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	03/06/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm 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** Based on observation, interview, and record review, the facility failed to administer long-acting insulin at consistent times for 2 of 3 residents (R1, R4), failed to appropriately respond to abnormal blood glucose levels, and failed to ensure monitoring and follow-up after interventions for hypoglycemia for 1 of 3 residents (R1) reviewed for diabetic management.R1's face sheet dated 3/5/26, identified a diagnosis type 2 diabetes mellitus.R1's comprehensive Minimum Data Set (MDS) dated [DATE], identified R1 had no cognition issues. R1 was on a therapeutic diet and received insulin injections seven days per week.R1's care plan revised on 3/4/25, identified a focus of risk for complications related to altered glucose metabolism. Diagnosis of diabetes mellitus with retinopathy (damage to retina of the eye). Interventions included:administer medication(s) to control glucose levels and/or insulin as ordered. Monitor for side effects and effectiveness. Report adverse effects to provider as needed. If infection is present, consult provider regarding any changes in diabetic medications as applicable. Follow up as indicated.Care: ALTERED GLUCOSE METABOLISM. General. Avoid exposure to extreme heat/cold. Moisturize dry skin daily. DO NOT apply lotion over breaks in skin or wounds. Provide and serve diet as ordered. Ensure that all solids/liquids meet dietary recommendations/orders and offer substitutes for foods not eaten as needed/if desired. Report changes in mentation, skin abnormalities, tremor/shaking, sweating, or changes in ability to perform activities of daily living (ADL)'s to nurse promptly.Care: ALTERED GLUCOSE METABOLISM. Nurse. Blood sugars per glucose monitor as ordered and as needed. Perform skin checks and observe for breaks in skin and treat new skin concerns promptly per orders and/or facility protocols as needed. Report abnormalities to provider. Refer to podiatrist/foot care nurse to cut long nails and determine foot care needs as needed. Report BGT (unknown what that stands for) outside of ordered parameters or significant blood sugar or intake trends to provider as needed. Follow up and document as indicated.Care: HYPOGLYCEMIA. Nurse. Blood sugars per glucose monitor as ordered or as needed. Administer rapid source of glucose per orders and/or facility protocols based on level of consciousness and route of glucose administration as needed. Obtain a blood sugar promptly if a diabetic patient has a significant change in mental status or loss of consciousness. Report BGT outside of ordered parameters or significant blood sugar trends to provider as needed. Follow up and document as indicated.Dietary Consult. Registered Dietician (RD) to monitor/record/document the residents usual eating habits, nutritional status, and patterns to assist with determining nutritional approaches that will enhance management of altered glucose metabolism. RD to evaluate and make dietary changes/recommendations and discuss food preference with the resident as needed. Encourage adequate nutrition and hydration. Consult with RD and/or provider regarding supplemental protein, amino acids, vitamins, and minerals as needed.Education: ALTERED GLUCOSE METABOLISM. Resident/family/caregiver; stress importance of compliance with ordered regimes and general health maintenance. Instruct on recognizing/preventing complications. Impress upon the resident the importance of adhering to dietary recommendations and RD consultation. Discuss possible barriers to success and solutions to minimize. Instruct on daily foot observations/care and appropriate footwear. Instruct to avoid over the counter corn/callous treatments and to consult (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 - Minimal harm or potential for actual harm Residents Affected - Few	podiatrist as needed.Notify primary physician immediately with blood sugar concerns, then hospice, then family.Monitor/document/report as needed compliance with diet and disease and/or medication management. Document problems and report noncompliance to provider. Follow up as indicated and as needed.Obtain and monitor lab/diagnostic work as ordered. Fasting serum blood sugars and hemoglobin(Hgb)A1C (lab that determines blood glucose levels over a three month time span) as ordered. Report abnormalities to provider and follow up as indicated and as needed.Resident has a Dexcom he uses to monitor blood sugars. Nursing will assist with changing Dexcom every 10 days.Signs/Symptoms: HYPERGLYCEMIA: monitor/document/report as needed any signs/symptoms of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, abdominal pain, Kussmaul breathing (deep, rapid, and labored breathing pattern), acetone breath (smells fruity), stupor (state of near-unconsciousness), and coma. Report significant abnormalities and/or BGT outside of usual resident parameters to provider and follow up as indicated and needed.Signs/symptoms: HYPOGLYCEMIA. Monitor/document/report any signs/symptoms of hypoglycemia: sweating, tremor, increased heart rate (tachycardia), pallor, nervousness, confusion, slurred speech, lack of coordination, staggering gait. Report significant abnormalities and/or BGT below parameters that is unresponsive to facility protocols to provider. Follow up as indicated and as needed.Nursing will change Dexcom sensor every 10 days. Order supplies from Veterans Affairs.Place Dexcom in night stand at hour of sleep.When asking resident what he would like for a snack at 7:00 p.m. please offer choices. Do not ask yes or no questions.R1's physician order dated 12/1/25, included glucose oral tablet chewable-give 4 tablets by mouth as needed for low blood sugar (54-70 milligrams (mg)/deciliter (dl). Chew 4 tablets as needed for low blood sugar.R1's physician order dated 12/1/25, included a sliding scale for Novolog (short-acting) insulin which included to call provider if blood glucose was above 379.R1's physician order dated 12/1/25, directed to notify provider right away if two blood glucose readings are below 70 or above 400 in a 24-hour timeframe and/or change in condition. If no change in condition, notify provider on the next business day.R1's physician order dated 12/16/25, included Glargine (type of insulin) 22 units subcutaneously daily.R1's medication administration record (MAR) for the month of January 2026, included the order for Glargine 22 units subcutaneously every day shift with an administration times between 6:30 a.m. - 1:00 p.m. In review of administration times in conjunction with documented blood glucose readings indicated when the insulin was administered later in the day, blood glucose levels were increased in the afternoon and evening. Excerpts from January glargine administration times with blood glucose readings for the day included:1/1/26-1/4/26 Glargine administered between 9:30 a.m. and 9:45 a.m.1/5/26 glargine administered at 10:34 a.m.R1's record identified that Glargine was not administered on 1/6/26, with no indication provided.1/7/26 Glargine administered at 9:22 a.m.glucose 84 at 8:33 a.m., 334 at 1:03 p.m., 257 at 4:31 p.m., and 127 at 7:05 p.m.1/8/26 Glargine administered at 11:28 a.m.Glucose 106 at 7:57 a.m., 145 at 11:17 a.m., 234 at 4:11 p.m., and 219 at 7:12 p.m.1/9/26 Glargine administered at 9:18 a.m.Glucose 120 at 9:11 a.m., 138 at 12:38 p.m., 112 at 4:17 p.m., and 154 at 7:04 p.m.1/10/26 Glargine administered at 12:17 p.m.Glucose 123 at 12:15 p.m., 314 at 5:29 p.m., 258 at 7:59 p.m.1/11/26 Glargine administered at 11:35 a.m.Glucose 115 at 9:44 a.m., 429 at 4:42 p.m., 214 at 9:23 p.m.1/18/26 Glargine administered at 1:09 p.m.Glucose 86 at 9:56 a.m., 133 at 1:08 p.m., 258 at 8:09 p.m.1/19/26 Glargine administered at 10:54 a.m.Glucose 52 at 3:51 a.m., 78 at 4:30 a.m., 108 at 4:59 a.m., 127 at 8:40 a.m., 156 at 11:55 a.m., 164 at 4:03 p.m., 150 at 7:03 p.m., 83 at 11:43 p.m.R1's progress notes from 1/19/26, did not identify physician notification or interventions provided for R1's blood glucose readings of 52 and 78.1/20/26 Glargine administered at 9:35 a.m.Glucose 121 at 1:20 a.m., 103 at 7:28 a.m., 126 at 12:14 p.m., 109 at 4:16 p.m., 241 at 8:34 a.m.1/21/26 Glargine administered at 12:14 p.m.Glucose 87 at 8:34 a.m., 174 at 11:41 a.m., 177 at 3:40 p.m., 129 at 4:33 p.m., 169 at 7:48 p.m.1/22/26 Glargine administered at 9:25 a.m.Glucose 94 at 9:12 a.m., 54 at 10:44 a.m., 130 at 3:56 p.m., 338 at 7:00 p.m.1/23/26 Glargine administered at 2:45 p.m.Glucose 97 at 9:26 a.m., 129 at 11:56 a.m., 243 at 4:17 p.m., 190 at 7:10 p.m.R1's Dexcom G7 