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	12/15/2025

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide sufficient staffing to ensure 7 of 7 residents (R4, R7, R10, R11, R14, R18, and R46) reviewed for adequate staffing received timely assistance with incontinence care, hydration, and prompt call light responses. The deficient practice had the potential to affect all 61 residents who resided in the facility. Finding include: See F676- Based on observation, interview and document review, the facility failed to ensure residents received assistance with meals for 1 of 2 resident (R5) reviewed for nutrition who required staff assistance and/or supervision with meals See F677- Based on observation, interview and document review, the facility failed to provide incontinence care for 1 of 1 resident (R12) reviewed who was dependent upon staff for assistance with activities of daily living (ADL). See 921- Based on observation and interview, the facility failed to provide a comfortable and sanitary environment for 1 of 1 resident (R4) reviewed for environment, when a bedside commode was observed overfilled and a soiled brief was observed in a wastebasket. See F880- Based on observation and interview, the facility failed to sanitize and/or replace resident water mugs on a daily basis for 7 of 7 residents (R10, R4, R7, R30, R39, R54, R17), reviewed for infection control practices, to ensure a safe and sanitary vessel from which residents consumed water. R7's annual Minimum Data Set (MDS) assessment dated [DATE], indicated no cognitive impairment, dependent staff for, toileting hygiene, lower body dressing; partial moderate/assistance with showers, lying to sitting, and required substantial/maximal assistance with toilet transfer, and utilized a wheelchair. R11's annual MDS assessment dated [DATE], indicated moderately impaired cognition, utilized a wheelchair, required partial/moderate assistance with toileting hygiene, lower body dressing, shower/bathe, sit to stand, sit to lying, and rolling. R14's quarterly MDS assessment dated [DATE], indicated no cognitive impairment, dependent staff for eating, toileting hygiene, showers, dressing, personal hygiene, transfers and utilized a wheelchair. R18's annual MDS assessment dated [DATE], indicated no indicated no cognitive impairment, partial moderate/assistance with toileting hygiene, upper body dressing, personal hygiene, required substantial/maximal assistance with showers/bathe, lower body dressing and lying to sitting; utilized (continued on next page)

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	a wheelchair. R4's quarterly MDS assessment dated [DATE], indicated history of stroke with hemiplegia (paralysis affecting one side of the body). R4 had intact cognition. R4 required substantial assistance or was dependent upon staff for help with activities of daily living (ADLs). R4 did not walk. R10's quarterly MDS assessment dated [DATE], included diagnoses of spinal stenosis (narrowing of spaces within the spine) and fibromyalgia (chronic condition that causes widespread pain). R10 had intact cognition. R10 had frequent urinary incontinence and required substantial assistance or was dependent upon staff for assistance with ADLs. R46's annual MDS assessment dated [DATE], indicated history of colon cancer. R46 had intact cognition. R46 had occasional urinary incontinence and had a colostomy for bowel. R46 required supervision or was dependent upon staff for ADLs. Call-light response times: R11's call light response times from 11/8/25-12/8/25, indicated 25 activations with response times as follows: 20-30 minutes = 4 31-40 minutes = 4 >60 minutes = 1 R14's call light response times from 11/8/25-12/8/25, indicated 268 activations with response times as follows: 20-30 minutes = 26 31-40 minutes = 12 41-50 minutes = 7 R18's call light response times from 11/8/25-12/8/25, indicated 527 activations with response times as follows: 20-30 minutes = 17 31-40 minutes = 17 41-50 minutes =9 >50 minutes = 2 3 hours = 1 R4's call light response times from 11/8/25, thru 12/8/25, indicated 251 activations with response (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	times as follows: 20-30 minutes = 18 times 31-40 minutes = 3 times 41-50 minutes = 3 times > 50 minutes = 4 times > 60 minutes = 3 times > 90 minutes = 3 times R10's call light response times from 11/8/25, thru 12/8/25, indicated 284 activations with response times as follows: 20-30 minutes = 17 times 31-40 minutes = 3 times 41-50 minutes = 3 times > 50 minutes = 1 times > 90 minutes = 1 times R46 call light response times from 11/8/25, thru 12/8/25, indicated 424 activations with response times as follows: 20-30 minutes = 21 times 31-40 minutes = 13 times 41-50 minutes = 4 times > 50 minutes = 5 times > 60 minutes = 1 times Observation: On 12/8/25 from 1:21 p.m. through 2:11 p.m., R11's call light outside the room door was observed illuminated continuously, indicating an unanswered request for assistance. R11 was observed seated in her chair in her room. Resident/Family Interviews: On 12/8/25 at 11:31 a.m., family member (FM)-G stated R10 had told her it took up to two hours for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff to respond to R10's call light; that staff were supposed to check and change R10 every two hours, but they didn't. R10 stated she waited the longest on the night shift. On 12/8/25 at 4:17 p.m., R46 stated he sometimes waited up to one to one- and one-half hours for his call light to be answered. On 12/8/25 at 2:57 p.m., R30 stated the facility did not have enough staff on the evening shift and staff consistently took approximately 30 minutes to answer her call light, with waits of up to 1 1/2 hours at times. On 12/8/25 at 4:17 p.m., R46 stated he sometimes waited up to one to one- and one-half hours for his call light to be answered. On 12/8/25 at 5:35 p.m., R14 stated staff consistently took 20 minutes to one hour to respond to her call light and stated this occurred too often, including when she requested assistance to use the bathroom. On 12/8/25 at 6:02 p.m., R7 stated the facility was short staffed and staff were untimely in responding to call lights. R7 stated that due to short staffing on a recent weekend, he did not receive timely assistance to get up in the morning and missed breakfast. On 12/8/25 at 6:45 p.m., R18 stated that on a daily basis she waited 30 minutes to one hour for staff to respond to her call light and therefore requested a urinal to keep in her room. On 12/8/25 at 4:17 p.m., R46 stated he sometimes waited up to one to one- and one-half hours for his call light to be answered. On 12/9/25 at 7:42 a.m., FM-A stated R4 called her from his [NAME] machine to have her call the facility to get him off the commode. FM-A stated the facility did not have enough staff to answer his call light timely. FM-A stated it took two staff to move R4 with a mechanical lift. Staff Interviews: On 12/8/25 at 1:59 p.m., nursing assistant (NA)-H stated residents were not always toileted prior to meals due to insufficient staffing and the number of residents requiring two-person assistance for transfers. NA-H stated that when the light above a resident's door was illuminated, it indicated the resident had activated their call light requesting assistance. On 12/9/25 at 4:23 p.m., licensed practical nurse (LPN)-A stated that when three nursing staff were present on the long-term care hallway, treatments were typically completed timely. LPN-A stated there were occasions when resident treatments were not completed due to insufficient staffing, and they level of care some of the residents required, and a one-time order was placed for the task to be completed on the next shift. LPN-A was unable to confirm whether those treatments were completed on the subsequent shift. LPN-A further stated residents consistently waited longer than 20 minutes for staff assistance. On 12/9/25 at 1:20 p.m., registered nurse (RN)-C confirmed residents consistently experienced call light wait times greater than 20 minutes. RN-C stated call light response times were reviewed and documentation verified prolonged wait times. RN-C stated the facility had an ongoing staffing (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shortage of staff to complete resident cares efficiently, and lacked sufficient leadership and management oversight to ensure resident needs were consistently met. RN-C stated, I get sick when I see the wait times when I review them. RN-C further stated resident acuity was high, many residents required two-person assistance, and staff needed more time to complete cares. RN-C stated staffing challenges were related to both the number of staff and staff competency. RN-C stated the facility previously had a dedicated staffing educator role; however, the assistant director of nursing (ADON) now held multiple roles including staff education and infection prevention. RN-C stated the facility did not currently have a permanent director of nursing (DON), and the interim DON had been in the role for approximately one week. RN-C stated the lack of education, competency, training, and staffing resulted in prolonged call light response times. On 12/11/25 at 12:46 p.m. ADON, stated the facility ran call light logs and looked at average response times, which were eight minutes. The ADON stated leadership wanted that number to go down but had not talked about a response time goal. The ADON stated if a resident complained about a call light response time, it was looked into and addressed with the staff. The ADON stated she was aware of some long call lights; she had seen them. The ADON stated although the acuity of some residents was high, she felt there was enough staff to meet the needs of residents in a timely manner. The ADON stated nursing could work better together as a team and work more efficiently by using their walkie talkies and asking for help. The ADON was shown the call light response time data collected from reports provided by the executive director (ED)-A and did not offer a comment. The ADON stated both she and nurse managers worked on the floor, so felt they were in tune to how nursing assistants utilized their time. On 12/11/25 at 4:12 p.m., ED-A stated call light response times were reviewed at QAPI (quality assurance and performance improvement) meetings; the topic had been added to the agenda in the past year. ED-A stated call light response times were a common grievance, and the facility monitored average call light response times, which were eight minutes. ED-A stated outliners -- call lights greater than 20 minutes were not monitored, but if identified, would generate a conversation with a resident and staff. ED-A stated nurse managers observed long call lights during heavy times such as getting residents up in the morning, around mealtimes and assisting residents at bedtime. ED-A was shown call light response time data for residents from logs she had provided. ED-A admitted the times surprised her; adding her first thought was a lot of residents required a two-person assist. ED-A stated staff hours were determined by hours per patient day, which included hours for the four nurse managers. ED-A acknowledged due to acuity; they might not have enough staff during heavy times. ED-A was informed of interviews with NA staff who stated tasks they could not do as often as they should due to lack of time were checking and changing residents, range of motion, and ambulating residents. ED-A acknowledged the long call light response times identified were not acceptable for residents. Facility assessment revised 2/24/25, indicated it was the philosophy of Pathstone Living to maintain the highest standards of competent, conscientious and consistent care for all residents. Maintaining adequate staffing levels to ensure each resident receives necessary and quality care is priority. Pathstone Living strives to meet the needs of its residents through on-going assessment, care protocols, and staffing levels and competencies. Facility assessment further indicated the following: Percentage of residents required 1-2 staff assist for (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dressing 94% Bathing 83% Transfer 81% Toileting 89% Facility Answering the Call Light policy with revised date of September 2022, indicated the purpose was to ensure timely responses to the resident's requests and needs. Staff were to answer recall call system immediately. If the resident needs assistance, indicate the approximate time it will take for you to respond. If the residents request requires another staff member, notify the individual. If the residents request is something you can fulfill, complete the task within five minutes if possible. If you are uncertain as to whether or not a request can be fulfilled, or if you cannot fulfill the residents request, ask the nurse supervisor for assistance. If assistance is needed when you enter the room, summon help by using the call signal. When answering a visual request for assistance (light above the room door), knock on the room door. When the resident responds, address the resident by his/her name and follow the prompts above.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure nursing staff had specific competencies and skill sets necessary to care for resident needs as identified through resident assessments and plan; failed to ensure accuracy of wound assessments for 2 of 3 residents (R12 and R13) reviewed for pressure wounds. In addition, failed to provide services to maintain and/or prevent loss of range of motion (ROM) for 1 of 3 residents (R4) reviewed for limited range of motion and ensure a hand splint was properly applied to ensure palmar protection. In addition, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R46) reviewed for colostomy care. Additionally, the facility failed to ensure staff competent in cleaning mechanical lift equipment. This had potential to affect all 61 residents who resided in the facility. In addition, the facility failed to ensure 1 of 5 personnel records (registered nurse (RN)-I) reviewed included evidence of orientation to facility. Findings include: See F684- Based on observation, interview and document review, the facility failed to ensure accuracy of wound assessments for 2 of 3 residents (R12 and R13) reviewed for pressure wound; failed to ensure an accurate, new, comprehensive assessment was completed for newly identified facility acquired toe wounds for 1 of 1 resident (R3) reviewed for non-pressure wounds. R12's quarterly minimum data set (MDS0 assessment dated [DATE], indicated: severe cognitive impairment, no rejection of care, dependent on staff for toileting hygiene, shower/bath, lower body dressing, personal hygiene, and transfers, utilized a wheelchair, current toileting program, always incontinent of urine, frequently incontinent of bowel; diagnoses included cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke, anxiety, depression, history of falling; at risk of developing pressure ulcers/injuries, no unhealed pressure ulcers/injuries, Moisture Associated Skin Damage (MASD). R12's document Weekly Ulcer/Complex Would Observation Tool dated 12/10/25 at 1:01 p.m., licensed practical nurse (LPN)-E indicated R12 had a stage one ulcer/wound, site: coccyx, type: pressure, length: 0.5 centimeters (cm), width: 0.5 cm, stage: 1, date acquired: 12/10/25, first observation, Mepilex dressing applied for healing and protection. On 12/11/25 at 8:20 a.m., LPN-E stated on 12/10/25, she was notified by a nursing assistant that R12 had a slit on her coccyx. LPN-E stated she assessed R12's coccyx. LPN-E stated the assessment in the EMR was documented as a pressure injury. LPN-E stated she had not received specific training on differentiating types of wounds or pressure injuries. LPN-E confirmed the assessment was inaccurately documented as pressure rather than moisture-associated. LPN-E stated she did not assess whether the area was blanchable and stated she was not trained to check for blanching as part of a wound assessment. LPN-E stated she notified registered nurse (RN)-C, the nurse manager, of R12's new skin concern and was instructed to complete a skin assessment. LPN-E stated RN-C did not complete the wound assessment with her. On 12/11/25 at 8:26 a.m., RN-C stated on 12/10/25, LPN-E reported R12 had a slit on her coccyx. RN-C stated the area was described as a small slit and not pressure-related, and confirmed the area was expected to be documented as moisture-associated rather than pressure. RN-C confirmed she did not assess R12's coccyx. RN-C stated the documentation discrepancy and inaccuracy reflected nursing staff training needs and stated the facility required more formal education, including (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	one-on-one education for nursing staff. R13's significant change MDS assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R13 required substantial staff assistance or was dependent on staff for activities of daily living (ADLs) and did not walk. R13 had a urinary catheter and was occasionally incontinent of bowel. R13 was at risk for pressure ulcers and had an unhealed pressure ulcer. R13 had two unstageable pressure injuries presenting as deep tissue injury, not present on admission. Nursing wound assessments provided by RN-A who was also the nurse manager included: 9/20/25: Unstageable pressure injury to buttocks. 10/17/25: No stage. Site was right and left buttocks. Type was pressure. 10/28/25: No stage. Site was right and left buttocks. Type was pressure. 11/21/25: Stage 2. Site was right and left buttocks. Type was pressure. The wound measurements within the assessments were significantly variable: Provider wound assessments provided by RN-A for the following dates 8/26/25, 9/2/25, 10/14/25, 10/18/25, 10/28/25, 11/24/25, and 12/2/25, consistently identified R13's skin problem as incontinence associated dermatitis, buttocks, bilateral. Pressure injury or ulcer had not been used to describe R13's skin on his buttocks. During an interview on 12/9/25 at 1:00 p.m., RN-A stated the wound measurements were variable because some nurses measured red areas on R13's buttocks and some nurses measured open areas. During an interview on 12/9/25 at 2:06 p.m., RN-A stated after reviewing nurse wound assessments and provider wound notes, realized R13's skin on his buttocks had been incorrectly identified; that R13 never had a pressure ulcer. RN-A stated she was aware nurses had documented both a stage 1 and stage 2 pressure ulcer to R13's buttocks, as well as deep tissue injury, but the provider had consistently identified the skin problem as incontinence associated dermatitis. During an interview on 12/10/25 at 1:42 p.m., ADON stated she had provided nurses with a folder that included resources to help nurses assess and document pressure ulcers. The ADON stated no in-person training or courses on wound care had been provided for the nurses, just the folder of material. ADON stated there were no nurses in the facility designated as wound nurses or who had special training, and no consistent nurse(s) were conducting wound assessments. ADON stated registered nurses should know how to assess pressure wounds because they would have learned it in nursing school. See F656- Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R46) reviewed for colostomy care. R46's annual MDS assessment dated [DATE], indicated intact cognition, clear speech, was understood and could usually understand. R46 had an ostomy, specifically a colostomy (an opening in the abdomen connecting the large intestine to the outside of the body), required supervision or was (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dependent upon staff for activities of daily living (ADLs). R46's Care Area Assessment (CAA) dated 10/27/25, did not identify an ostomy or colostomy. R46's care plan reviewed on 12/9/25, did not include R46's colostomy; nothing about ostomy care, skin observations, family member (FM)-A tips for an effective seal, and reporting problems. During an interview on 12/8/25 at 4:21 p.m., FM-A stated R46's colostomy bag was often not placed correctly and separated from his skin and leaked stool. FM-A stated she had talked to many staff about it and had trained nursing staff on her own. FM-A stated she told them the biggest thing was, they did not let the skin prep dry -- I think they hurry too much. During an interview on 12/10/25 at 1:46 p.m., LPN-G stated she was aware of R46's colostomy and was aware his bag came off quite a bit. LPN-G stated FM-A posted instructions in R46's room and they were also in his electronic medical record (EMR). LPN-G stated she was not sure if all nursing staff used binders - sticky things that went on either side of the ostomy, supplied by FM-A. During an interview on 12/10/25 at 1:50 p.m., RN-A, who was also the nurse manager for the unit on which R46 resided, stated she had talked with staff about how FM-A would like R46's colostomy care done. RN-A stated she went through the instructions with LPN-G with the intent that LPN-G would teach each nurse. RN-A