. R1's late entry progress note documented on [DATE] and 5:40 p.m. for entry from [DATE] at 8:05 a.m., identified R1 was complaining of chest pain and nausea. R1 did not complain of increased pain with breathing and pain was not radiating. R1 did have a small, clear emesis with continued nausea. Continue to monitor symptoms and notified nurse manager and told her it was put on rounds for the provider to address when she arrived. R1's vital sign record on [DATE] at 8:15 a.m. were BP ,d+[DATE], T 97.5, P 61, R 16, 02 99% room air. R1's late entry progress note documented on [DATE] at 5:45 p.m. for entry from [DATE] at 8:29 a.m., identified R1's family member (FM-A) came to the nurse's station after the provider recommendation to be sent to the emergency room . Nurse asked FM-A if they wanted to transport R1 or if the facility should call the ambulance. R1's late entry progress note documented on [DATE] at 5:43 p.m. for [DATE] at 8:30 a.m., identified LPN-B called provider about R1's symptoms and physician requested R1 be sent to the emergency room . In review of R1's record on [DATE], the record did not identify continuous monitoring of R1's condition and did not include a comprehensive assessment of R1's cardiac status. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Interact Transfer to Hospital form dated [DATE] at 8:30 a.m., identified most recent vital signs were on: [DATE]- BP ,d+[DATE], R 18, T 98.7, P 80, 02 97%, [DATE], vital signs were not recorded, Pain level 6 R1's progress note dated [DATE] at 8:38 a.m., identified R1 stated pain was ,d+[DATE], not radiating and not worse when he takes a deep breath or with exertion. Vitals within normal limits and 2+ pitting edema to BLE. R1 stated Tylenol was not effective, provider notified and recommended to send to emergency room . Ambulance called and FM-A was with R1. R1's late entry progress note dated [DATE] at 8:45 a.m., identified ambulance was dispatched to facility. Fire department arrived and said the ambulance was approximately 45 minutes out. R1 complained of pain radiating in the upper extremities to the fire department. R1's progress note dated [DATE] at 9:37 a.m., identified R1 discharged to the hospital on [DATE] at 9:00 a.m. R1's hospital records dated [DATE], identified on [DATE], R1 had an electrocardiogram performed which showed acute anterior STEMI (severe type of heart attack that affects the lower chambers of the heart and can cause permanent damage or death). R1 had a surgical procedure however after procedural intervention, R1 suffered complications that included cardiogentic shock and pulmonary hemorrhage (acute bleeding from the lung).R1 transferred to comfort cares and expired on [DATE] at 7:50 p.m., with preliminary cause of death listed as cardiac arrest. During an interview on [DATE] at 11:42 a.m., licensed practical nurse LPN-A stated on [DATE] an aide came to her around 6:00 a.m. and informed her R1 had chest pain. LPN-A stated R1 had never had chest pain before. LPN-A stated she went and did a little check on him. LPN-A examined his legs and noted they were bigger than she had seen them before. LPN-A listened to R1's lungs and noted wheezing in the lower lobes and heard it more in the left than the right. LPN-A asked R1 if the pain radiated, any SOB or hurting with taking a deep breath, and took a set of vital signs. R1's vital signs were as close to perfect as anyone could get which did not seem like they would be for someone in distress. However, LPN-A could not recall what R1's vital signs were that she had collected. At that point she left the room and told R1 to call if he had any questions and she would be back to check on him. LPN-A told LPN-B of her findings and they both felt the R1's symptoms were associated with the six-pound weight gain in 1.5 weeks and made sure that R1 was on the rounding sheet for physician to see him later that morning. Sometime before before 8:00 a.m., R1 had an emesis bag in his hand and had spit up of clear fluid, no frothiness. LPN-A reported R1's emesis to LPN-B who told her it is something that would happen with fluid build-up in the lungs. At 8:00 a.m. LPN-A informed the nurse managers (NM) of R1's condition and R1 was on rounds for later that morning. Around 8:25 a.m., NM-A came over with R1's family member (FM)-A and asked her what we were doing with the situation. LPN-A explained to FM-A that they were waiting for physician rounds. NM-A then told LPN-A to call the provider and not wait. LPN-B called provider while LPN-A called the ambulance. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 2:43 p.m., LPN-B indicated on [DATE] at approximately 6:00 a.m., during morning shift report LPN-A mentioned R1 had chest pain and she assessed him, so LPN-B began the medication pass. LPN-B entered R1's room around 7:00 a.m. and checked his blood sugar. R1 and LPN-B discussed the high reading and the new symptom of nausea. LPN-B did not see any emesis in the emesis bag and did not listen to his lungs. LPN-B stated R1 explained the pain was above the belly button at the center of his chest and not worse with movement and not radiating. LPN-B had R1 eat a yogurt because he had a diagnosis of GERD; the yogurt would coat his stomach lining and relieve his nausea. She offered R1 Tylenol for the chest pain but R1 declined. He did request the Tylenol a short time later when his family member was present. A short time later R1' FM-A came out of R1's room and told her the Tylenol was not working and the pain had increased. LPN-B went straight to the phone and called the physician who ordered R1 to be sent to the hospital urgently. During a phone interview on [DATE] at 4:10 p.m., family member (FM)-A stated she got a call from (R1) around 7:00 a.m. complaining he had heavy chest pain and had been trying to reach staff and was told by staff the provider would be at the facility around 8:00 a.m. I was irritated and told them to call the doctor, how can you provide better service in that situation because clearly he was having a major heart attack!. During an interview on [DATE] at 1:24 p.m., NM-A stated on [DATE] around 8:,d+[DATE]:30 a.m., she was informed FM-A was upset and at the nursing desk, so she went to talk with her. NM-A explained that was when she found out R1 had chest pain. When she asked LPN-A and LPN-B they informed her the physician had not been notified of R1's chest pain but his was added to the physician round list to be seen that morning, NM-A directed them to call the physician immediately because R1 had chest pain and could be a cardiac event which would need emergency intervention. In those cases we should call 911 and notify the physician after. During an interview on [DATE] at 10:13 a.m., nurse practitioner (NP)-A stated R1 was very in tune with his body and would ask questions about the healing process and about anything that happened during his stay health related. NP-A received a call from the facility at 8:26 a.m., R1 had been having chest pain since 5:30 a.m. I would expect the facility to call for chest pain, any word of chest pain. We were already behind [with emergency treatment]when they did call because they had not called at the onset of chest pain and I said to send him in immediately. R1 died last evening from complications, whether R1 died as a result of delayed treatment or surgery NP-A was unsure. NP-A stated R1 was planning to discharge home in the next couple of weeks when therapy was complete. During an interview on [DATE] at 1:38 p.m., administrator stated she expected the staff to notify the doctor for a change in condition and not wait until the provider is going to round on the resident, even if the provider is scheduled to come the next morning. Administrator stated after the incident occurred the facility began immediate actions to remedy the situation by providing education to all nursing staff, which included re-education on change of condition, signs and symptoms of cardiac conditions, a quiz that inquired of nurses what they considered a change of condition, and what do nurses do when a change of condition occurs along with a nurse meeting that was scheduled for next week to again review change of condition. Administrator and DON reviewed all residents by running a report and reviewing all other residents with recent changes in condition and identified no other at-risk residents. The facility Change in a Resident's Condition or Status policy revised February 2021 directed: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-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. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider; including information prompted by the Interact SBAR Communication Form. 8. the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition of status. The facility Resident Examination and Assessment revised February 2014 directed the facility to examine and assess the resident for nay abnormalities in health status, which provides a basis for the care plan. Physical Exam included: -vital signs (blood pressure, pulse, respirations, and temperature) -cardiovascular (heart rate and rhythm, peripheral pulses, capillary refill) -respiratory (lung sounds, irregular or labored respirations, cough, sputum) -neurological (alertness and orientation, speech clarity) -genitourinary (urine clear or cloudy, presence of catheter) The past non-compliance IJ that began on [DATE] and was removed on [DATE] when it was verified the facility implemented the following: 1) re-education on change of condition with nurse management team prior to next shift 2) posters of signs/symptoms of cardiac episodes posted at nurses stations and reviewed with all staff (continued on next page)

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