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Manual undated, identified the sensor sends a glucose reading to the receiver every five minutes.R1's physician order dated 1/22/26, included glucagon injection to inject1 milligram (mg) intramuscularly one time for low blood sugar.R1's progress note dated 1/22/6 at 10:48 a.m., identified R1's blood glucose was 54. Gave R1 orange juice to drink, R1 could not drink it all. Retook blood glucose 57. R1 leaving for appointment. Administered glucagon per house standing orders. R1 then left for appointment.R1's progress note dated 1/22/26, identified a Situation, Background, Assessment, Recommendation/Response was completed at 11:31 a.m., identified R1's blood sugar 54. R1 leaving for appointment. R1 was alert and able to communicate. Sluggish. Gave a glass of orange juice but R1 did not want to drink it. R1 did take about 90 cubic centimeters (cc). Rechecked blood glucose 57. Administered glucagon out of emergency kit per house standing orders. R1 left for appointment. Recommended to family member (FM)-A to recheck blood glucose in half an hour. Called nurse practitioner and hospice and informed of situation.R1's record review did not identify a comprehensive assessment that was completed for signs/symptoms of hypoglycemia and not evident monitoring was completed to ensure blood glucose returned to safe levels after administering the glucagon. R1 did not have his blood glucose read again until 3:56 p.m.During an interview on 3/4/26 at 2:47 p.m., licensed practical nurse (LPN)-B stated R1 had a Dexcom (continuous blood glucose monitoring system). There was a button on the monitor that when pressed it showed the blood glucose readings. R1 did not show signs or symptoms with high or low blood glucose readings. LPN-B had not ever seen R1 have really high or low blood glucose levels. R1 was not on her list of residents to take care of on 1/22/26, R1 was either cared for by the trained medication aide (TMA) or the other nurse. On 1/22/26, R1 and family member (FM)-A were in the dining room. FM-A was upset because R1 had low blood glucose and had appointments that he was supposed to be leaving the facility to attend. LPN-B thought either a TMA or a nursing assistant (NA) had alerted her that R1's blood glucose was low. The Dexcom was not beeping when LPN-B was by R1. LPN-B could not recall if a fingerstick glucose was obtained or if only the Dexcom monitor was read. 54 is a low reading, like comatose level, and LPN-B was just fixing the problem by getting him safe. LPN-B could not locate R1's glucose tablets in the medication cart. LPN-B obtained the glucagon injection from the emergency medication kit and administered it to R1. R1's blood glucose rose to 58 after the glucagon administration and was rising. LPN-B stated she told the van driver and told FM-A to watch the Dexcom and if it started to go low have the driver stop. LPN-B stated she was uncomfortable with R1 leaving the building. R1 was fine when he returned after his appointments.During a phone interview on 3/5/26 at 2:26 p.m., FM-A stated on 1/22/6, R1 had a breakfast tray in the dining room. FM-A sat by R1 and heard a beeping noise. FM-A was unsure what had beeped. A few minutes later, the beeping began again. FM-A realized it was R1's Dexcom beeping because R1 was out of the range he should be in. FM-A went to the kitchen and obtained a glass of orange juice because she knew that would help immediately. When the Dexcom beeped again, FM-A went to the nurse's station, found a staff member and told them the situation. The person stated they were trying to find out what they could do because the facility did not have any glucose tablets. The staff person called someone on the phone and shortly after she came to R1. No one took a manual reading of R1's blood glucose. The staff just came out and gave him an injection. FM-A recalled the blood glucose rose two points from the original number. FM-A did not recognize R1 acting or behaving any different than usual. FM-A was concerned if the monitor was working properly but the nurse went with it. FM-A was concerned about leaving with R1 to go to his appointments and asked the nurse what to do. The response was call 9-1-1. The nurse did not tell FM-A to wait to make sure the blood glucose rose. FM-A stated she would have cancelled R1's appointments if the facility showed