did not ask LPN-G to keep track of who she had trained and who still needed training so was not able to say if all nurses who changed R46's ostomy bag had the training. RN-A acknowledged ostomy care should be on R46's care plan to ensure nursing staff knew how to manage his colostomy. During an interview on 12/11/25 at 12:46 p.m., the ADON who was also responsible for staff education, was informed of findings and stated nurse managers were responsible for making sure staff were trained on ostomy care and acknowledged ostomy care should be on the care plan to ensure consistent care. See F688: Based on observation, interview and document review, the facility failed to ensure a hand splint was properly applied to ensure palmar protection for 1 of 1 resident (R4) reviewed for range of motion (ROM). R4's quarterly MDS dated [DATE], identified they required substantial assistance or were dependent upon staff for activities of daily living (ADL's). R4's provider orders dated 12/2/25, included to appl a resting hand splint when in wheelchair and at bedtime and in the morning and remove it while resting in bed. R4's care plan dated 5/27/25, directed range of motion exercises per instructions located in a black book at the nurse's station. During observation on 12/9/25 at 8:30 a.m. R4 had a splint on left hand, however the palmar padding was not positioned in the palm of the hand. At 9:36 a.m. occupational therapist (OT)-I removed the hand splint stating the palm protector had not been placed into the palm. OT-I replaced the splint after carefully and slowly opening R4's finders and slid the support into the palm. During observation on 12/10/25 at 8:41 a.m. NA-J applied the splint to R4's left hand. NA-J did not open the fingers on R4's hand to place the protector into the palm, instead NA-J set the palm protector under R4's clenched fingers and wrapped the strap around R4's fist. At 5:01 p.m. NA-J stated no one had shown her the proper way to place the hand splint and had not noticed instructions that were in R4"s room. RN)-A stated she had trained NA's on how to place the hand splint, but did (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	not document it and was unable to determine who had been trained and who had not been trained. On 12/9/25 at 5:00 p.m., RN-I stated she had worked at the facility for approximately four weeks and had trained on all shifts. RN-I stated she had an orientation packet that was in completed with the exception of two additional meetings to complete as part of the orientation packet, and she had not turned the orientation packet into Family Interviews: On 12/9/25 at 7:42 p.m., FM-A stated the facility used to have one person who trained all nursing assistants (NAs), but now NAs trained each other and if one NA did not provide good care, that's how others were trained. FM-A stated, It takes a special person to wipe butts; and they needed a more consistent trainer. Staff Interviews: On 12/9/25 at 1:20 p.m., registered nurse (RN)-C confirmed residents consistently experienced call light wait times greater than 20 minutes. RN-C stated call light response times were reviewed and documentation verified prolonged wait times. RN-C stated the facility had an ongoing staffing shortage of staff to complete resident cares efficiently, and lacked sufficient leadership and management oversight to ensure resident needs were consistently met. RN-C stated, I get sick when I see the wait times when I review them. RN-C further stated resident acuity was high, many residents required two-person assistance, and staff needed more time to complete cares. RN-C stated staffing challenges were related to both the number of staff and staff competency. RN-C stated the facility previously had a dedicated staffing educator role; however, the assistant director of nursing (ADON) now held multiple roles including staff education and infection prevention. RN-C stated the facility did not currently have a permanent director of nursing (DON), and the interim DON had been in the role for approximately one week. RN-C stated the lack of education, competency, training, and staffing resulted in prolonged call light response times. On 12/11/25 at 8:26 a.m., RN-C stated inaccurate wound documentation for R12 was related to inadequate nurse training and education. RN-C stated the ADON was responsible for nursing education in addition to other duties, limiting the ability to provide adequate education to nursing staff. On 12/11/25 at 8:30 a.m., RN-A stated the facility lacked one-on-one and individualized education for staff and relied on generalized training. RN-A confirmed the facility needed more specific training for all staff. On 12/8/25 at 1:25 p.m., nursing assistant (NA)-J stated she cleaned mechanical lifts at the start of each shift but had not been trained to clean lift equipment after each resident use. leadership to verify completion of the packet. RN-I confirmed she was no longer on orientation and was working independently. During an interview on 12/11/25 at 12:46 p.m., assistant director of nursing (ADON) stated up until about two years ago, the facility had a dedicated nurse educator. Since that time, the term had changed to staff development, and in addition to ADON and infection preventionist roles, the ADON was also responsible for staff development of registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The ADON described the process for onboarding RNs, LPNs and NAs. Licensed nurses trained licensed nurses and NA coaches trained NAs. Paper orientation packets were used, and a new nurse or NA received a minimum of eight shifts of orientation and could ask for additional days if needed. The ADON provided copies of the blank orientation packets. Nurse education related to competency findings during survey included four bullet points: 1) how/where to enter assessments, 2) skin assessment, 3) wound care, 4) where to find supplies for ostomy cares. NA education related to competency findings during survey included: 1) restorative room/exercise programs, 2) splints/braces. The ADON stated she met with staff at the end of orientation but did not valid competencies completed by trainers during orientation. The ADON stated the facility did not conduct annual hands-on skill competency assessments to ensure staff remained competent after initial hire. The ADON stated no nurses in the facility had specialized training in wound identification and management. The ADON stated she was aware R13 had a pressure wound but did not know how nurses were describing/documenting it. The ADON stated licensed nurses, including licensed practical nurses (LPNs), should know how to assess a pressure wound as they would have learned that in nursing school. The ADON acknowledged an LPN did not have the same scope and educational background as a registered nurse but could determine if a wound was caused by pressure. The ADON stated there were paper resources at the nurses' station that nurses were expected to use to guide them in describing/documenting pressure wounds. The ADON stated it was important for nurses to be accurate with skin and wound assessments because it would affect resident treatments and their MDS (Minimums Data Set) assessments. The ADON was informed nursing staff were documenting R13's buttocks as having various stages of pressure wounds when according to nurse practitioner (NP)-G, R13 did not have a pressure wound on his buttocks but rather incontinence associated dermatitis of bilateral buttocks. The ADON had not been aware of this. The ADON stated whichever NA was assigned to a resident, was responsible for ensuring their restorative program, including ROM, was completed. The ADON stated nurse managers where responsible for training NAs to apply a splint and/or how to conduct ROM exercises. The ADON was informed of findings related to R4's splint not being applied correctly and ROM exercises not being done. The ADON was informed of FM-A's concerns regarding the application of R46's ostomy bag. The ADON did not know if specific in-person training had been conducted with nursing staff and that would have been the responsibility of nurse managers. The ADON stated the facility relied heavily on written communication via Microsoft Teams application for resident cares, including R46's ostomy care. The ADON stated she expected staff to ask questions if unsure of care or treatments but acknowledged it was possible staff might not know the questions to ask. The ADON admitted more in-person, hands-on training would be beneficial and nursing staff had been asking for that. The ADON stated the majority of training occurred via online courses through Relias or through written communication via Teams. During an interview on 12/11/25 at 4:12 p.m., the executive director (ED)-A was informed of findings related to gaps in nursing education and training. ED-A stated the ADON was responsible for training nursing staff and the director of nursing (DON) checked in with staff at the end of orientation. A policy on nursing orientation, education and training was requested and not provided. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Personnel Record Review During review of registered nurse (RN)-I's personnel record on 12/11/25 at 4:38 p.m., no orientation checklist was included. During interview on 12/11/25 at 12:47 p.m., ADON stated new staff were given an orientation and skills packet to complete with staff training them. ADON further stated staff train for eight shifts. ADON stated she expected the orientation packet turned in prior to staff working on their own, and RN-I's orientation packet should have been turned in if she was working by herself. ADON stated based off what she had heard though the week, more staff training was needed. During interview on 12/15/25 at 8:45 a.m., executive director ED-A stated she was not aware RN-I's orientation and competency had not been completed or turned into leadership and was not aware RN-I was working independently without having her orientation and competency fully evaluated

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to ensure dietary staff adhered to basic infection control practices, specifically hand-hygiene, when serving residents in the dining room. This had the potential to affect all residents who ate meals in the dining room. Findings include: During an observation on 12/8/25 at 11:55 a.m., during lunch service, observed dining assistant (DA)-A fill beverages from a beverage cart for residents seated at the supervised table. DA-A was observed touching her face and eyeglasses with her hands, then fill a cup of juice and set it in front of an unidentified resident. DA-A then filled a cup of milk and holding it by the rim where the resident would place his lips, placed it on the table. During an observation on 12/8/25, at 12:00 p.m., as DA-A was walking toward the kitchen, observed DA-A rub her nose with her hand, then touch her hair, then using the palm of her right hand, rubbed it up and down against her nose. DA-A then entered the kitchen to do something at the cappuccino dispenser. While DA-A was at the cappuccino dispenser, the culinary director (CD)-B was informed of observations who stated she would take DA-A aside and have her wash her hands and remind her not to touch her face while serving residents. During an interview on 12/8/25 at 12:28, CD-B stated DA-A would have had training on hand hygiene by taking online education modules. CD-B did not know if DA-A had received face to face training when DA-A started the dining assistant role, and if standard infection control practices had been covered, such as hand hygiene. During an interview on 12/11/25 at 9:34 a.m., CD-B stated there had been no documentation that DA-A had received face to face training/competencies regarding hand hygiene, only online modules. CD-B stated when she spoke to DA-A on 12/8/25, DA-A told her she had only touched her face once. CD-B stated today 12/11/25, CD-B was having a meeting with DA-A to further discuss observations related to hand hygiene. On 12/8/25 at 12:07 p.m., DA-C was observed in the kitchen holding a plate of food and using her other bare hand to separate two pieces of bread. DA-C then placed the plate with food in front of R55. DA-C confirmed the bread was touched with bare hands and stated gloves were expected to be worn when handling food. DA-C stated R55 did not like his bread placed together. DA-C was not observed to remove the food from R55 after handling it with bare hands. On 12/8/25 at 12:09 p.m., nursing assistant (NA)-C was seated at the table with R55. Prior to assisting R55 with eating, NA-C was informed that R55's food had been handled with bare hands. NA-C then returned the plated food to the kitchen. On 12/8/25 at 12:18 p.m., DA-C was observed entering the kitchen and wiping her bare hands on her clothing. DA-C was not observed to wash her hands after touching her clothing. DA-C was then observed touching her face and nose with bare hands and again was not observed to wash her hands. DA-C then placed a glove on her left hand, picked up a fork and plate with food, exited the kitchen, and delivered the plate to a resident seated in the dining area. DA-C was subsequently observed reentering the kitchen without washing their hands, removing the glove from her left hand, and standing in the kitchen plating area with ungloved hands without handwashing. DA-C was then observed taking a tray with plated food from the kitchen to residents seated in the dining area. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview on 12/8/25 at 12:25 p.m., DA-C stated it was not common practice to disinfect or wash hands when entering the kitchen from the dining room. DA-C further stated if staff touched their face, they were expected to do a quick rinse of their hands prior to touching plates, silverware, or serving residents their food. DA-C confirmed R55's food was not remade after she became aware it had been handled with bare hands and stated the food should have been discarded and remade. On 12/8/25 at 12:42 p.m., the CD-B stated food should not be handled with bare hands and then served to residents. CD-B stated if staff touched their face or clothing with bare hands, staff were expected to wash their hands with soap and water prior to plating, serving food, or handling dishware. CD-B stated culinary staff had recently met and were receiving education regarding proper handwashing Facility Preventing Foodborne Illness – Employee Hygiene and Sanitary Practices policy dated October 2017, indicated food and nutrition services employees would follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. All employees who handle, prepare or serve food would be trained in the practices of safe food handling and preventing foodborne illness. Employees would demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. Employees must wash their hands after personal body functions (i.e., toileting, blowing/wiping nose, coughing, sneezing, etc.).

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview, and document review, administration failed to exercise effective oversight and ensure corrective action of multiple, ongoing deficient practices across departments. The administration had knowledge of these issues through staffing data, QAPI activities, staff reports, and prior monitoring, yet failed to implement timely and effective interventions, resulting in continued noncompliance. The deficient practice had the potential to affect all 61 residents who resided in the facility.Findings include:See F609/F610- Based on observation, interview, and document review, the facility failed to protect personal property from misappropriation of funds, failed to secure and account for the resident's money, failed to report the allegation, and failed to conduct a comprehensive documented investigation, despite repeated concerns expressed by the resident and staff. As a result, R55 experienced ongoing emotional distress, anxiety, and agitation related to the missing funds and the lack of response from the facility. The facility also allowed the accused staff member to maintain custody of the resident's remaining funds, posing a continued risk of further misappropriation for this resident and potentially others, as no assessment was completed to determine whether other residents' funds may have been at risk. This deficient practice affected 1 of 1 resident (R55) reviewed for missing money.On 12/9/25 at 2:34 p.m., the executive director (ED)-A who also served as the administrator confirmed R55 had expressed concerns regarding missing money. The ED-A stated a VA report was not filed because there was no indication of theft or suspicious activity, and the amount of missing money could not be verified. The ED-A stated R55 requested law enforcement be contacted and SS-A assisted R55 in contacting the police. The ED-A stated the police did not express concerns; however, the ED-A stated she was not aware of the specifics of the police report. The ED-A further stated she would need to review facility policy and regulations regarding reporting of missing money. The ED-A stated there was a safe in the administration specialist office, however the ED-A stated she currently had R55's money in a money bag locked in her office and had completed a reconciliation of the money. On 12/10/25 at 8:54 a.m., the ED-A stated that when a report of missing money was received and the money may have been stolen, it would be an immediate concern. The ED-A stated R55 did not directly report to her that money had been stolen; however, the ED-A stated the ADON informed her that R55 believed SS-A had taken his money. The ED-A confirmed that after receiving this information, the allegation should have been reported to the state agency. The ED-A further confirmed no formal or comprehensive investigation was completed. The ED-A stated an investigation should have included documented staff interviews, family interviews, review of police involvement, a formal documented room audit, and a documented interview with R55. The ED-A stated SS-A confirmed R55 had $5,000 in cash at one time and that SS-A removed $550 with R55's permission to pay for two attendants to accompany him to a medical appointment and stated the money was secured in SS-A's office. The ED-A further stated she had possession of 18 one-dollar bills in a blue money bag from R55's room and stated she received verbal consent to keep the money in her office. The ED-A confirmed there was no documentation of the money and stated the handling of funds was based on verbal communication only. The ED-A stated she did not notify or consult the financial POA, regarding the missing money and acknowledged she should have contacted the POA. The ED-A confirmed there was no money remaining in R55's room, no chronological money ledger, and no two-person verification process in place. The ED-A further stated that if SS-A was the staff member accused of taking the money, SS-A should not have been responsible for securing the funds. The ED-A stated the facility had a locked safe; however, it was not accessible because the access code was unknown. The ED-A confirmed R55's money should have been secured in the safe. The ED-A stated she did not interview staff or residents and did not conduct an assessment to determine whether other residents had concerns regarding missing money or valuables. The ED-A stated part of the admission process included educating residents not to keep money in their rooms and to secure funds in the facility safe. The (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ED-A stated R55 had approximately $3,618 unaccounted for, confirmed approximately $850 was spent on hockey tickets, and confirmed $550 was set aside to pay attendants for a medical appointment. The ED-A confirmed she received messages from the ADON and LPN-A regarding R55's missing money. The ED-A stated she was aware R55 had $5,000 in cash and acknowledged no action was taken at that time, stating the money should have been removed from R55's room and placed in the safe. The ED-A further stated the missing money was not reported to the state agency because it was not considered misappropriation of funds due to a lack of evidence or suspicion of theft.See F684- Based on observation, interview and document review the facility failed to ensure a skin injury had a timely assessment and documentation for 1 of 1 resident (R30), reviewed for non-pressure wounds; failed to ensure accuracy of wound assessments for 2 of 3 residents (R12 and R13) reviewed for pressure wound; failed to ensure an accurate, new, comprehensive assessment was completed for newly identified facility acquired toe wounds for 1 of 1 resident (R3) reviewed for non-pressure wounds. During interview on 12/10/25 at 3:50 p.m., registered nurse (RN)-F stated she had not seen a new comprehensive skin assessment for the newly identified toe wounds, did see a provider notification for the new fourth toe wound, but no other notification to provider about the new second and fifth toe wounds. RN-F stated she expected a new skin