any concern about the low blood glucose. FM-A was not used to a situation like this. They didn't even make sure he got out to the car, just gave the shot and left. It was terrifying and unnecessary. If he would have crashed, I wouldn't have known what to do.During a phone interview on 3/5/26 at 2:15 p.m., the van company president stated, referred to R1's transport on 1/22/26 to the clinic and asked how would we have known R1 had a low blood sugar?During a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	phone interview on 3/5/26 at 1:02 p.m., registered nurse (RN)-V from R1's appointment indicated they had not received any communication from the facility on 1/22/26 and they were unaware of R1's low blood glucose reading.During a phone interview on 3/5/26 at 3:25 p.m., medical doctor (MD)-A stated R1's blood glucose should have been manually checked on 1/22/26 to verify the Dexcom was giving correct reading. Blood glucose levels presenting that low could cause a person to go into a coma and possibly die. Administering long-acting insulin at random times each day could potentially lead to overlap and drop the resident low.R1's record identified that glargine was not administered on 1/29/26, and no blood glucose was obtained in the sliding scale insulin given in the morning or lunchtime, with no indication provided. Blood glucose readings were 103 at 9:43 a.m. and 158 at 12:44 p.m., which indicated R1 should have been provided 2 units of insulin. At 9:11 p.m. R1's blood glucose reading was 70.R1's progress note dated 1/30/26 at 7:52 a.m., identified when blood glucose of 70 was obtained at hour of sleep, R1 was provided orange juice and the reading increased to 86. R1 was provided with another glass of orange juice and registered blood glucose of 110 at 11:20 p.m.R1's progress note dated 2/2/26 at 4:39 a.m., identified Dexcom was beeping and showed a glucose reading of 70 at 12:30 a.m., denied symptoms. When nurse was informed glucose reading was 68, given 6 ounces of orange juice. Glucose was 97 fifteen minutes later. Rechecked four hours later and it was 73. Will provide 6 ounces orange juice and awaken R1 to drink. At 6:09 a.m., glucose was 82 and R1 had not drank the orange juice that had been provided earlier.R1's physician visit note dated 2/5/26, identified an order to decrease glargine (long-acting insulin) to 20 units daily.R1's MAR dated February 2026, identified Glargine insulin administer 20 units subcutaneously every day shift. The time to administer was 6:30 a.m.-1:00 p.m. Excerpts from February and March glargine administration times included:2/8/26 Glargine administered at 9:19 a.m.2/9/26 Glargine administered at 11:08 a.m.2/10/26 Glargine administered at 9:43 a.m.R1's blood glucose reading at 7:02 p.m. was 66. At 7:31 p.m., 107.2/12/26 Glargine administered at 1:01 p.m.R1's blood glucose reading at 10:19 a.m. was 69. At 12:53 154. No further documentation provided.2/16/26 Glargine administered at 8:38 a.m.Glucose reading at 7:04 a.m. was 70. Progress note identified orange juice provided. No further follow-up until glucose monitored at 11:10 a.m. 129.2/25/26 Glargine administered at 11:30 a.m.2/26/26 Glargine administered at 9:10 a.m.2/27/26 Glargine administered at 11:40 a.m.3/1/26 Glargine administered at 9:30 a.m.3/2/26 Glargine administered at 2:43 p.m.3/3/26 Glargine administered at 8:23 a.m.3/4/25 Glargine administered at 9:45 a.m.3/5/26 Glargine administered at 11:10 a.m.R1's record review between 1/1/26-3/4/26, identified an order to replace Dexcom sensor every 10 days and as needed but did not provide directions on how to change sensor, to complete a manual reading to verify results, or what to set the alarm for until 3/5/26, while surveyor was onsite.During a phone interview on 3/4/26 at 2:59 p.m., FM-A stated R1 has had diabetes for years. R1 never had the trouble with blood sugar going high and low at home or at prior facility. All of the issues with blood glucose have taken a huge toll on R1. On 1/22/26, R1 could have died, that was absolutely unacceptable. FM-A questioned if it could be the facility giving morning medications at 10:00 a.m. and giving afternoon medications an hour and a half later. we don't know any different, we are not medical professionals.During an interview on 3/5/26 at 1:38 p.m., health unit coordinator who was also a nursing assistant, NA-E stated she was unsure why she transcribed the order for every day shift. NA-E stated it should be input for one time a day. Sometimes, the order was put in and the nurse who confirmed the order would change the times so that they were more suitable. The system would not identify if the nurse changed the administration time prior to confirming the order.During a continuous observation and interview on 3/5/26 beginning at 9:20 a.m. R1 was in his room, getting into his wheelchair with NA-B. NA-B and R1 continued with morning routine of placing hearing aids in ears, brushing teeth, and putting on glasses. During cares NA-B stated she was aware that R1 was diabetic. There was a sheet at the nurse's station that informed who was diabetic and in the charting there was a prompt that would ask if the resident had shown signs like shakiness. NA-B stated R1 had a port that helped with his blood glucose numbers. NA-B was unable to articulate a sign of low (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood sugars other than weakness. NA-B propelled R1 out of his room and to the nurse's station to check a piece of paper. NA-B then wheeled R1 to the scale and weighed him. NA-B brought R1 to the commons room and set him up at a table that had a tray on it. NA-B put straws in the drink cups. R1 asked for peanut butter. At 10:11 a.m., R1's blood glucose had not been obtained and Glargine and sliding scale insulin had not been given. R1 began to take sips from his orange juice and coffee. NA-B placed peanut butter packet on table and left to wash her hands. R1 picked up the peanut butter and attempted to open it with his teeth. NA-B returned to the table and opened the peanut butter and spread it on a bagel. R1 took the bagel and brought it to his mouth. NA-B put brown sugar on R1's oatmeal. R1 also had 3 sausage patties, 3 bacon strips, and 2 eggs on his plate. R1's Dexcom displayed 0 and had a message to start a new sensor. R1 showed NA-B. NA-B stated she would get the nurse. At 10:24 a.m., R1 finished the bagel. At 10:29 a.m., R1 finished eating the sausage at 10:32 a.m. and completed both by 10:35 a.m. At 10:38 a.m. No nurse/TMA had gotten his blood glucose reading and no insulin had been administered. At 10:47 a.m., R1 began eating his bacon. At 10:48 a.m., TMA-A verified she had not obtained a blood glucose reading for R1 that morning. TMA-A walked over to R1 and pressed his Dexcom I thought they just put a new one on but it isn't working, guess I will take it manually. At 10:50 a.m., TMA-A went to the medication cart to get the manual glucometer. TMA-A returned to R1 and stated LPN-A would put a new Dexcom on R1 later. At 10:52 a.m., R1's blood glucose was 153. TMA-A stated blood glucose should be obtained at 7:30 a.m. or prior to eating. R1 was not up at 10:00 a.m. and I just got back from break. R1 had not received his long-acting insulin either, the insulin can be given anytime from 6:00 a.m.-2:30 p.m. TMA-A stated R1 has short-acting insulin and his blood glucose was usually around 90 but today he would get around 2 units. TMA-A did not tell the nurse that she did not obtain the blood glucose prior to R1eating. At 11:04 a.m., R1 was consuming the third sausage. LPN-D stated she needed to remove him from the table, take him to his room, and administer his insulin. At 11:08 a.m., LPN-D administered 20 units of long-acting insulin and 2 units of short-acting sliding scale insulin. After administration, LPN-D brought R1 back to the commons area table to continue eating.During an interview on 3/5/26 at 11:13 a.m., LPN-D stated R1 received his long-acting insulin between 10:00 a.m.-2:00 p.m. R1 received his short-acting at the same time. Blood glucose should technically be checked before eating and insulin should also be given before meals. he is not my patient today. Blood glucose can spike after eating, so the short-acting should be given before meals and long-acting can be given whenever the doctor prescribes. LPN-D stated she did not trust Dexcom systems, they never work and can be off by 50.During an interview on 3/5/26 at 12:20 p.m., R1 sat in his wheelchair in his room with the overbed table in front of him, and breakfast tray with oatmeal and drinks. FM-C sat next to R1. FM-C stated staff would now give him R1 a rice crispy bar and yogurt for lunch. R1 stated he did not