assessment and provider notification for all new wounds.During an interview on 12/9/25 at 2:06 p.m., RN-A stated after reviewing nurse wound assessments and provider wound notes, realized R13's skin on his buttocks had been incorrectly identified; that R13 never had a pressure ulcer. RN-A stated she was aware nurses had documented both a stage 1 and stage 2 pressure ulcer to R13's buttocks, as well as deep tissue injury, but the provider had consistently identified the skin problem as incontinence associated dermatitis. RN-A stated the facility did not have nurses with specialized training in wound care, adding the assistant director of nursing (ADON) had recently provided nurses with a folder with some printed wound resources to review. During an interview on 12/10/25 at 1:42 p.m., ADON stated she had provided nurses with a folder from a company called Curitec (a provider specializing in advanced wound care for long term care) that included resources to help nurses assess and document pressure ulcers. The printed material was reviewed and included photos of pressure ulcers, information on documenting wounds and described some treatments. ADON stated no in-person training or courses on wound care had been provided for the nurses, just the folder of material. ADON stated there were no nurses in the facility designated as wound nurses or who had special training, and no consistent nurse(s) were conducting wound assessments. ADON stated registered nurses should know how to assess pressure wounds because they would have learned it in nursing school. ADON was informed of the concern of nurses documenting R13 having a pressure ulcer when he did not. During a telephone interview on 12/11/25 at 2:28 p.m., nurse practitioner (NP)-G stated she saw R13 for wound care; her last visit was 11/24/25. NP-G was informed nursing staff had documented R13 as having pressure ulcers of various stages to his buttocks, yet her documentation consistently indicated he had incontinence associated dermatitis of bilateral buttocks. NP-G stated she had not been aware nurses were documenting pressure. NP-G stated R13 did not have pressure wounds to his buttocks. Further, NP-G stated someone at the facility would have added the diagnosis of pressure ulcer of contiguous site of back, buttock and hip, unstageable, to R13's diagnosis list as providers sent dictation with the diagnoses they assessed.During an interview on 12/11/25 at 4:12 p.m., the executive director (ED)-A was informed of findings related to inaccurate nurse documentation of skin wounds on R13's, specifically nurses identifying R13 having a pressure ulcer when he did not. ED-A stated nurse training was the responsibility of the ADON. ED-A was informed wound care training currently consisted of nurses taking personal responsibility to review a folder of paper documents provided by a wound care company, and no in-person training or specialized courses had been provided.On 12/9/25 at 2:52 p.m., the interim director of nursing (DON) stated a skin assessment and documentation would be expected if a resident sustained an injury to the skin that required treatment and stated the provider would be expected to be notified.See F725- Based on observation, interview, (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and document review, the facility failed to provide sufficient staffing to ensure residents had adequate staffing, received care and assistance in a timely manner. The deficient practice had the potential to affect all 61 residents who resided in the facility.During an interview on 12/11/25 at 12:46 p.m. the ADON stated the facility ran call light logs and looked at average response times, which were eight minutes. The ADON stated leadership wanted that number to go down but had not talked about a response time goal. The ADON stated if a resident complained about a call light response time, it was looked into and addressed with the staff. The ADON stated she was aware of some long call lights; she had seen them. The ADON stated although the acuity of some residents was high, she felt there was enough staff to meet the needs of residents in a timely manner. The ADON stated nursing could work better together as a team and work more efficiently by using their walkie talkies and asking for help. The ADON was shown the call light response time data collected from reports provided by the executive director (ED)-A and did not offer a comment. The ADON stated both she and nurse managers worked on the floor, so felt they were in tune to how nursing assistants utilized their time.During an interview on 12/11/25 at 4:12 p.m., ED-A stated call light response times were reviewed at QAPI (quality assurance and performance improvement) meetings; the topic had been added to the agenda in the past year. ED-A stated call light response times were a common grievance, and the facility monitored average call light response times, which were eight minutes. ED-A stated outliners -- call lights greater than 20 minutes were not monitored, but if identified, would generate a conversation with a resident and staff. ED-A stated nurse managers observed long call lights during heavy times such as getting residents up in the morning, around mealtimes and assisting residents at bedtime. ED-A was shown call light response time data for residents from logs she had provided. ED-A admitted the times surprised her; adding her first thought was a lot of residents required a two-person assist. ED-A stated staff hours were determined by hours per patient day, which included hours for the four nurse managers. ED-A acknowledged due to acuity; they might not have enough staff during heavy times. ED-A was informed of interviews with NA staff who stated tasks they could not do as often as they should due to lack of time were checking and changing residents, range of motion, and ambulating residents. ED-A acknowledged the long call light response times identified were not acceptable for residents. F726- Based on observation, interview and document review, the facility failed to ensure nursing staff had specific competencies and skill sets necessary to care for resident needs as identified through resident assessments and plan of care. This had potential to affect all 61 residents who resided in the facility.During an interview on 12/11/25 at 12:46 p.m., ADON stated up until about two years ago, the facility had a dedicated nurse educator. Since that time, the term had changed to staff development, and in addition to ADON and infection preventionist roles, the ADON was also responsible for staff development of registered nurses (RNs), licensed practical nurses (LPNs) and nursing assistants (NAs).The ADON described the process for onboarding RNs, LPNs and NAs. Licensed nurses trained licensed nurses and NA coaches trained NAs. Paper orientation packets were used, and a new nurse or NA received a minimum of eight shifts of orientation and could ask for additional days if needed. The ADON provided copies of the blank orientation packets. Nurse education related to survey competency findings included four bullet points: 1) how/where to enter assessments, 2) skin assessment, 3) wound care, 4) where to find supplies for ostomy cares. NA education related to survey competency findings included: 1) restorative room/exercise programs, 2) splints/braces. There had been no specific training content identified along with the bullet points.The ADON stated she met with staff at the end of orientation but did not validate competencies completed by trainers during orientation. The ADON stated the facility did not conduct annual hands-on skill competency assessments to ensure staff remained competent after initial hire.During an interview on 12/11/25 at 4:12 p.m., the ED-A was informed of findings related to gaps in nursing education and training. ED-A stated the ADON was responsible for training nursing staff and the interim director of nursing (DON)checked in with staff at the end of orientation.During interview on 12/11/25 at 12:47 p.m., ADON also known as the staff developer (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	stated new staff were given an orientation and skills packet to complete with staff training them. ADON further stated staff train for eight shifts. ADON stated she expected the orientation packet turned in prior to staff working on their own, and RN-I's orientation packet should have been turned in if she was working by herself. O-C stated based off what she had heard though the week, more staff training was needed.During interview on 12/15/25 at 8:45 a.m., ED-A stated she was not aware RN-I's orientation and competency had not been completed or turned into leadership and was not aware RN-I was working independently without having her orientation and competency fully evaluated.See F865- Based on interview and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement action plans in order to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of. This had the potential to affect all 61 residents residing in the facility.During interview on 12/15/25 at 8:45 a.m., ED-A stated she was currently in charge of the QAPI program. ED-A stated they held meetings monthly and reviewed patterns and trends. ED-A stated they used to meet with other Ecumen sites for QAPI, but had transitioned to having their own QAPI meetings in early 2025. In review of areas of concerns for this survey, ED-A stated the QAPI team was not aware of most of the survey teams findings until brought to her attention while on site during survey.In continued interview on 12/15/25 at 8:45 a.m., ED-A stated she expected the leadership in each department to take ownership for concerns identified through QAPI meetings. ED-A stated she was unsure of any specific audits being completed, did not specifically monitor that projects are being completed, and would have to ask the specific person who took ownership of that discussion item. ED-A stated she completed general one-to-one check-ins with the leadership team, but most follow-up on areas of identified concern was verbal. Verbal discussions were held in morning meetings and with individual check-ins. ED-A stated the facility does not formally track performance to ensure improvements are realized and sustained, it is tracked through verbal discussion.

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Pathstone Living	718 Mound Avenue Mankato, MN 56001

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement action plans in order to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of. This had the potential to affect all 61 residents residing in the facility.Findings include:Review of Quality Assurance Performance Improvement (QAPI) meeting minutes since last survey 2/2025, indicated the following:2/24/25: Care Center clinical data was reviewed for trends and patterns. Care Center annual survey results reviewed, awaiting 2567.3/24/25: Review of hospitalizations/ED visits, risk management, wounds, weight trends, pain, unmet needs. February 2025 annual survey-four citations. Current one star rating, team review and discussion.4/28/25: Review of hospitalizations/ED visits, risk management, wound, weight trends, pain, unmet needs. Hospital transfers, review of trends.5/2025: No meeting.6/23/25: Review of witnessed/unwitnessed falls, medication errors. Review of hospitalizations/ED visits, risk management, wounds, weight trends, pain, behaviors-unmet needs.7/28/25: Review of witnessed/unwitnessed falls, medication errors. Review of hospitalizations/ED visits, risk management, wounds, weight trends, pain, behavior-unmet needs.8/25/25: Review of witnessed/unwitnessed falls, medication errors. Review of hospitalization/ED visits, risk management, wounds, weight trends, pain, behaviors-unmet needs.9/2025: No meeting.10/27/25: Review of witnessed/unwitnessed falls, medication errors. Review of hospitalization/ED visits, risk management, wounds, weight trends, pain, behaviors-unmet needs.11/2025: No meeting, rescheduled for 12/2025.During interview on 12/15/25 at 8:45 a.m., executive director (ED)-A stated she was currently in charge of the QAPI program. ED-A stated they held meetings monthly and reviewed patterns and trends. ED-A stated they used to meet with other Ecumen sites for QAPI but had transitioned to having their own QAPI meetings in early 2025. In review of areas of concerns for this survey, ED-A stated the QAPI team was not aware of most of the survey teams findings until brought to her attention while on site during survey.See below:F580: ED-A stated the QAPI team had not previously identified notification to provider as an area of concern for the facility and it had not come up in QAPI meetings.F609 and F610: ED-A stated QAPI team reviewed vulnerable adult reports, and was not aware lack of investigating and reporting was an area of concern prior to survey. ED-A stated staff were educated on vulnerable adult reporting at the time of hire and annually and expected to make reports as necessary.F628: ED-A stated facility had a procedure and process for bed holds and transfer forms and QAPI team was not aware this was an area of concern.F641: ED-A stated minimum data set (MDS) assessments were completed offsite, and QAPI team was not aware of inaccurate assessments as an area of concern.F656: ED-A stated QAPI team had done a plan of care audit recently and was surprised to hear of identified item missing from care plan. QAPI team had not identified this area of concern.F676 and F677: ED-A stated unaware care plan was not being followed, QAPI team had not identified concern of staff not available to provide activities of daily living for residents.F684: ED-A stated QAPI team had not identified or discussed concern of wound assessments inaccurate or not completed timely.F688: ED-A stated QAPI team unaware of splint being applied incorrectly and no discussion regarding range of motion not completed.F725 and F726: ED-A stated QAPI team did complete audits related to call light times, and averages were within expectations. ED-A stated QAPI team unaware of identified staff competency concerns prior to survey.F732: ED-A stated the required nurse staffing posting was auto generated, and ED-A was unaware the report did not contain the required census information. ED-A stated the problem had already been corrected.F807: ED-A stated QAPI team was unaware of concerns with water pitchers not being passed without residents having to ask.F812: ED-A stated QAPI team was unaware of unsanitary practices by some dining staff, staff had education on hand washing and expected to wash hands.In continued interview on 12/15/25 at 8:45 a.m., ED-A stated she expected the leadership in each department to take ownership for concerns identified through QAPI meetings. (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ED-A stated she was unsure of any specific audits being completed, did not specifically monitor that projects are being completed, and would have to ask the specific person who took ownership of that discussion item. ED-A stated she completed general one-to-one check-ins with the leadership team, but most follow-up on areas of identified concern was verbal. Verbal discussions were held in morning meetings and with individual check-ins. ED-A stated the facility does not formally track performance to ensure improvements are realized and sustained, it is tracked through verbal discussion.Facility Quality Assurance and Performance Improvement (QAPI) Program policy dated 2/2020, indicated the following:The QAPI plan described the process for identifying and correcting quality deficiencies. Key components of the process include:a. Tracking and measuring performanceb. Establishing goals and thresholds for performance measurementc. Identifying and prioritizing quality deficienciesd. Systemically analyzing underlying causes of systemic quality deficienciese. Developing and implementing corrective action or performance improvement activitiesf. Monitoring and evaluating the effectiveness of corrective action/performance improvement activities, and reviewing as needed

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to sanitize and/or replace resident water mugs on a daily basis for 7 of 7 residents (R10, R4, R7, R30, R39, R54, R17), reviewed for infection control practices, to ensure a safe and sanitary vessel from which residents consumed water. This had the potential to affect all 61 residents residing in the facility. In addition, the facility failed to ensure basic infection control practices were followed when 3 of 3 residents (R13, R3, R43) urinary drainage bags were observed resting on the floor. Findings include: WATER MUG DISINFECTING R30's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R30 had no cognitive impairment, no rejection of care, utilized a wheelchair, independent with eating, required substantial/maximal assistance with shower/bath, lower body dressing, dependent on toileting hygiene and transfers, diagnoses included anxiety and depression R30's care plan dated 9/11/25, indicated R30 has risk for constipation r/t (related to) decreased mobility, use/side effects of medication and interventions included: ensure adequate fluid intake, offer fluids and keep water at bedside for easy access unless contraindicated per nurse, has a foley catheter r/t incontinence, risk for UTI r/t catheter use and interventions included adequate hydration and develop a hydration plan On 12/8/25 at 3:05 p.m., R30 was lying in bed and stated fresh water was brought to her when she requested the water or when her family member (FM)-E brought her water. R30 was observed with an insulated mug on her bedside table in front of her. R30 stated she was not aware of a process for washing the mugs and was not sure if the mugs were washed. R10's face sheet provided on 12/15/25, included diagnoses of spinal stenosis (narrowing of spaces within spine causing pain), diabetes and chronic kidney disease (kidneys cannot filter waster and fluid from blood effectively). R10's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, could understand and was usually understood. R10 required substantial assistance or was dependent upon staff for activities of daily living (ADLs) but could eat and drink independently. R10 did not walk. R10's provider orders dated 6/4/25, indicated a diet with thin liquids. R10's care plan dated 9/27/24, indicated ensure adequate fluid intake, offer fluids and keep water at bedside for easy access. Care plan dated 12/18/24, indicated staff were to refill water cup every day after lunch. Care plan dated 6/4/25, indicated staff were to encourage adequate hydration. Care plan dated 7/18/25, indicated R10 had risk for dehydration related to diuretic (medication to remove excess body fluid) use. During an interview on 12/10/25 at 9:54 a.m., R10 was sitting in her wheelchair in her room. Three thermal cups with lids were observed on her overbed table. R10 did know if they had ever been washed. R4's face sheet provided on 12/15/25, included diagnoses of hemiplegia (paralysis affecting one side (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the body) following stroke, diabetes, congestive heart failure (when the heart cannot pump blood effectively) and dementia. R4's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, was usually understood and was usually able to understand. R4 had highly impaired vision. R4 required substantial assistance or was dependent upon staff for help with most ADLs but could eat and drink independently with set up help. R4 did not walk. R4's provider orders dated 12/2/25, indicated a diet with thin liquids. R4's care plan dated 9/23/24, indicated staff were to ensure adequate fluid intake, offer fluids and keep water at bedside for easy use. Care plan with revised dated of 12/9/24, indicated R4 required set up assistance for meals. During an interview and observation on 12/8/25 at 6:45 p.m., R4 was sitting in a wheelchair in his room next to an overbed table. On the table was a large maroon colored thermal water mug with a straw in it. R4 stated he never received a clean water mug. During an interview on 12/9/25 at 7:42 a.m., family member (FM)-A stated she did not know if or when R4 received a clean water mug. FM-A stated R4 told her the water smelled bad and they thought it might be bacteria from a dirty mug. During resident council meeting interviews on 12/9/25, at 3:30 p.m., five of six residents in attendance stated they were not provided a clean water mug daily. R7's annual MDS assessment dated [DATE], indicated intact cognition and was independent with meals. R7 stated he got a clean mug sometimes, but not daily. R39's quarterly MDS assessment dated [DATE], indicated intact cognition and was independent with meals. R39 stated he never got a clean mug that he was aware of. R54's quarterly MDS assessment dated [DATE], indicated intact cognition and was independent with meals. R54 stated he did not know if he ever got a clean mug. R4 restated that he never received a clean mug. R17's quarterly MDS assessment dated [DATE], indicated moderate cognitive impairment; could