feel any different when he has high or low blood glucose. FM-C stated FM-B told her the Dexcom had not been working since 3/4/26. FM-C thought the battery was dead and took the machine and plugged it in. Its 100%. Let's look at the sensor and make sure it is connected. FM-C stated there was not a sensor on R1, only a clear patch where the sensor should be. R1 stated the sensor came off during his shower on 3/4/26 and the staff did not notice.During an interview on 3/5/26 at 1:18 p.m., LPN-D stated the preference for medications to be scheduled for AM/PM/HS blocks so there was more time to administer. If something was scheduled for a specific time, it just did not happen, there was not enough time. R1's physician order for Glargine dated 1/2/26 read daily (administration), and on 2/5/26, it also read to decrease to 20 units daily (administration). When the order read daily without a specific time identified, staff would pick the administration time. The nurse would then acknowledge or confirm the order. LPN-D stated she realized the error and told RN-C about it. Giving the glargine at different times could absolutely affect the blood glucose readings and the littlest difference in time administration can really affect the care. LPN-D worked the evening of 3/4/26, and was unaware that R1's sensor had fallen off, aides didn't tell me. LPN-D stated she changed the sensor once but there were no instructions on how to change it so I do what all nurses do, I YouTube itDuring an interview (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 3/5/26, clinical manager RN-C stated the Dexcom instructions on how to change the Dexcom should be included in the residents MAR or treatment administration record (TAR). Fortunately, when the Dexcom had needed to be replaced, the same nurse was doing it. RN-C stated if she was inputting orders for long-acting insulin in the MAR she would have the administration times between 6:00 a.m.-10:00 a.m. RN-C acknowledged that administering long-acting insulin over various times will bottom them out or something will happen. On 1/22/26, when R1 was given glucagon, his blood glucose should have been checked manually. R1 should not have left the facility with a reading of 58, he should have stayed and waited until the reading was higher. RN-C stated the van driver was unaware of the low blood sugar and that would have been awful if something happened during the ride. RN-C stated the facility did not conduct audits on when blood glucose readings are obtained or when insulin is administered. R4R4's face sheet dated 3/9/26, identified diagnoses of type 2 diabetes with chronic kidney disease with heart failure, chronic kidney disease stage 4, diabetic peripheral angiopathy without gangrene, nonproliferative diabetic retinopathy without macular degeneration bilateral, hyperglycemia, and diabetic polyneuropathy.R4's quarterly MDS dated [DATE], identified R4 had no cognition issues, had moderate difficulty with hearing, and had corrective lenses. R4 was independent with eating. R4 followed a therapeutic diet, and had insulin injections seven days/week.R4's physician order dated 10/14/25, identified Glargine 30 units daily.R4's MAR dated February 2026, identified Glargine 20 units daily. This order was scheduled for AM. Excerpts from February and March Glargine administration times included:2/10/26 Glargine administered at 7:53 a.m.2/11/26 Glargine administered at 12:10 p.m.2/12/26 Glargine administered at 9:00 a.m.2/19/26 Glargine administered at 7:07 a.m.2/20/26 Glargine administered at 12:17 p.m.2/21/26 Glargine administered at 11:33 a.m.2/22/26 Glargine administered at 7:18 a.m.3/1/26 Glargine administered at 8:38 a.m.3/2/26 Glargine administered at 6:59 a.m.3/3/26 Glargine administered at 8:33 a.m.3/4/26 Glargine administered at 6:49 a.m.3/5/26 Glargine administered at 8:12 a.m.During an interview on 3/5/26 at 12:37 p.m., RN-B stated long-acting insulin should be given before breakfast or at bedtime, depending on the order. It should generally not be given at anytime during the shift. Blood glucose should be obtained before meals and at bedtime. If taken during a meal it could skew the reading and the resident could be given too high of a dose and crash later. During a phone interview on 3/5/26 at 11:36 a.m., pharmacist (P)-A stated administering long-acting insulin between 6:00 a.m.