understand and be understood, required supervision with meals. R17 stated he received a clean water mug occasionally, but not every day. During an observation on 12/10/25, at 8:56 a.m., on both the short-term care unit and the long-term care unit kitchenettes, there were no extra or clean water mugs available for nursing staff to utilize for residents. On 12/9/25 at 12:09 p.m., nursing assistant (NA)-G stated water mugs were not washed daily and stated she tried to remember to have the water mugs washed on the second day she worked in a row. On 12/9/25 at 12:28 p.m., registered nurse (RN)-A and RN-C confirmed there was not a current process for ensuring resident water mugs were washed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/9/25 at 1:20 p.m., NA-F stated resident water mugs were supposed to be changed out daily on the evening shift but was not confident it happened as she had never seen it being done. NA-F stated residents should get a clean mug every day because some [mugs] can get nasty. During an interview on 12/9/25 at 5:06 p.m., NA-B stated she thought the day shift staff passed out clean water mugs in the morning. During an interview on 12/9/25 at 5:09 p.m., on the short term stay unit, RN-B stated she did not know who was responsible for collecting resident water mugs and replacing them with clean mugs, adding she had never seen anyone do that on her shifts. NA-C stated she did not know if or when residents received clean water mugs. On 12/10/25 at 3:21 p.m., the dining specialist stated would expect water mugs washed daily. On 12/10/25 at 3:55 p.m., dietary director (DD)- B stated the facility previously had a process under the former director of nursing (DON) in which overnight staff obtained clean mugs from the kitchen, passed water to residents, and returned the used mugs daily to the kitchen for washing. DD-B stated she was not aware of a current process in place to ensure residents received a clean water mug and fresh water daily. On 12/11/25 at 8:04 a.m., dietary aide (DA)-B stated she consistently washed dishes for the facility and that resident water mugs were washed in the dish room. DA-B stated the water mugs did not come through the kitchen to be washed on a consistent basis and stated she might receive one or two water mugs in a week but did not receive a large quantity of water mugs to wash daily basis. On 12/11/25 at 10:22 a.m., assistant director of nursing (ADON), who also served as the infection prevention nurse, stated the expectation was that night shift staff would exchange resident water mugs every 24 hours. The ADON further stated kitchen staff were expected to notify nursing staff or leadership if they were not receiving dirty cups nightly as expected. On 12/11/25 at 4:16 p.m., the executive director (ED)-A stated she expected staff to pass water daily and provide residents with a clean mug daily. Facility policy on clean water mugs for residents was requested. ED-A indicated via email on 12/15/25, at 8:20 a.m., that the facility did not have a policy. URINARY DRAINAGE BAGS R13's face sheet provided on 12/15/25, included a diagnosis of urinary retention. R13's significant change MDS assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R13 required substantial staff assistance or was dependent on staff for activities of daily living (ADLs) and did not walk. R13 had an indwelling urinary catheter, R13's provider orders dated 12/5/25, indicated foley (a type of indwelling catheter) output every shift. R13's care plan with revised date of 10/28/25, indicated staff were to provide catheter care with soap and water every shift and after each incontinent episode as needed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview and observation on12/9/25 at 1:13 p.m., together with RN-A who was also the nurse manager on the unit on which R13 resided, entered R13's room to observe his skin. R13's urinary drainage bag was hooked to the side of a wastebasket with the bottom resting on the floor. RN-A adjusted it and since it still rested on the floor, placed it in a gray plastic basin next to the recliner. RN-A stated the bag should not be on the floor due to risk of infection. During an observation on 12/10/25 at 12:02 p.m., in his room, R13 was resting in his recliner. Observed his urinary drainage bag hooked to the side of the wastebasket on the right side of his recliner. The bottom of the bag was resting on the floor. Next to the wastebasket was an empty gray basin. R43's face sheet provided on 12/15/25, included a diagnosis of urinary retention. R43's annual MDS assessment dated [DATE], indicated intact cognition; clear speech, was understood and could understand. R43 required substantial assistance for most ADLs and did not walk. R43 had a suprapubic catheter (a catheter inserted into abdomen and directly into bladder). R43's provider orders dated 9/10/24, indicated catheter output every shift. R43's care plan with revised date of 6/18/25, indicated R43 had a suprapubic catheter, and would not develop any active infections. During a medication pass observation in R43's room at 12/10/25 at 12:19 p.m., observed R43's urinary drainage bag hooked to the side of a wastebasket next to his recliner with the bottom of the bag resting on the floor. During an observation and interview on 12/10/25 at 12:35 p.m., together with nursing assistant (NA)-H, went to both R13 and R43's rooms to view the location of their urinary drainage bags. NA-H looked at R43's bag hooked to the side of the wastebasket and the bottom of the bag resting on the floor and stated the bag shouldn't be on the floor -- could transfer bacteria to the resident. NA-H stated she was aware of staff hooking the catheter bag to the wastebasket because there was not a great place to put it when a resident sat in their recliner. NA-H stated she was aware of residents hospitalized recently due to urinary tract infections (UTI's) and acknowledged this practice could be a contributing factor. In R13's room, NA-H verified the urinary drainage bag had been hanging from the wastebasket and the bottom of the bag resting on the floor. NA-A stated staff should have put the bag in the gray plastic basin on the floor next to the recliner. During an interview and observation on 12/10/25 at 12:46 p.m., together in R13's room with ADON who was also the infection preventionist, observed R13's urinary drainage bag hooked to the side of the wastebasket with the bottom of the bag resting on the floor. ADON stated the bag should be up off the floor as resting on the floor had the potential for germs and bacteria to enter the drainage system. ADON stated hanging the bag from a wastebasket wasn't good practice either. ADON moved the urinary drainage bag to the gray basin. At 12:49 p.m., went to R43's room and observed the location of the urinary drainage bag hooked to the side of the wastebasket. ADON stated she had not been aware staff were hooking urinary drainage bags to the wastebaskets – she had not seen that before. ADON obtained a gray plastic basin in which to set the bag. R3's face sheet printed 12/10/25, included diagnosis of urinary retention, urinary tract infection, and chronic kidney disease. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R3's significant change MDS assessment dated [DATE], indicated R3 had no cognitive impairment, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with shower/bath, partial/moderate assistance with toilet use and upper/lower body dressing. R3's provider orders dated 12/10/25, indicated foley catheter, indwelling placement. Complete cares with soap and water every shift, document output every shift. R3's care plan revised 10/24/25, indicated bowel and bladder tasks, complete catheter care with soap and water every shift and after each incontinent episode as needed. During observation and interview on 12/10/25 at 11:20 a.m., R3's urinary drainage bag was attached to his garbage can, hanging, with the bottom of the bag resting on the floor. R3 was seated in his wheelchair and stated staff always hung the bag from the garbage can because it was close to his wheelchair. During interview on 12/10/25 at 2:21 p.m., NA-M stated she hung the urinary drainage bag from the garbage can because it was close to where R3 was sitting. NA-M stated she did not think about the urinary drainage bag resting on the floor and how that could lead to infection for R3. During interview on 12/10/25 at 11:35 a.m., RN-H stated the urinary drainage bag should not be hanging from the garbage can or resting on the floor because both could lead to infection concerns for R3. During interview on 12/10/25 at 2:29 p.m., RN-F stated she would expect the urinary drainage bags to be hung somewhere other than the garbage can and not resting on the floor, but ADON who was also the infection preventionist took care of those things. Facility Urinary Catheter Care policy with revised date of 8/2022, indicated the purpose was to prevent urinary catheter-associated complications, including urinary tract infection. Staff were to be sure the catheter tubing and drainage bag were kept off the floor.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a comfortable and sanitary environment for 1 of 1 resident (R4) reviewed for environment, when a bedside commode was observed overfilled and a soiled brief was observed in a wastebasket. In addition, the facility failed to maintain a clean and sanitary environment in the kitchen food preparation and service areas, this had the potential to affect all 61 residents residing in the facility. Findings include: R4's face sheet provided on 12/15/25, included diagnoses of hemiplegia (paralysis affecting one side of the body) following stroke, diabetes, chronic pain, and dementia. R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was usually understood and was usually able to understand. R4 had highly impaired vision with adequate hearing. R4 required substantial assistance or was dependent upon staff for help with activities of daily living (ADLs). R4 did not walk. R4's care plan with revised date of 5/27/25, indicated R4 had an ADL self-care performance deficit related to left sided hemiplegia. Care plan with revised date of 8/19/25, indicated R4 required assist of two staff with a Hoyer (mechanical transfer device) and preferred to use commode vs toilet. R4's care plan with revised date of 12/9/24, indicated R4 had impaired visual function and was legally blind. During an observation on 12/9/25 at 8:33 a.m., R4 was being escorted from his room via wheelchair with an unidentified nursing assistant. In R4's room, observed an extra wide commode with the waste bucket filled to the rim of the seat with toilet paper. The odor of BM (bowel movement) permeated the room. A package of wet wipes was resting on the arm of the commode with the lid open. R4's overbed table with an empty popcorn bowl, glass of juice and mug of water was directly next to the commode and touching the commode. One bed pillow was on the floor at the head of the bed. In the corner of room by window was a heap of various items, including wheelchair legs, bed and decorative pillows, and gown. The wastebasket next to the bedside dresser was full, with a soiled brief on top and hanging over the side. During an observation and interview on 12/9/25 at 8:40 a.m., after not being able to locate the nursing assistant who had been observed assisting R4, brought registered nurse (RN)-A who was also the nurse manager on the unit on which R4 resided, into the room. RN-A observed the room and stated it was not okay to leave a commode like that. RN-A stated staff were expected to remove and/or empty a commode right away and take trash out when they left the room. RN-A stated staff should be picking up the room before they exit it. RN-A stated newer staff had issues with time management, and at nursing report times, they talked about key things that should be happening, such as removing trash when exiting a room, closing packages of wet wipes, and cleaning commodes. During an interview on 12/10/25 at 8:41 a.m., R4 stated he was not aware of the cleanliness of his room due to his limited eyesight. R4 stated he thought the staff did a good job keeping his room clean, but he didn't know that for sure. R4 stated he expected staff to keep his room clean and pick up because he could not do it. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 12/11/25 at 10:12 a.m., RN-A stated she conducted corrective action with nursing assistant (NA)-A regarding the condition in which she left R4's room on the morning of 12/9/25. NA-A told RN-A she was busy and didn't have time to clean up the room. A policy on clean and sanitary environment related to commodes and wastebaskets in resident rooms was requested and an unrelated housekeeping policy was received. KITCHEN On 12/8/25 at 9:35 a.m., during the initial tour of the kitchen, an electrical outlet and extension cord located above the food service area were observed to have gray, fuzzy debris present. The cord extended downward approximately 5–6 inches from the ceiling and was connected to a printer. The debris-covered cords were located directly above clean plates, near the steam table area on the left, and adjacent to a food preparation area on the right. The culinary director (CD)-B stated maintenance was responsible for cleaning cords extending from the ceiling. CD-B confirmed the cords were dirty, covered in debris, and required cleaning. CD-B further stated she would not expect debris to be present above a food preparation area and acknowledged the debris could fall onto uncovered plates during meal plating. On 12/8/25 at 10:10 a.m., during observation and interview, the environmental director (ED)-K confirmed the extension cords and plug-in area were dirty with debris and lint and required cleaning. ED-K stated cleaning of the cords was the responsibility of maintenance and confirmed the cords were not on a routine cleaning schedule. ED-K further stated culinary staff were expected to notify maintenance when cleaning was needed. ED-K stated debris-covered cords would not be expected over a food preparation area due to the risk of debris falling onto plates or food being prepared. Facility Schedule Cleaning Policy and Procedure dated 5/25, indicated: To maintain the sanitation of the kitchen, provide clear expectations, and to assign responsibility for scheduled cleaning in the dining areas and kitchen through a written, comprehensive cleaning schedule. Cleaning assignment sheets will be posted and signed off for completion of scheduled cleaning by the cooks, dining assistants, dining room servers, bistro staff and dish room staff. Cleaning tasks will be assigned daily, weekly, monthly, quarterly and every six (6) months. Method and materials/cleaning compounds will be trained by the person in charge. Daily cleaning assignments will be posted by position and completed/initialed before the end of each shift

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 document review, the facility failed to ensure a skin injury had a timely assessment and documentation for 1 of 1 resident (R30), reviewed for non-pressure wounds; failed to ensure accuracy of wound assessments for 2 of 3 residents (R12 and R13) reviewed for pressure wound; failed to ensure an accurate, new, comprehensive assessment was completed for newly identified facility acquired toe wounds for 1 of 1 resident (R3) reviewed for non-pressure wounds. Findings include: TIMELY ASSESSMENT R30's annual Minimum Data Set (MDS) assessment dated [DATE], indicated R2 had no cognitive impairment, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with shower/bath, lower body dressing, dependent on toileting hygiene and transfers, diagnoses included diabetes and arthritis. R30's Care Area Assessment (CAA) worksheet dated 9/9/25, indicated staff will monitor skin and report changes for further evaluation/intervention/treatment as appropriate. R30's care plan dated 9/11/25, indicated R55 had limited physical mobility related to (r/t) immobility, spondylosis, osteoarthritis and weakness, totally dependent on staff for locomotion, uses a manual wheelchair for locomotion, risk for complications r/t diabetes check all of body for breaks in skin and treat promptly as ordered by doctor, cautious transfers/mobility to prevent striking limbs on hard/sharp surfaces, padded rails, wheelchair arms or any other source of potential injury as ordered/applicable, observe skin every shift for abnormalities or new injury. R30's skin assessment document dated 12/2/25 indicated right lower leg (front) discoloration, right gluteal (buttocks) fold [NAME] 1 pressure sore, zinc applied - this remains pink and blanchable, provider assessed today, left shoulder (front) fading bruise to l shoulder from immunizations, scattered bruising to BLE (bilateral lower extremities) and BUE (bilateral upper extremities), assessment done during resident's shower on 11/25/25. R30's skin assessment document dated 12/10/25, indicated right lower leg (front) discoloration, left lower leg (front) purple bruise noted. 4 cm (centimeters) x 1.5 cm, right gluteal fold [NAME] 1 pressure sore. zinc applied, this remains pink and blanchable. triad (used for managing various wounds) applied; other (specify) 11 cm x 5 cm bruise (the document did not identify location), 2.5 cm x 1.4 cm open area to anterior lower left arm, left lower arm has bruise and skin tear. resident would not let writer remove bandage to assess, scattered bruising to BLE & BUE, left lower arm has bruise and skin tear. Resident would not let writer remove bandage to assess, new concern noted 12/10/25. This document failed to indicate the right forearm dressing or wound. R30's treatment administration record (TAR) dated 12/1/25-12/31/25, indicated order date 12/4/25, change dressing on right arm, clean, bacitracin, no-adherent dressing, kerlix (woven gauze bandage), and top with koban [sic] (self-adherent elastic wrap). Order was discontinued on 12/9/25. R30's treatment administration record (TAR) dated 12/1/25-12/31/25, indicated order date 12/10/25, wound care right arm, cleanse with normal saline, apply non-adherent dressing wrap with Kerlix and Coban (self-adherent elastic wrap) one time daily. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R30's late entry progress note dated 12/9/25 at 5:02 p.m., licensed practical nurse (LPN)-D indicated on 12/4/25, writer was notified by PT (physical therapy) R30 had ran into her sink while practicing with her motorized wheelchair, upon assessment, writer found three skin tears on right forearm, cleaned, bacitracin was applied and covered with a non-adherent dressing, kerlix and Coban, added to TAR to change and monitor daily. R30's record review lacked an assessment and skin documentation of R30's arm injury and wound obtained on 12/4/25, until 12/10/25. On 12/8/25 at 3:02 p.m., during observation with R30's right arm was observed with tan wrap on the right forearm. On 12/9/25 at 11:42 a.m., R30 was observed lying in bed with a bandage in place on the right forearm. R30 stated that the injury occurred the previous week while working with physical therapy (PT) using her electric wheelchair. R30 reported she moved the wheelchair incorrectly, causing her right forearm to become caught underneath the bathroom counter. R30 stated she was unsure whether the provider was aware of the injury. R30 further stated that nursing staff completed a dressing change, but she was not aware whether the wound had been measured. On 12/9/25 at 12:18 p.m., RN-A stated that on 12/4/25, R30 was working with therapy using her electric scooter when her arm was injured after becoming caught on the bathroom counter. RN-A was observed reviewing the electronic medical record (EMR) and stated there was no assessment or documentation regarding the injury to R30's arm. RN-A stated a comprehensive skin assessment would be expected, and the provider would be expected to be notified on the date the injury occurred for awareness and to determine whether any wound care orders were needed. On 12/9/25 at 2:52 p.m., the interim director of nursing (DON) stated a skin assessment and documentation would be expected if a resident sustained an injury to the skin that required treatment and stated the provider would be expected to be notified. ACCURATE ASSESSMENT R12's quarterly MDS dated [DATE], indicated: severe cognitive impairment, no rejection of care, dependent on staff for toileting hygiene, shower/bath, lower body dressing, personal hygiene, and transfers, utilized a wheelchair, current toileting program, always incontinent of urine, frequently incontinent of bowel; diagnoses included cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke, anxiety, depression, history of falling; at risk of developing pressure ulcers/injuries, no unhealed pressure ulcers/injuries, Moisture Associated Skin Damage (MASD). R12's document Weekly Ulcer/Complex Would Observation Tool dated 12/10/25 at 1:01 p.m., licensed practical nurse (LPN)-E indicated R12 had a stage one ulcer/wound, site: coccyx, type: pressure, length: 0.5 centimeters (cm), width: 0.5 cm, stage: 1, date acquired: 12/10/25, first observation, Mepilex dressing applied for healing and protection. R12's TAR dated 12/1/25-12/31/25, indicated start date monitor dressing and open area to coccyx, Mepilex dressing to be changed q (every) 3 days. R12's provider communication tool dated 12/10/25, LPN-E indicated 0.5 cm x 0.5 cm open area on the coccyx, Mepilex dressing applied, orders placed to change q3days, monitor with Mepilex in place for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	protection? Provider response indicated see faxed orders 12/11. R12's provider visit note dated 12/11/25 1 at 8:21 a.m., nurse practitioner (NP)-H indicated reviewed request from nurse regarding 0.5 cm x 0.5 cm open area on the coccyx, new orders cleanse affected area with normal saline and pat dry, apply triad to affected area twice daily and as needed, notify if no improvement or worsening and will add to wound rounds. On 12/11/25 at 8:20 a.m., LPN-E stated on 12/10/25, she was notified by a nursing assistant that R12 had a slit on her coccyx. LPN-E stated she assessed R12's coccyx and observed a slit measuring approximately 0.5 centimeters (cm) x 0.5 cm. and applied a Mepilex was applied to the area. LPN-E described the area as a slit related to moisture, wrote a note for the provider to review and confirmed she documented the assessment in the electronic medical record (EMR). LPN-E stated the assessment in the EMR was documented as a pressure injury. LPN-E stated she had not received specific training on differentiating types of wounds or pressure injuries and stated she was currently in school and learning the differences in wound identification and assessment. LPN-E confirmed the assessment was inaccurately documented as pressure rather than moisture-associated. LPN-E stated she did not assess whether the area was blanchable and stated she was not trained to check for blanching as part of a wound assessment. LPN-E stated she notified registered nurse (RN)-C, the nurse manager, of R12's new skin concern and was instructed to complete a skin assessment. LPN-E stated RN-C did not complete the wound assessment with her. On 12/11/25 at 8:26 a.m., RN-C stated on 12/10/25, LPN-E reported R12 had a slit on her coccyx. RN-C stated LPN-E was instructed to cleanse the area, apply Mepilex, notify the provider, and monitor the area. RN-C stated the area was described as a small slit and not pressure-related, and confirmed the area was expected to be documented as moisture-associated rather than pressure. RN-C confirmed she did not assess R12's coccyx. RN-C stated the documentation discrepancy and inaccuracy reflected nursing staff training needs and stated the facility required more formal education, including one-on-one education for nursing staff. On 12/11/25 at 8:30 a.m., NP-H stated she was provided documentation regarding R12's skin concern on 12/11/25. NP-H stated the area was described as a 0.5 cm x 0.5 cm open area on the coccyx. NP-H stated she did not assess R12's coccyx and would expect an accurate assessment to be documented by nursing staff in the EMR. NP-H stated she wrote orders to apply Triad (wound dressing paste) to the area. R13's face sheet provided on 12/15/25, included diagnoses of pressure ulcer of contiguous site of back, buttock and hip, unstageable, and irritant contact dermatitis due to fecal, urinary or dual incontinence. R13's significant change MDS assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R13 required substantial staff assistance or was dependent on staff for activities of daily living (ADLs) and did not walk. R13 had a urinary catheter and was occasionally incontinent of bowel. R13 was at risk for pressure ulcers and had an unhealed pressure ulcer. R13 had two unstageable pressure injuries presenting as deep tissue injury, not present on admission. R13's pressure ulcer/injury care area assessment (CAA) dated 9/23/25, indicated R13 had suspected deep tissue injuries to bilateral buttocks. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R13's provider orders dated 10/27/25, indicated weekly skin check every day shift every Friday. Orders dated 12/5/25, included skin/wound care to buttocks. Cleanse entire buttock with Vashe (hypochlorous acid solution) wound cleanser, pat dry and apply a nickel thick layer of zinc barrier cream two times a day for skin/wound care. R13's orders did not include treatment for a pressure ulcer. R13's care plan indicated the following: Care plan initiated on 7/8/25, and revised on 11/12/25, indicated R13 had actual impairment to skin integrity related to stage 2 pressure injury on right buttock. Care plan initiated on 7/13/25, and revised on 10/20/25, indicated pressure injury, stage 1 present on admission. (Did not identify location of pressure injury). Care plan initiated on 7/13/25, and revised on 10/20/25, indicated R13's pressure ulcer would show signs of healing and remain free from infection. (Did not identify location of pressure ulcer) Care plan initiated on 9/16/25, and revised on 10/17/25, indicated SDTI (suspected deep tissue injury) to bilateral buttocks. Care plan dated 10/20/25, indicated R13's pressure ulcer would show signs of healing and remain free from infection. Care plan dated 10/28/25, indicated weekly skin assessment to include measurement of each area of skin breakdown if applicable (width, depth, type of tissue/exudate, etc.). Provide wound/skin treatments as ordered. Nursing wound assessments provided by RN-A who was also the nurse manager included: 9/20/25: Unstageable pressure injury to buttocks. 10/17/25: No stage. Site was right and left buttocks. Type was pressure. 10/28/25: No stage. Site was right and left buttocks. Type was pressure. 11/21/25: Stage 2. Site was right and left buttocks. Type was pressure. The wound measurements within the assessments were significantly variable: Right buttocks length ranged from 8 cm to 15 cm, and left buttocks length ranged from 9 cm to 14.7 cm. Right buttocks width ranged from 4 cm to 8.4 cm, and left buttocks width ranged from 3.3 cm to 8 cm. Provider wound assessments provided by RN-A for the following dates 8/26/25, 9/2/25, 10/14/25, 10/18/25, 10/28/25, 11/24/25, and 12/2/25, consistently identified R13's skin problem as incontinence associated dermatitis, buttocks, bilateral. Pressure injury or ulcer had not been used to describe R13's skin on his buttocks. During an interview on 12/9/25 at 1:00 p.m., RN-A stated the wound measurements were variable because some nurses measured red areas on R13's buttocks and some nurses measured open areas. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 12/9/25, at 1:13 p.m., together with RN-A, went to R13's room to ask if the skin on his buttocks could be observed and R13 declined. During an interview on 12/9/25 at 2:06 p.m., RN-A stated after reviewing nurse wound assessments and provider wound notes, realized R13's skin on his buttocks had been incorrectly identified; that R13 never had a pressure ulcer. RN-A stated she was aware nurses had documented both a stage 1 and stage 2 pressure ulcer to R13's buttocks, as well as deep tissue injury, but the provider had consistently identified the skin problem as incontinence associated dermatitis. RN-A stated the facility did not have nurses with specialized training in wound care, adding the assistant director of nursing (ADON) had recently provided nurses with a folder with some printed wound resources to review. During an interview on 12/10/25 at 1:42 p.m., ADON stated she had provided nurses with a folder from a company called Curitec (a provider specializing in advanced wound care for long term care) that included resources to help nurses assess and document pressure ulcers. The printed material was reviewed and included photos of pressure ulcers, information on documenting wounds and described some treatments. ADON stated no in-person training or courses on wound care had been provided for the nurses, just the folder of material. ADON stated there were no nurses in the facility designated as wound nurses or who had special training, and no consistent nurse(s) were conducting wound assessments. ADON stated registered nurses should know how to assess pressure wounds because they would have learned it in nursing school. ADON was informed of the concern of nurses documenting R13 having a pressure ulcer when he did not. During a telephone interview on 12/11/25 at 2:28 p.m., NP-G stated she saw R13 for wound care; her last visit was 11/24/25. NP-G was informed nursing staff had documented R13 as having pressure ulcers of various stages to his buttocks, yet her documentation consistently indicated he had incontinence associated dermatitis of bilateral buttocks. NP-G stated she had not been aware nurses were documenting pressure. NP-G stated R13 did not have pressure wounds to his buttocks. Further, NP-G stated someone at the facility would have added the diagnosis of pressure ulcer of contiguous site of back, buttock and hip, unstageable, to R13's diagnosis list as providers sent dictation with the diagnoses they assessed. During an interview on 12/11/25 at 4:12 p.m., the executive director (ED)-A was informed of findings related to inaccurate nurse documentation of skin wounds on R13's, specifically nurses identifying R13 having a pressure ulcer when he did not. ED-A stated nurse training was the responsibility of the ADON. ED-A was informed wound care training currently consisted of nurses taking personal responsibility to review a folder of paper documents provided by a wound care company, and no in-person training or specialized courses had been provided. A wound assessment policy was requested, and a policy on identification of residents at risk of developing new pressure injuries or worsening of exiting pressure injuries was provided. ACCURATE/ NEW COMPRENESIVE ASSESSMENT R3's significant change MDS assessment dated [DATE], indicated R3 had no cognitive impairment, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with shower/bath, partial/moderate assistance with toilet use and upper/lower body dressing, and diagnoses included heart failure and diabetes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R3's care plan revised 10/24/25, indicated R3 had skin health and pressure injury prevention needs with interventions that included foot care: wash feet as needed with mild soap and water, dry thoroughly, may use diabetic foot lotion, observe for open areas, sores, pressure areas, blisters, edema or redness. Report any abnormalities to nurse promptly. R3's skin assessment dated [DATE], indicated shearing of skin to second toe of left foot measuring 0.1 cm x 0.1 cm and shearing of skin to left great toe measuring 1.5 cm x 1.5 cm., both present on admission and improving. R3's skin assessment dated [DATE], indicated shearing of skin to second toe of left foot measuring 1 cm x 0.5 cm, shearing of skin to left great toe measuring 2 cm x 0.5 cm, additional shearing of skin to second toe of left foot measuring 0.4 cm x 0.4 cm, shearing of skin to fourth toe of left foot measuring 0.3 cm x 0.3 cm, and shearing of skin to fifth toe of left foot measuring 0.3 cm x 0.3 cm., all present on admission and unchanged. Facility document title SBAR Communication Tool dated 11/23/25, indicated R3 had a small 0.3 cm x 0.3 cm blister at the tip of fourth left toe that had popped a few days ago. No documentation of other new wounds was included in the notification to provider. During interview on 12/8/25 at 3:04 p.m., R3 stated he had lost some toes on his right foot and had new wounds on his left foot due to staff running his foot over with a wheeled table. R3 was unsure if a provider knew about his new wounds or the incident with the table. R3's left foot was observed to be wrapped and in a protective boot. During interview on 12/10/25 at 4:01 p.m., LPN-F stated she completed the wound assessment on 11/23/25 and indicated the new wounds on the assessment but could not remember why she reported the fourth toe wound to the provider, but no other new wounds. LPN-F further stated a separate comprehensive wound assessment should have been completed for the new facility acquired wounds, rather than documenting them as present since admission and unchanged. During interview on 12/10/25 at 3:50 p.m., RN-F stated she had not seen a new comprehensive skin assessment for the newly identified toe wounds, did see a provider notification for the new fourth toe wound, but no other notification to provider about the new second and fifth toe wounds. RN-F stated she expected a new skin assessment and provider notification for all new wounds. Facility Wound Care Policy and Procedure undated, indicated: Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide fresh drinking water to 7 of 7 residents (R10, R4, R30, R7, R49, R54, R17) on a daily basis who were reviewed for hydration. Findings include: R10's face sheet provided on 12/15/25, included diagnoses of spinal stenosis (narrowing of spaces within spine causing pain), diabetes and chronic kidney disease (kidneys cannot filter waster and fluid from blood effectively). R10's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, could understand and was usually understood. R10 required substantial assistance or was dependent upon staff for activities of daily living (ADLs) but could eat and drink independently. R10 did not walk. R10's provider orders dated 6/4/25, indicated a diet with thin liquids. R10's care plan dated 9/27/24, indicated ensure adequate fluid intake, offer fluids and keep water at bedside for easy access. Care plan dated 12/18/24, indicated staff were to refill water cup every day after lunch. Care plan dated 6/4/25, indicated staff were to encourage adequate hydration. Care plan dated 7/18/25, indicated R10 had risk for dehydration related to diuretic (medication to remove excess body fluid) use. During an interview on 12/8/25 at 11:24 a.m., R10 who resided on the short-term care unit stated she was not offered fresh water daily, she had to ask for it or her daughter who came daily, got fresh water for her. R4's face sheet provided on 12/15/25, included diagnoses of hemiplegia (paralysis affecting one side of the body) following stroke, diabetes, congestive heart failure (when the heart cannot pump blood effectively) and dementia. R4's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, was usually understood and was usually able to understand. R4 had highly impaired vision. R4 required substantial assistance or was dependent upon staff for help with most ADLs but could eat and drink independently with set up help. R4 did not walk. R4's provider orders dated 12/2/25, indicated a diet with thin liquids. R4's care plan dated 9/23/24, indicated staff were to ensure adequate fluid intake, offer fluids and keep water at bedside for easy use. Care plan with revised dated of 12/9/24, indicated R4 required set up assistance for meals. During an interview and observation on 12/8/25 at 6:45 p.m., R4 stated he had to ask staff for drinking water which staff obtained from his bathroom. R30's annual MDS assessment dated [DATE], indicated R30 had no cognitive impairment, no rejection of care, utilized a wheelchair, independent with eating, required substantial/maximal assistance with shower/bath, lower body dressing, dependent on toileting hygiene and transfers, diagnoses included (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	anxiety and depression R30's care plan dated 9/11/25, indicated R30 has risk for constipation r/t (related to) decreased mobility, use/side effects of medication and interventions included: ensure adequate fluid intake, offer fluids and keep water at bedside for easy access unless contraindicated per nurse, has a foley catheter r/t incontinence, risk for UTI r/t catheter use and interventions included adequate hydration and develop a hydration plan On 12/8/25 at 3:05 p.m., R30 was lying in bed and stated fresh water was brought to her when she requested the water or when her family member (FM)-E brought her water. R30 was observed with an insulated mug on her bedside table in front of her. R30 On 12/9/25 at 11:42 a.m., R30 was lying in bed and stated she received fresh water today in the same mug she used yesterday after she requested the water from staff. R30 stated staff have never offered her water. On 12/10/25 at 3:32 p.m., R30 stated she received water today after she requested water. RESIDENT COUNCIL During resident council meeting interviews on 12/9/25, at 3:30 p.m., five of six residents in attendance stated they had to ask for fresh drinking water -- that staff did not provide fresh water daily. --R7's annual MDS assessment dated [DATE], indicated intact cognition and was independent with meals. R7 stated staff did not ask him if he wanted fresh water; he had to ask them, and that staff went into his bathroom to refill his mug. --R49's annual MDS assessment dated [DATE], indicated severe cognitive impairment; was understood and could understand, and was independent with meals. R49 stated he had to ask for fresh water. --R54's quarterly MDS assessment dated [DATE], indicated intact cognition and was independent with meals. R54 stated he had to ask for fresh water. --R4 repeated that he had to ask for water which staff obtained from his bathroom. --R17's quarterly MDS assessment dated [DATE], indicated moderate cognitive impairment; could understand and be understood, required supervision with meals. R17 stated he had to ask for fresh water or he obtained fresh water himself from the water jug dispenser by the nurse's station. On 12/9/25 at 5:06 p.m., nursing assistant (NA)-B working on the long-term care unit, stated nursing staff were responsible for refilling resident water mugs. NA-B stated residents asked when they needed or wanted water, adding no one passed water to all residents on a regular basis that she was aware of. On 12/9/25 at 5:09 p.m., on the short term stay unit, registered nurse (RN)-B stated she did not know who was responsible for refilling resident mugs with fresh water, adding she had never seen anyone do that on her shifts. RN-B stated she got residents fresh water when they asked. RN-B stated she (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was not aware that anyone was assigned to give residents fresh water daily. On 12/9/25 at 12:09 p.m., NA-G stated there was not a process for passing water, stated there previously was a NA assigned to pass water. On 12/9/25 at 12:28 p.m., RN-A and RN-C, who were both known as nurse managers, stated the facility had a hydration center located by the nursing station during the summer, and there were cups and water available. RN-A and RN-C confirmed there was not a current process for providing water pass to the residents and stated would expect the residents offered water and would not be expected to ask for water. RN-C stated that hydration as important to prevent urinary tract infections and dehydration for the residents. On 12/10/25 at 3:21 p.m., the dining specialist stated during the summer there was a water dispenser located at the nursing station for hydration and stated was not sure what the process was for residents to receive water and stated would expect residents offered water daily, would not expect residents to have to request water. On 12/10/25 at 11:38 a.m., licensed practical nurse (LPN)-A stated she had never observed nursing assistants (NAs) formally pass water to residents and stated she had only observed staff refilling a resident's cup upon request. LPN-A stated there had previously been a water cooler near the nurses' station during the summer months. LPN-A stated she was not aware of a current process in place to ensure residents received water without having to request it. On 12/10/25 at 3:55 p.m., culinary director (CD)- B stated dietary staff were not responsible for passing water to residents, other than supplying mugs. DM-B stated the facility previously had a process under the former director of nursing (DON) in which overnight staff obtained clean mugs from the kitchen, passed water to residents, and returned the used mugs daily to the kitchen for washing. DM-B stated she was not aware of a current process in place to ensure residents received a clean water mug and fresh water daily. On 12/11/25 at 8:04 a.m., dining assistant (DA)-B stated she consistently washed dishes for the facility and that resident water mugs were washed in the dish room. DA-B stated the water mugs did not come through the kitchen to be washed on a consistent basis and stated she might receive one or two water mugs in a week but did not receive a large quantity of water mugs to wash on a daily basis. On 12/8/25 through 12/11/25, did not observe staff pass water to resident rooms. On 12/11/25 at 4:16 p.m., the executive director (ED)-A stated she expected staff to pass water daily and provide residents with a clean mug daily. Facility Serving Drinking Water policy with revised day of October 2010 indicated the purpose was to of the procedure was to provide the resident with a fresh supply of drinking water and to provide adequate fluids for the resident. Drinking water would be obtained from an approved source that was a public water system or nonpublic water system that is constructed, maintained and operated according to applicable state/federal law. Staff were to assemble the equipment and supplies necessary to perform the procedure and arrange them on a rolling cart. Supplies included a movable serving cart, ice, scoop, water pitcher and cup, flexible straws, paper towels and personal protective wear as needed. Steps in the procedure included filling the ice chest with ice and coving the chest, rolling the cart to the outside entrance of the resident's room. Going into the resident's bedside stand (continued on next page)