-2:30 p.m. was not okay, it would need to be more specific than that. Manufacturer recommendations directed to administer at the same time every day. P-A would not be worried if the administration time was within an hour each day but if they are administering at 6:00 a.m. one day and 2:30 p.m. then the resident would not get consistent levels and would have high and low blood glucose readings. Blood glucose readings should be obtained before the resident ate and before insulin was given. If it was taken while eating, the risk is the blood glucose could still be rising, and the resident could get too much or too little insulin.The facility Diabetes-Clinical Protocol policy revised March 2025, identified For residents with confirmed diabetes, the nurse will assess and document/report the following during the initial assessment:Level of consciousness, change in orientation;Signs or symptoms of cognitive decline;History of medication management;Dose and time of most recent anti-hyperglycemic given;All other current medications;Any signs or symptoms of infection (urine, skin/wound, upper respiratory, etc.) or other acute illnesses;Foot complications;Vision or hearing impairment;Recent weight loss/failure to thrive;Usual patterns of eating and drinking;Approximate intake over the last 24 hours;Recent change in intake/thirst;Resident's blood sugar history over 48 hours;Usual patterns (fluctuations, trends) of blood sugar over recent months;Onset, duration of any changes; andRecent labs.The staff will incorporate orders and reporting parameters into the Medication Administration Record and care plan.An example of an appropriate hypoglycemia treatment protocol is:For a conscious resident:administer 15 g of carbohydrate;recheck the resident's blood glucose in 15 minutes;if blood glucose is still below 70 mg/dL, administer another 15 g of carbohydrates and recheck;repeat until blood glucose increases to at least 70 mg/dL or resident is without symptoms (continued on next page)

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	03/06/2026

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 - Minimal harm or potential for actual harm Residents Affected - Few	and then;offer a snack or meal containing carbohydrates and protein.For an unconscious resident:Call 911 (in accordance with the resident's advance directive);administer 1mg of glucagon subcutaneously or intravenous 50% glucose (if there is IV access);obtain IV access, as soon as possible;glucagon peak effect is reached in 30 minutes. Do not administer glucagon more than twice.recheck blood sugar every 15 minutes until blood glucose is above 70 mg/dL and/or resident is without symptoms and then;offer snack or meal with carbohydrates.Staff will notify the practitioner immediately (but not delay intervention) when the resident's blood glucose is less than 70 mg/dL AND is unresponsive OR consecutive blood glucose readings are less than 70 mg/dL.HyperglycemiaStaff will notify the practitioner as soon as possible when:the resident has two or more blood glucose readings higher than 250 mg/dL within a 24-hour period accompanied by a new medical problem or a change in condition or functional status;the resident has blood glucose readings higher than 300 mg/dL during all or part of 2 consecutive days;the resident is not eating well or is vomiting, or an antidiabetic medication has been held;the resident is not eating well or consuming sufficient fluids and has 1 or more additional symptoms suggesting an acute illness.The facility Insulin Administration policy revised March 2025, identified long-acting insulin glargine had an onset time of 2-4 hours, peak was flat, duration of 20-24 hours.The facility Standing Orders dated 10/3/25 and signed by the Medical Director, identified if the patient has a continuous glucose monitor, initiate the below orders:set alarms for <100 LOW and >400 HIGHwith first application do fingerstick 2 times 3 hours apart and document both fingerstick and continuous glucose monitor readings. Notify provider if readings are >20 points differencefinger stick as needed if blood glucose is <100 or >400, change in condition, or concerns arise of continuous glucose monitor accuracy or not reading.Charge display every night-keep within 20 ft of the patient.Apply a new sensor every 14 days or per sensor instructions.