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

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and pick up the water pitcher. Taking the water pitcher into the bathroom. Emptying the contents into the commode. Flush the commode. Rinse the water pitcher with tap water. Pour the water down the sink. Fill the water pitcher one-half full with tap water. Unless the resident is in isolation, take the water pitcher to the ice cart outside the room. Fill the pitcher with ice. Do not let the ice scoop touch the water pitcher. Return the water pitcher to the resident's bedside stand. Wipe the bedside stand with a clean paper towel. Discard used paper cups, paper towels and other disposable items into designated container. Offer the resident a fresh cup of water. Place the water pitcher and cup within easy reach of the resident. Place flexible straws next to the water pitcher. Repeat until the procedure has been completed for each of assigned residents. Wash your hands. The person performing this procedure should record the following information, the time that the procedure was performed. (Note on daily flow sheet or record). The name and title of the individual(s) who performed the procedure. If the resident refused the drinking water, the reason(s) why and the intervention taken. Notify the supervisor if the resident refuses the drinking water. Report other information in accordance with facility policy and professional standards of practice.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to notify the provider of a choking episode for 1 of 2 residents (R11) reviewed for accidents and skin injury for 2 of 2 residents (R30, R3) reviewed for skin. Findings include: Accidents R11's annual minimum data set (MDS) assessment dated [DATE], indicated moderately impaired cognition, no rejection of care, use of walker and wheelchair, independent with eating, and diagnosis of heart failure and fracture. R11's care plan revised 5/21/25, indicated self-care performance deficit related to weakness associated with fracture and eating assistance for set up and clean up but could eat independently. R11's physician's orders dated 4/9/25, indicated regular diet, regular texture, thin liquid consistency. Facility progress note dated 12/6/25 at 5:15 p.m., indicated R11 choked at dinner table, raised her hand and pointed at throat, staff performed Heimlich maneuver and resident started coughing and worked through episode. Emergency contact made aware. Monitoring in place. Facility progress note dated 12/7/25 at 7:15 a.m., indicated R11 had a choking episode from previous shift. Writer completed bowel sounds and lung sounds. Lung sounds clear. Bowel sounds active in all four quadrants. During interview on 12/8/25 at 7:36 p.m., executive director (ED)-A stated no provider was notified of the choking incident for R11 on 12/6/25, and further stated the provider should be notified of any resident incident or change in condition. O-A stated since being made aware of the lack of provider notification, she had educated nurses to notify providers of any resident incident and complete a facility risk management report. Skin Injury R3's significant change MDS assessment dated [DATE], indicated R3 had no cognitive impairment, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with shower/bath, partial/moderate assistance with toilet use and upper/lower body dressing, an diagnoses included heart failure and diabetes. R3's care plan revised 10/24/25, indicated R3 had skin health and pressure injury prevention needs with interventions that included foot care: wash feet as needed with mild soap and water, dry thoroughly, may use diabetic foot lotion, observe for open areas, sores, pressure areas, blisters, edema or redness. Report any abnormalities to nurse promptly. R3's skin assessment dated [DATE], indicated shearing of skin to second toe of left foot measuring 0.1 cm x 0.1 cm and shearing of skin to left great toe measuring 1.5 cm x 1.5 cm., both present on (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission and improving. R3's skin assessment dated [DATE], indicated shearing of skin to second toe of left foot measuring 1 cm x 0.5 cm, shearing of skin to left great toe measuring 2 cm x 0.5 cm, additional shearing of skin to second toe of left foot measuring 0.4 cm x 0.4 cm, shearing of skin to fourth toe of left foot measuring 0.3 cm x 0.3 cm, and shearing of skin to fifth toe of left foot measuring 0.3 cm x 0.3 cm., all present on admission and unchanged. Facility document title SBAR Communication Tool dated 11/23/25, indicated R3 had a small 0.3 cm x 0.3 cm blister at the tip of fourth left toe that had popped a few days ago. No documentation of other new wounds was included in the notification to provider. During interview on 12/8/25 at 3:04 p.m., R3 stated he had lost some toes on his right foot and had new wounds on his left foot due to staff running his foot over with a wheeled table. R3 was unsure if a provider knew about his new wounds or the incident with the table. During interview on 12/10/25 at 4:01 p.m., licensed practical nurse (LPN)-F stated she completed the wound assessment on 11/23/25, and indicated the new wounds on the assessment, but could not remember why she reported the fourth toe wound to the provider, but no other new wounds. LPN-F further stated a separate wound assessment should have been completed for the new facility acquired wounds, rather than documenting them as present since admission. During interview on 12/10/25 at 3:50 p.m., registered nurse (RN)-F stated she had not seen a new comprehensive skin assessment for the newly identified toe wounds, did see a provider notification for the new fourth toe wound, but no other notification to provider about the new second and fifth toe wounds. RN-F stated she expected a new skin assessment and provider notification for all new wounds. R30's annual MDS assessment dated [DATE], indicated R30 had no cognitive impairment, no rejection of care, utilized a wheelchair, required substantial/maximal assistance with shower/bath, lower body dressing, dependent on toileting hygiene and transfers, diagnoses included diabetes and arthritis. R30's Care Area Assessment (CAA) worksheet dated 9/9/25, indicated staff will monitor skin and report changes for further evaluation/intervention/treatment as appropriate. R30's care plan dated 9/11/25, indicated R30 had limited physical mobility related to (r/t) immobility, spondylosis, osteoarthritis and weakness, totally dependent on staff for locomotion, uses a manual wheelchair for locomotion, risk for complications r/t diabetes check all of body for breaks in skin and treat promptly as ordered by doctor, cautious transfers/mobility to prevent striking limbs on hard/sharp surfaces, padded rails, wheelchair arms or any other source of potential injury as ordered/applicable, observe skin every shift for abnormalities or new injury. R30's skin assessment document dated 12/2/25, indicated right lower leg (front) discoloration, right gluteal (buttocks) fold [NAME] 1 pressure sore, zinc applied - this remains pink and blanchable, provider assessed today, left shoulder (front) fading bruise to l shoulder from immunizations, scattered bruising to BLE (bilateral lower extremities) and BUE (bilateral upper extremities), assessment done during resident's shower on 11/25/25. R30's skin assessment document dated 12/10/25, indicated right lower leg (front) discoloration, left (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lower leg (front) purple bruise noted. 4 cm (centimeters) x 1.5 cm, right gluteal fold [NAME] 1 pressure sore. zinc applied, this remains pink and blanchable. triad (used for managing various wounds) applied; other (specify) 11 cm x 5 cm bruise (the document did not identify location), 2.5 cm x 1.4 cm open area to anterior lower left arm, left lower arm has bruise and skin tear. resident would not let writer remove bandage to assess, scattered bruising to BLE & BUE, left lower arm has bruise and skin tear. Resident would not let writer remove bandage to assess, new concern noted 12/10/25. This document failed to indicate the right forearm dressing or wound. R30's treatment administration record (TAR) dated 12/1/25-12/31/25, indicated order date 12/4/25, change dressing on right arm, clean, bacitracin, no-adherent dressing, kerlix (woven gauze bandage), and top with koban [sic] (self-adherent elastic wrap). Order was discontinued on 12/9/25. R30's treatment administration record (TAR) dated 12/1/25-12/31/25, indicated order date 12/10/25, wound care right arm, cleanse with normal saline, apply non-adherent dressing wrap with Kerlix and Coban (self-adherent elastic wrap) one time daily. R30's late entry progress note dated 12/9/25 at 5:02 p.m., LPN-D indicated on 12/4/25, writer was notified by PT (physical therapy) R30 had ran into her sink while practicing with her motorized wheelchair, upon assessment, writer found three skin tears on right forearm, cleaned, bacitracin was applied and covered with a non-adherent dressing, kerlix and Coban, added to TAR to change and monitor daily. R30's progress note dated 12/9/25 at 3:57 p.m., RN-A, also known as nurse manager, indicated, provider was updated on how R30 obtained a skin tear on 12/4, okay with nursing cleaning daily and applying an island dressing. R30's progress note dated 12/10/25 at 11:39 a.m., LPN-E indicated R30 has orders in for wound on right arm to be cleaned with NS (normal saline) and apply island dressing, attempted to do dressing change, skin is very fragile and pealed with the dressing change. R30 states she does not have problems with other nurses, but writer carefully pulled back on dressing (skin pulls with carefully removing dressing). R55 refused to continue with dressing change and would like someone else to finish, this was reported this to another nurse to finish residents wound care. I also spoke with nurse practitioner (NP)-E and would like current dressing with island dressing to be discontinued, new order is to use non-adherent dressing with Kerlix and Coban and placed on round for NP-E on 12/11. R30's record review lacked documentation the provider had been notified of R30's arm injury and wound obtained on 12/4/25, until 12/10/25. On 12/8/25 at 3:02 p.m., during observation with R30's right arm was observed with tan wrap on the right forearm. On 12/9/25 at 11:42 a.m., R30 was observed lying in bed with a bandage in place on the right forearm. R30 stated that the injury occurred the previous week while working with physical therapy (PT) using her electric wheelchair. R30 reported she moved the wheelchair incorrectly, causing her right forearm to become caught underneath the bathroom counter. R30 stated she was unsure whether the provider was aware of the injury. R30 further stated that nursing staff completed a dressing change, but she was not aware whether the wound had been measured. On 12/9/25 at 12:18 p.m., RN-A stated that on 12/4/25, R30 was working with therapy using her (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electric scooter when her arm was injured after becoming caught on the bathroom counter. RN-A was observed reviewing the electronic medical record (EMR) and stated there was no assessment or documentation regarding the injury to R30's arm. RN-A stated a comprehensive skin assessment would be expected, and the provider would be expected to be notified on the date the injury occurred for awareness and to determine whether any wound care orders were needed. On 12/9/25 at 2:52 p.m., the interim director of nursing (DON) stated a skin assessment and documentation would be expected if a resident sustained an injury to the skin that required treatment and stated the provider would be expected to be notified. Facility Change in a Resident's Condition or Status Policy undated, indicated: Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse will notify the resident's attending physician or physician on call when there has been a(an): accident or incident involving the resident.Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. Facility Wound Care Policy and Procedure undated, indicated: Documentation The following information should be recorded in the resident's medical record: 1. The type of wound care given. 2. The date and time the wound care was given. 3. The position in which the resident was placed. 4. The name and title of the individual performing the wound care. 5. Any change in the resident's condition. 6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound. 7. How the resident tolerated the procedure. 8. Any problems or complaints made by the resident related to the procedure. 9. If the resident refused the treatment and the reason(s) why. 10. The signature and title of the person recording the data. Reporting 1. Notify the supervisor if the resident refuses the wound care. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure allegations of missing money were reported timely to the State Agency for 1 of 1 resident (R55) reviewed missing property. In addition, the facility to report choking incident with care plan not being followed for 1 of 2 residents (R5) reviewed for accidents. R55's 5-day Minimum Data Set (MDS) assessment dated [DATE], indicated R55 initial admit date was 12/30/2020, makes self-understood, ability to understand others, adequate hearing, severely impaired vision, moderately impaired cognition, no hallucinations or delusions, no rejection of care, utilized a manual wheelchair, required substantial/maximal assistance with eating, showers, upper body dressing; dependent on toileting, lower body dressing, putting on footwear, and transfers; diagnoses included Non-Alzheimer's Dementia, depression, end stage renal disease with dialysis, muscle weakness, difficulty in walking, and essential tremor. Department of Public Safety Report dated 12/1/25 at 2:11 p.m., law enforcement ([NAME]) indicated the following: offense: theft, SS-A called on behalf of R55 wanted to report money missing from his room. SS-A stated in August of 2025, R55 had $5000 plus in a bank bag in the top drawer of the nightstand next to his bed, and a week ago he had approximately $550 dollars left. SS-A had been concerned over the amount of cash he was keeping in his room. SS-A advised that she had been working on setting up a Resident Trust to keep R55's money secure. SS-A questioned R55 about the declining amount of funds in his nightstand, he told her that he has given money to his sister to pay for her husband's funeral. SS-A didn't believe this and called family member (FM)-B who denied receiving money from R55. SS-A said she confronted R55 about this new information, and R55 told SS-A that he lied about giving money to his sister and said he went to a casino and gambled away some of his money. On 10/28/2025, SS-A counted how much money he had left which totaled $1,400. SS-A said R55 purchased $800 plus in hockey tickets which he gives away to people. SS-A stated R55 suffers from short term memory loss and dementia and believes that he is spending or giving his money away without recollection. SS-A stated she was aware that R55 has an eye appointment and wanted to make sure that he had money for his trip, so she collected his remaining cash and secured it in her office; $550. SS-A also advised that R55 had memory loss, hearing loss, dementia, and is blind. [NAME] spoke with R55 and stated he had $1000 in twenties and $1000 in fifties in his nightstand; however, when SS-A collected his money for safe keeping a week ago, there was $550 .difficulty understanding and responding to questions. Due to R55's visual impairment he was unable to count his money or determine the denominations of the bills in his possession, and there are no records or accounting of how when or where he has been spending his money that he had in his possession. There is no information that supports R55's claim of stolen money: however, there is a large pool of individuals that theoretically could have had access to his cash. SS-A advised that on any given day, there are roughly 50-100 employees and service providers on-site .other residents that freely move about the facility, R55 was out of his room and off-site three days a week for most of the day, and due to his hearing loss and blindness he may not know someone was in his room when he is in his room. At this time, there is not enough information to substantiate the allegation that someone stole money from R55 or identify a suspect Electronic messages between staff: 11/27/25 at 9:07 a.m., licensed practical nurse (LPN)-A to the administrator: last night after shift change R55 talked about some financial concerns keeping him up at night. I've been told you're aware of some of them, but could we have a conversation about it on the phone at some point? (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/28/25 8:06 a.m., administrator to LPN-A: SS-A primarily works with R55, I'll connect with SS-A, and we'll connect with R55 between the two of us. I will talk to R55. This is not a new report from R55 - so I have addressed it in the past . 11/28/25 at 9:17 a.m., LPN-A to administrator: If it's ok, I'd rather talk to you. It's about SS-A. R55 is accusing SS-A of financial impropriety . I'm conflicted because as a mandated reporter I should call this in. 11/28/25 at 9:46 a.m., LPN-A to administrator: R55 is also having issues with his cash, that's mainly what's keeping him up at night. He should have several 50s and 20s in his pouch. He said he planned on using some of these for Christmas card gifs to his family. Right now, he has two 20s and a large stack of ones. He doesn't know why he has ones. He thought SS-A who took the cash out gave him ones instead of the larger bills. Or someone else is doing odd things with his money. 11/28/25 at 9:51 a.m., administrator to LPN-A: I will speak with R55 11/28/25 2:36 p.m. administrator to LPN-A: Just want to let you know that I checked in with R55 this afternoon - he was sleepy so didn't have much to say today let him know I could follow up again next week. 11/28/25 4:59 p.m., LPN-A to administrator indicated: I also thought maybe his petty cash could be locked up in the nurse's office. Right now, he asks a lot of people to check his cash and it's easy to access. I'll ask registered nurse (RN)-C about it. 12/1/25 at 12:21 p.m., LPN-A to SS-A: I'm sure you know all about what R55 is saying. He is desperate to talk to you today and he is talking about calling the police . saying that $2000 cash is missing, and that a bank account is closed without his consent, and that his money has fraudulently been put in a trust without his consent, . he is openly accusing you of crimes and I thought you should know. I was conflicted last week because as a mandated reporter I'm supposed to call this in, but I talked to the administrator who told me this is a well-known problem. 12/1/25 at 12:23 p.m., SS-A to LPN-A: I will come and talk to him after 3:00 today. This is an ongoing issue. I assure you there is no fowl [sic] play. He's having trouble understanding and remembering. Yes, I'm aware. 12/1/25 at 12:33 p.m., assistant director of nursing (ADON) message to administrator: LPN-A informed me and is very concerned about R55 and his money and was accusing SS-A of doing something with R55's money and threatening to call the police. Are you aware of this issue? I know SS-A is aware, but thinking we maybe need to take more drastic steps. LPN-A said R55 has a lot less money than he said he's supposed to have. 12/1/25 at 12:48 p.m., administrator response to ADON: SS-A had reached out to me- but it was on Friday and over the weekend and planned to connect with SS-A today. We have recently taken $550 from R55 to pare for a care escort for appointment later this month, and don't think R55 is remembering that. Other than that, we have not done anything with the cash in his drawer, but it seems as though he may be spending it on hockey tickets and other items like that. I think we need to talk to R55 about having it stored somewhere other than his room to avoid any confusion or allegations like this The police will be contacted if we decide to file a VA, but we need more info first. There is no evident to report based on only what R55 is reporting. I also stated visited with R55 on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Friday per LPN-A request and he did not have concerns for me at that time. Progress notes: 12/1/2025 at 4:26 p.m., SS-A indicated this writer met with the resident in his room, accompanied by an activities staff member. R55 was upset and reported that money was missing and that he should have $2,000 in his room. This writer clarified that $550 had been set aside in the social services office for escort costs to his eye appointment and R55 had $18 remaining in his room. R55 accused this writer of lying and stealing his money and requested to call the police. Per R55's request, this writer contacted the Police Department. An investigator arrived approximately 30 minutes later and met separately with R55 and this writer. The investigator determined the case would not be pursued, noting the resident's limited vision and hearing and inability to accurately recall how much money was in his possession. The officer requested documentation of the denominations of the $550 held in the social service office and related notes, which were provided via email. 12/2/2025 at 9:27 a.m., RN-C indicated physician note: virtual visit with Dr. Service, (psych). R55 appeared sad, reports he is upset about his money being stolen R55 called the police department yesterday. Police came to facility to see resident. Dr. Service will keep resident's meds the same. 12/2/2025 at 3:11 p.m., administrator indicated this writer spoke with R55 in follow up to his concern about the money in his room. Writer reminded resident that a police report had been filed yesterday (12/1), and the police investigator did not find evidence of theft or financial malpractice. Writer reminded R55 that $550 has been set aside in a secure location to be used for a care escort for an upcoming appointment. R55 informed the writer that he spent $850 on hockey tickets in September, as he gets a bulk ticket order each year. R55 was unable to repeat the same information consistently. Writer recommended that the facility keep R55's current money bag in a secure safe in the front office hub; R55 in agreement to this at this time. Writer informed nurses on shift that money bag would be put secure safe at this time. 12/5/2025 at 2:54 p.m., SS-A indicated RN-C and SS-A social worker met with resident in his room and explained to him that the eye clinic appt is cancelled and that money was returned to him and secured in his locked drawer. On 12/9/25 at 2:09 p.m., SS-A stated R55 had a financial POA. SS-A stated she was made aware by staff a couple months ago, that R55 had a large amount of cash in his room and that she counted the money, totaling $5,000. SS-A confirmed she personally counted the $5,000 in R55's room; however, the facility maintained no log, ledger, or two-person verification of the funds. SS-A stated she attempted to establish a resident trust account for R55 but did not complete the process because the amount exceeded what could be placed in a trust account. SS-A stated the money was returned to R55's locked bedside drawer, although the date of return was not documented. SS-A stated she later went to R55's room to obtain funds for the appointment and observed the cash balance had decreased to approximately $1,400. SS-A stated R55 explained he had purchased college season hockey tickets and gone to the casino and gave money to his sister for her husband's funeral. SS-A stated no money was taken at that time. SS-A stated she returned to R55's room on a different day and requested to set aside $550 to pay the personal attendants an eye doctor appointment. SS-A stated R55 agreed and allowed her to remove $550 from his room. SS-A stated that after the removal of the $550, R55 had approximately $18 remaining in one-dollar bills. SS-A further stated that on the Monday following Thanksgiving, R55 became upset and accused SS-A of stealing his money and requested to call the police. SS-A stated she assisted R55 in contacting law enforcement, and police responded and (continued on next page)

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	245390	A. Building B. Wing	12/15/2025

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed R55. SS-A stated police informed her they were unable to reach a conclusion due to R55's inability to provide consistent information. SS-A stated the administrator was informed of R55's accusation of missing money and was advised she did not need to file a vulnerable adult (VA) report with the state agency because law enforcement had been contacted. SS-A stated she was not aware of any facility investigation completed regarding the missing money and was unsure why an investigation was not conducted when the money had not been accounted for. On 12/9/25 at 2:34 p.m., the executive director (ED)-A who also served as facility administrator confirmed R55 had expressed concerns regarding missing money. The ED-A stated a VA report was not filed because there was no indication of theft or suspicious activity, and the amount of missing money could not be verified. The ED-A stated R55 requested law enforcement be contacted and SS-A assisted R55 in contacting the police. The ED-A stated the police did not express concerns; however, ED-A stated she was not aware of the specifics of the police report. The ED-A further stated she would need to review facility policy and regulations regarding reporting of missing money. The ED-A stated there was a safe in the administration specialist office, however ED-A stated she currently had R55's money in a money bag locked in her office and had completed a reconciliation of the money. On 12/9/25 at 2:55 p.m., the interim director of nursing (DON) stated she was not aware of any concerns regarding R55's missing money. The Interim DON stated that, as an interim staff member, she would defer concerns regarding missing money to the ED-A and would rely on ED-A to determine whether reporting to the state agency was required. On 12/9/25 at 3:24 p.m., during a telephone interview, R55's financial POA stated they had served as R55's financial POA for several years, beginning on 3/15/21. The POA stated SS-A informed them in August 2025, that a large amount of cash was found in R55's room. The POA stated they advised SS-A that R55 could retain possession of the money but would be required to spend the funds down prior to R55's next medical assistance (MA) renewal. The POA confirmed they did not take control of the money, and SS-A maintained notes documenting communications regarding the funds and provided updates to the POA. The POA stated they were not notified of R55's accusations of missing money. On 12/9/25 4:06 p.m., R55 was seated in recliner in his room and stated money had gone missing stated 1450.00 was missing and stated, I know that girl named [used SS-A's name] took it. On 12/10/25 at 8:54 a.m., the ED-A stated that when a report of missing money was received and the money may have been stolen, it would be an immediate concern. The ED-A stated R55 did not directly report to her that money had been stolen; however, the ED-A stated the ADON informed her that R55 believed SS-A had taken his money. The ED-A confirmed that after receiving this information, the allegation should have been reported to the state agency. The ED-A further confirmed no formal or comprehensive investigation was completed. The ED-A stated an investigation should have included documented staff interviews, family interviews, review of police involvement, a formal documented room audit, and a documented interview with R55. The ED-A stated SS-A confirmed R55 had $5,000 in cash at one time and that SS-A removed $550 with R55's permission to pay for two attendants to accompany him to a medical appointment and stated the money was secured in SS-A's office. The ED-A further stated she had possession of 18 one-dollar bills in a blue money bag from R55's room and stated she received verbal consent to keep the money in her office. The ED-A confirmed there was no documentation of the money and stated the handling of funds was based on verbal communication only. The ED-A stated she did not notify or consult the financial POA, regarding the missing money and acknowledged she should have contacted the POA. The ED-A confirmed there was no money remaining in R55's room, no chronological money ledger, and no two-person verification (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	process in place. The ED-A further stated that if SS-A was the staff member accused of taking the money, SS-A should not have been responsible for securing the funds. The ED-A stated the facility had a locked safe; however, it was not accessible because the access code was unknown. The ED-A confirmed R55's money should have been secured in the safe. The ED-A stated she did not interview staff or residents and did not conduct an assessment to determine whether other residents had concerns regarding missing money or valuables. The ED-A stated R55 had approximately $3,618 unaccounted for, confirmed approximately $850 was spent on hockey tickets, and confirmed $550 was set aside to pay attendants for a medical appointment. The ED-A confirmed she received messages from the ADON and LPN-A regarding R55's missing money. The ED-A stated she was aware R55 had $5,000 in cash and acknowledged no action was taken at that time, stating the money should have been removed from R55's room and placed in the safe. The ED-A further stated the missing money was not reported to the state agency because it was not considered misappropriation of funds due to a lack of evidence or suspicion of theft. On 12/10/25 at 10:40 a.m., the ADON stated that on 12/1/25, she became aware of R55's missing money from LPN-A. The ADON stated that staff were aware of R55's funds, as he frequently requested staff to unlock the drawer containing his money and to count the money to verify the amount. The ADON further stated that R55 fixates on his money and repeatedly wants to know the amount in the drawer. The ADON reported that she sent a message to the ED-A on 12/1/25 at 12:33 p.m. regarding R55's accusations of missing money, and the ED-A indicated she was already aware of the situation. The ADON stated she recommended that the ED-A take more drastic steps, including removing the money from R55's room or conducting a more in-depth investigation if money was actually missing. The ADON stated that the police responded and found no evidence of theft, but police did not interview staff. The ADON confirmed she was able to file VA report and worked with the ED-A during that process. The ADON stated that the facility did not conduct an internal investigation regarding the missing money to her knowledge. On 12/10/25 at 10:54 a.m., trained medication aide (TMA)- A stated they were aware R55 kept money in his room. TMA-A reported that for approximately the past month, R55 had repeatedly stated that money was missing, and estimated that R55 believed approximately $1,000 was unaccounted for. TMA-A stated that R55 kept his money in a locked bedside drawer. TMA-A further stated that they notified the ED-A of R55's concerns regarding missing money, and the ED-A responded that she was already aware of the situation about the missing money. On 12/10/25 at 10:57 a.m., nursing assistant (NA)-C stated R55 kept money in a locked top drawer in his room, stored in a blue cloth bag. NA-C stated R55 made reports of missing money and the facility was aware of R55's reports of missing money but did not take action, and all staff had access to the key used to unlock the drawer containing R55's funds. On 12/10/25 at 11:01 a.m., NA-D stated became aware of R55's accusations of missing money approximately two weeks prior. NA-D stated she was assisting R55 in writing Christmas cards, and R55 wanted to send money to family members, believing he had $50 bills available. NA-D stated that R55 became upset because the amount of money he expected in the drawer was not present. NA-D reported that R55 accused SS-A, the last person who had assisted him with his money. NA-D stated she was aware that R55 kept his money in a locked top drawer, but she was unsure of the exact amount. NA-D stated that the nursing staff were aware of the concerns because R55 was visibly and vocally upset about the missing money. On 12/10/25 at 11:06 a.m., NA-E stated they became aware of R55's missing money a couple of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weeks prior when R55 was asking for assistance to write Christmas cards and send money to family members. R55 wanted to send some family members $50 and others $20 and was writing down the amounts he intended to give each person, totaling $400. NA-E stated that R55 indicated there was money in the drawer, but not enough to cover the amounts he wanted to give, which caused him to become upset and worried. NA-E stated they notified the nurse on duty that day but could not recall the nurse's name. On 12/10/25 at 11:12 a.m., during a telephone interview R55's friend stated that the last time he saw R55 at the facility was approximately one month ago. At that time, R55 had more money in his drawer than he should have and R55 had him count the money during that visit and observed approximately $2,000 in the drawer. The friend stated he had previously purchased football ticket with R55's money. On 12/10/25 at 11:14 a.m., RN-C, the nurse manager for R55, stated SS-A and the ED-A spoke with R55 regarding the missing money and were unaware of the specifics of the situation. On 12/10/25 at 11:31 a.m., LPN-A stated R55 repeatedly stated that money was missing and sent an electronic message via Microsoft Teams to the ED-A regarding concerns about R55's missing money. LPN-A stated the ED-A instructed her to send the message to SS-A. LPN-A stated she did not feel comfortable discussing the matter with SS-A because SS-A was the staff member being accused of taking the money. LPN-A stated she believed the ED-A went and spoke with R55. LPN-A stated R55 continued to talk about missing money the following week, and sent a Teams message to SS-A, identifying herself as a mandated reporter and stating R55 was accusing SS-A of a crime. LPN-A stated SS-A thanked her for the information and stated R55 was forgetful and that she would follow up with him. LPN-A stated R55 continued to express concerns about missing money the next day and requested to speak with the ED-A. LPN-A stated she believed the ED-A had spoken with R55. LPN-A confirmed R55 kept money in a locked top drawer in his room. LPN-A stated she had personally checked the drawer and observed the money secured in a blue bag. LPN-A stated R55 reported there should have been $2,000 in the drawer; however, she observed two $20 bills and multiple $1 bills. LPN-A stated she discussed concerns regarding the management of R55's money during shift report, noting R55 was blind and that this presented an ongoing concern. LPN-A stated she believed at that time the ED-A may have taken possession of R55's money. LPN-A stated R55 continued to accuse staff of stealing his money, referred to the situation as a scam, and stated someone had taken his money. LPN-A stated police were called regarding the allegation, however R55 continued to ask about his money after police involvement. LPN-A stated she remained concerned about the missing money and questioned whether the situation should have been reported to the state agency. LPN-A stated, I still don't know what to do. On 12/10/25 at 11:43 a.m., the ED-A stated that SS-A was sent home pending an investigation regarding R55's accusations of missing money and that a VA report had been filed. R5's five-day MDS assessment dated [DATE], indicated severely impaired cognition, no behaviors or rejection of care, use of wheelchair, substantial/maximal assistance for eating and oral hygiene, dependent for shower/bath, dressing, and toileting hygiene, and diagnoses of Alzheimer's disease, depression, and pressure ulcers. R5's care plan revised 10/27/25, indicated self-care performance deficit related to cognitive and physical limitations with intervention of supervision/touch assistance of one helper for eating. Helper to provide verbal cues, touch/steady, and/or contact guard assist intermittently. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's physician orders dated 10/15/25, indicated regular diet, soft and bite sized texture, thin liquids. Facility chart progress note dated 12/7/25 at 2:28 p.m., indicated R5 choked on dessert and juice while unsupervised and was supposed to have assist of one helper and supervision for all meals. Daughter and provider notified, chest X-ray ordered for tomorrow. Daughter in agreement with plan. During observation on 12/8/25 at 6:45 p.m., four hand-written signs were observed posted in R5's room. All signs indicated the following: assist him from start to finish with each meal. During interview with RN-F on 12/8/25 at 6:59 p.m., she stated she heard about the choking incident when she came to work today, R5 was eating alone, choked, and was supposed to supervised while eating all meals. RN-F further stated she was unsure if any education or interventions were put in place at the time of the incident on 12/7/25, but had done some education with a few staff today and did an audit at one meal time to make sure he was supervised, but did not complete an evening audit. RN-F stated she was not aware if anyone had reported the lack of supervision of R5 to the state agency. During interview on 12/10/25 at 11:08 a.m., NA-M stated R5 would eat breakfast in the common area, lunch in his room, and supper in the common area. NA-M stated sometimes she would have to step away when feeding him to help other residents, but no choking had happened until this recent incident on 12/7/25. NA-M stated she knew R5 was supposed to be supervised during all meals. During interview on 12/10/25 at 11:11 a.m., NA-N stated she was working at the time of R6's choking episode. NA-N stated she had been assisting R5. R5 had completed most of his meal and had ice cream and juice left. NA-N said some other call lights were on in the hall and she had to answer them because she did not want someone to fall. NA-N stated she left R5 alone, assisted another resident with toilet use, and when she returned R5 had choked, another NA had heard him, and a nurse was already in the room. NA-N stated she was aware R5 needed to be supervised for all meals. During interview on 12/9/25 at 2:20 p.m., RN-G stated she was working during R5's choking episode. RN-G stated she assessed R5 after the choking episode and provided education to NA-N to not leave R5 unattended while eating. RN-G stated she was not aware of any notification made to the state agency about the lack of supervision while eating for R5. During interview on 12/9/25 at 1:12 p.m., RN-F stated after discussion with ED-A they filed a report to the state agency on 12/8/25. RN-F stated due to the lack of supervision of R5, and the care plan not followed, a report should have been filed immediately after the choking episode on 12/7/25, and was unsure why they didn't think of doing that. During interview on 12/9/25 at 2:15 p.m., ED-A stated she filed a report with the state agency on 12/8/25, in the evening regarding R5's choking incident and lack of supervision. O-A further stated it did not cross her mind to file a report at the time she was made aware of the incident, but looking at it after, with the lack of supervision and the care plan not being followed, she would have expected a report filed to the state agency immediately. Facility Abuse Prevention Plan dated 3/22, indicated -Requires that all suspected maltreatment be reported to the appropriate state agency. All staff are required to report suspected maltreatment of a vulnerable adult to the executive director/director of (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing/clinical director/designee in accordance with this policy and procedure. The leadership designee oversees the completion of the report, ensures that the internal investigation begins immediately, ensures the appropriate reporting takes place and those interventions are implemented to make provide the vulnerable adult with a safe living environment. All alleged incidents of maltreatment are reported to the state agency and to other agencies as required and all necessary corrective actions depending on the results of the investigation are taken immediately means as soon as possible, but not more than 24 hours after the discovery of the incident. Facilities that fall under CMS requirements: Ensure that all alleged violations involving abuse, exploitation, or mistreatment, including injuries of unknown origin source and misappropriation of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that caused the allegation involve abuse or result in serious bodily injury

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure actions were taken to prevent further misappropriation of funds for 1 of 1 and resident (R55) reviewed for missing property and prevent further neglect due to lack of following the care plan for 1 of 2 residents (R5) reviewed for accidents. Further the facility failed to fully investigate these allegations or take actions to protect other residents. Finding include: R55's 5-day Minimum Data Set (MDS) assessment dated [DATE], indicated R55 initial admit date was 12/30/2020, makes self-understood, ability to understand others, adequate hearing, severely impaired vision, moderately impaired cognition, no hallucinations or delusions, no rejection of care, utilized a manual wheelchair, required substantial/maximal assistance with eating, showers, upper body dressing; dependent on toileting, lower body dressing, putting on footwear, and transfers; diagnoses included Non-Alzheimer's Dementia, depression, end stage renal disease with dialysis, muscle weakness, difficulty in walking, and essential tremor. R55's document Power of Attorney (POA) dated 3/15/21, indicated R55 granted [name of attorney in fact company] independently exercises the financial powers. Department of Public Safety Report dated 12/1/25 at 2:11 p.m., law enforcement ([NAME]) indicated the following: offense: theft, SS-A called on behalf of R55 wanted to report money missing from his room. SS-A stated in August of 2025, R55 had $5000 plus in a bank bag in the top drawer of the nightstand next to his bed, and a week ago he had approximately $550 dollars left. SS-A had been concerned over the amount of cash he was keeping in his room. SS-A advised that she had been working on setting up a Resident Trust to keep R55's money secure. SS-A questioned R55 about the declining amount of funds in his nightstand, he told her that he has given money to his sister to pay for her husband's funeral. SS-A didn't believe this and called family member (FM)-B who denied receiving money from R55. SS-A said she confronted R55 about this new information, and R55 told SS-A that he lied about giving money to his sister and said he went to a casino and gambled away some of his money. On 10/28/2025, SS-A counted how much money he had left which totaled $1,400. SS-A said R55 purchased $800 plus in hockey tickets which he gives away to people. SS-A stated R55 suffers from short term memory loss and dementia and believes that he is spending or giving his money away without recollection. SS-A stated she was aware that R55 has an eye appointment and wanted to make sure that he had money for his trip, so she collected his remaining cash and secured it in her office; $550. SS-A also advised that R55 had memory loss, hearing loss, dementia, and is blind. [NAME] spoke with R55 and stated he had $1000 in twenties and $1000 in fifties in his nightstand; however, when SS-A collected his money for safe keeping a week ago, there was $550 .difficulty understanding and responding to questions. Due to R55's visual impairment he was unable to count his money or determine the denominations of the bills in his possession, and there are no records or accounting of how when or where he has been spending his money that he had in his possession. There is no information that supports R55's claim of stolen money: however, there is a large pool of individuals that theoretically could have had access to his cash. SS-A advised that on any given day, there are roughly 50-100 employees and service providers on-site .other residents that freely move about the facility, R55 was out of his room and off-site three days a week for most of the day, and due to his hearing loss and blindness he may not know someone was in his room when he is in his room. At this time, there is not enough information to substantiate the allegation that someone stole money from R55 or identify a suspect (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronic messages between staff: 11/27/25 at 9:07 a.m., licensed practical nurse (LPN)-A to the administrator: last night after shift change R55 talked about some financial concerns keeping him up at night. I've been told you're aware of some of them, but could we have a conversation about it on the phone at some point? 11/28/25 8:06 a.m., administrator to LPN-A: SS-A primarily works with R55, I'll connect with SS-A, and we'll connect with R55 between the two of us. I will talk to R55. This is not a new report from R55 - so I have addressed it in the past . 11/28/25 at 9:17 a.m., LPN-A to administrator: If it's ok, I'd rather talk to you. It's about SS-A. R55 is accusing SS-A of financial impropriety . I'm conflicted because as a mandated reporter I should call this in. 11/28/25 at 9:46 a.m., LPN-A to administrator: R55 is also having issues with his cash, that's mainly what's keeping him up at night. He should have several 50s and 20s in his pouch. He said he planned on using some of these for Christmas card gifs to his family. Right now, he has two 20s and a large stack of ones. He doesn't know why he has ones. He thought SS-A who took the cash out gave him ones instead of the larger bills. Or someone else is doing odd things with his money. 11/28/25 at 9:51 a.m., administrator to LPN-A: I will speak with R55 11/28/25 2:36 p.m. administrator to LPN-A: Just want to let you know that I checked in with R55 this afternoon - he was sleepy so didn't have much to say today let him know I could follow up again next week. 11/28/25 4:59 p.m., LPN-A to administrator indicated: I also thought maybe his petty cash could be locked up in the nurse's office. Right now, he asks a lot of people to check his cash and it's easy to access. I'll ask registered nurse (RN)-C about it. 12/1/25 at 12:21 p.m., LPN-A to SS-A: I'm sure you know all about what R55 is saying. He is desperate to talk to you today and he is talking about calling the police . saying that $2000 cash is missing, and that a bank account is closed without his consent, and that his money has fraudulently been put in a trust without his consent, . he is openly accusing you of crimes and I thought you should know. I was conflicted last week because as a mandated reporter I'm supposed to call this in, but I talked to the administrator who told me this is a well-known problem. 12/1/25 at 12:23 p.m., SS-A to LPN-A: I will come and talk to him after 3:00 today. This is an ongoing issue. I assure you there is no fowl [sic] play. He's having trouble understanding and remembering. Yes, I'm aware. 12/1/25 at 12:33 p.m., assistant director of nursing (ADON) message to administrator: LPN-A informed me and is very concerned about R55 and his money and was accusing SS-A of doing something with R55's money and threatening to call the police. Are you aware of this issue? I know SS-A is aware, but thinking we maybe need to take more drastic steps. LPN-A said R55 has a lot less money than he said he's supposed to have. 12/1/25 at 12:48 p.m., administrator response to ADON: SS-A had reached out to me- but it was on Friday and over the weekend and planned to connect with SS-A today. We have recently taken $550 (continued on next page)

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from R55 to pare for a care escort for appointment later this month, and don't think R55 is remembering that. Other than that, we have not done anything with the cash in his drawer, but it seems as though he may be spending it on hockey tickets and other items like that. I think we need to talk to R55 about having it stored somewhere other than his room to avoid any confusion or allegations like this The police will be contacted if we decide to file a VA, but we need more info first. There is no evident to report based on only what R55 is reporting. I also stated visited with R55 on Friday per LPN-A request and he did not have concerns for me at that time. Progress notes: 12/1/2025 at 4:26 p.m., SS-A indicated this writer met with the resident in his room, accompanied by an activities staff member. R55 was upset and reported that money was missing and that he should have $2,000 in his room. This writer clarified that $550 had been set aside in the social services office for escort costs to his eye appointment and R55 had $18 remaining in his room. R55 accused this writer of lying and stealing his money and requested to call the police. Per R55's request, this writer contacted the Police Department. An investigator arrived approximately 30 minutes later and met separately with R55 and this writer. The investigator determined the case would not be pursued, noting the resident's limited vision and hearing and inability to accurately recall how much money was in his possession. The officer requested documentation of the denominations of the $550 held in the social service office and related notes, which were provided via email. 12/2/2025 at 9:27 a.m., RN-C indicated physician note: virtual visit with Dr. Service, (psych). R55 appeared sad, reports he is upset about his money being stolen R55 called the police department yesterday. Police came to facility to see resident. Dr. Service will keep resident's meds the same. 12/2/2025 at 3:11 p.m., administrator indicated this writer spoke with R55 in follow up to his concern about the money in his room. Writer reminded resident that a police report had been filed yesterday (12/1), and the police investigator did not find evidence of theft or financial malpractice. Writer reminded R55 that $550 has been set aside in a secure location to be used for a care escort for an upcoming appointment. R55 informed the writer that he spent $850 on hockey tickets in September, as he gets a bulk ticket order each year. R55 was unable to repeat the same information consistently. Writer recommended that the facility keep R55's current money bag in a secure safe in the front office hub; R55 in agreement to this at this time. Writer informed nurses on shift that money bag would be put secure safe at this time. 12/5/2025 at 2:54 p.m., SS-A indicated RN-C and SS-A social worker met with resident in his room and explained to him that the eye clinic appt is cancelled and that money was returned to him and secured in his locked drawer. On 12/9/25 at 2:09 p.m., SS-A stated R55 had a financial POA. SS-A stated she was made aware by staff a couple months ago, that R55 had a large amount of cash in his room and that she counted the money, totaling $5,000. SS-A confirmed she personally counted the $5,000 in R55's room; however, the facility maintained no log, ledger, or two-person verification of the funds. SS-A stated she attempted to establish a resident trust account for R55 but did not complete the process because the amount exceeded what could be placed in a trust account. SS-A stated the money was returned to R55's locked bedside drawer, although the date of return was not documented. SS-A stated she later went to R55's room to obtain funds for the appointment and observed the cash balance had decreased to approximately $1,400. SS-A stated R55 explained he had purchased college season hockey tickets and gone to the casino and gave money to his sister for her husband's funeral. SS-A stated no money (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was taken at that time. SS-A stated she returned to R55's room on a different day and requested to set aside $550 to pay the personal attendants an eye doctor appointment. SS-A stated R55 agreed and allowed her to remove $550 from his room. SS-A stated that after the removal of the $550, R55 had approximately $18 remaining in one-dollar bills. SS-A further stated that on the Monday following Thanksgiving, R55 became upset and accused SS-A of stealing his money and requested to call the police. SS-A stated she assisted R55 in contacting law enforcement, and police responded and interviewed R55. SS-A stated police informed her they were unable to reach a conclusion due to R55's inability to provide consistent information. SS-A stated the administrator was informed of R55's accusation of missing money and was advised she did not need to file a vulnerable adult (VA) report with the state agency because law enforcement had been contacted. SS-A stated she was not aware of any facility investigation completed regarding the missing money and was unsure why an investigation was not conducted when the money had not been accounted for. On 12/9/25 at 2:34 p.m., the executive director (ED)-A who also served as facility administrator confirmed R55 had expressed concerns regarding missing money. The ED-A stated a VA report was not filed because there was no indication of theft or suspicious activity, and the amount of missing money could not be verified. The ED-A stated R55 requested law enforcement be contacted and SS-A assisted R55 in contacting the police. The ED-A stated the police did not express concerns; however, the ED-A stated she was not aware of the specifics of the police report. The ED-A further stated she would need to review facility policy and regulations regarding reporting of missing money. The ED-a stated there was a safe in the administration specialist office, however the ED-A stated she currently had R55's money in a money bag locked in her office and had completed a reconciliation of the money. On 12/9/25 at 2:55 p.m., the interim director of nursing (DON) stated she was not aware of any concerns regarding R55's missing money. The Interim DON stated that, as an interim staff member, she would defer concerns regarding missing money to the ED-A and would rely on the ED-A to determine whether reporting to the state agency was required. On 12/9/25 at 3:24 p.m., during a telephone interview, R55's financial POA stated they had served as R55's financial POA for several years, beginning on 3/15/21. The POA stated SS-A informed them in August 2025, that a large amount of cash was found in R55's room. The POA stated they advised SS-A that R55 could retain possession of the money but would be required to spend the funds down prior to R55's next medical assistance (MA) renewal. The POA confirmed they did not take control of the money, and SS-A maintained notes documenting communications regarding the funds and provided updates to the POA. The POA stated they were not notified of R55's accusations of missing money. On 12/9/25 4:06 p.m., R55 was seated in recliner in his room and stated money had gone missing stated 1450.00 was missing and stated, I know that girl named [used SS-A's name] took it. On 12/10/25 at 8:54 a.m., the ED-A stated that when a report of missing money was received and the money may have been stolen, it would be an immediate concern. The ED-A stated R55 did not directly report to her that money had been stolen; however, the ED-A stated the ADON informed her that R55 believed SS-A had taken his money. The ED-A confirmed that after receiving this information, the allegation should have been reported to the state agency. The ED-A further confirmed no formal or comprehensive investigation was completed. The ED-A stated an investigation should have included documented staff interviews, family interviews, review of police involvement, a formal documented room audit, and a documented interview with R55. The ED-A stated SS-A confirmed R55 had $5,000 in cash at one time and that SS-A removed $550 with R55's permission to pay for two attendants to accompany him to a medical appointment and stated the money was secured in SS-A's office. The (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the resident and/or legal representative received a bed hold notice and written notice of transfer for 2 of 2 residents (R13 and R4), reviewed for hospitalization, who were transferred to the hospital for overnight stays. Findings include:R13's face sheet provided on 12/15/25, included diagnoses of congestive heart failure (when the heart cannot pump effectively), chronic kidney disease (kidneys cannot filter blood well) and urinary retention. R13's face sheet indicated R13 was the responsible party and other individuals were listed as emergency contacts.R13's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was able to understand and be understood. R13 required substantial assistance or was dependent upon staff for most activities of daily living (ADLs). R13 had an indwelling urinary catheter. R13 did not walk. R13's progress note order dated 12/2/25 at 1:15 p.m., indicated nurse practitioner (NP)-E directed staff to send R13 to the emergency room (ER).R13's care plan with revised date of 7/18/25, indicated R13 had a urinary catheter related to urinary retention and was at risk for UTI (urinary tract infection). Care plan dated 7/8/25, indicated staff were to report signs of UTI and/or complications related to catheter. R13's hospital history and physical dated 12/2/25, indicated R13 was hospitalized for catheter associated UTI.R13's progress note dated 12/2/25 at 12:04 p.m., indicated staff spoke to family member (FM)-D on the phone to update on R13's low blood pressure and that the provider recommended sending R13 to the ER. R13's progress note dated 12/2/25 at 1:00 p.m., indicated FM-D was called and notified of R13's transfer to hospital and got VM (voicemail). A message was left. R13's progress note dated 12/2/25 at 3:15 p.m., indicated R13 was transferred to the hospital with low blood pressure. Message had been left for FM-D regarding bed hold. R13's progress note dated 12/2/25 at 3:18 p.m., indicated attempt to reach FM-D and got VM. Message was left to call back to discuss bed hold. R13's progress note dated 12/5/25 at 12:31 p.m., indicated R13 was re-admitted from the hospital via wheelchair with a UTI. During an interview on 12/8/25 at 3:24 p.m., R13 stated he had recently been admitted to the hospital for a UTI and did not recall signing a bed hold or receiving a written notice of transfer form. R13 did not know if someone else would have done that on his behalf. R4's face sheet provided on 12/15/25, included diagnoses of hemiplegia (paralysis affecting one side of the body) following stroke, diabetes, chronic pain, and dementia. R4's quarterly MDS assessment dated [DATE], indicated intact cognition, clear speech, was usually understood and was usually able to understand. R4 had highly impaired vision with adequate hearing. R4 required substantial assistance or was dependent upon staff for help with ADLs. R4 did not walk. R4's progress note order dated 11/30/25 at 6:09 p.m., provider recommended R4 be sent in for further evaluation.R4's care plan with revised date of 5/3/25, indicated R4 had chronic pain and staff were to respond immediately to any complaint of pain. R4's progress note dated 11/30/25 at 6:09 p.m., indicated R4's right upper quadrant [of abdomen] was very distended. R4's progress note dated 11/30/25 at 6:15 p.m., indicated family member (FM)-A was called and informed the provider recommended R4 be sent to the ER for further evaluation due to right upper quadrant distention. The note indicated FM-A gave a verbal bed hold.R4's progress note dated 11/30/25 at 8:46 p.m., indicated R4 was sent to the ER at 4:40 p.m.R4's progress note dated 12/2/25, indicated R4 returned from the hospital 1:15 p.m.During a telephone interview on 12/9/25 at 7:42 a.m., family member (FM)-A stated R4 had been hospitalized a week ago with norovirus and low blood pressure. FM-A stated she gave a verbal bed hold but did not sign a bed hold form nor receive written notice of transfer form.During an interview on 12/10/25 at 2:30 p.m., registered nurse (RN)-A who was also the nurse manager for the unit on which R13 and R4 resided looked in the electronic medical record (EMR) and did not find a bed hold or written notice of transfer for R13's hospitalization on 12/2/25, nor R4's hospitalization on 11/30/25. RN-A stated there should have been a red folder at the (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded for 1 of 1 resident (R13) reviewed for MDS accuracy and 1 of 1 resident (R55) reviewed for dialysis. Findings include: R13's face sheet provided on 12/15/25, included diagnoses of pressure ulcer of contiguous site of back, buttock and hip, unstageable, and irritant contact dermatitis due to fecal, urinary or dual incontinence. R13's significant change Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R13 required substantial staff assistance or was dependent on staff for activities of daily living (ADLs) and did not walk. R13 had a urinary catheter and was occasionally incontinent of bowel. R13 was at risk for pressure ulcers and had an unhealed pressure ulcer. R13 had two unstageable pressure injuries presenting as deep tissue injury, not present on admission. R13's pressure ulcer/injury Care Area Assessment (CAA) dated 9/23/25, indicated R13 had suspected deep tissue injuries to bilateral buttocks. R13's provider orders dated 10/27/25, indicated weekly skin check every day shift, every Friday. Orders dated 12/5/25, included skin/wound care to buttocks. Cleanse entire buttock with Vashe (hypochlorous acid solution) wound cleanser, pat dry and apply a nickel thick layer of zinc barrier cream two times a day for skin/wound care. R13's orders did not include treatment for a pressure ulcer. R13's care plan indicated the following: Care plan initiated on 7/8/25, and revised on 11/12/25, indicated R13 had actual impairment to skin integrity related to stage 2 pressure injury on right buttock. Care plan initiated on 7/13/25, and revised on 10/20/25, indicated pressure injury, stage 1 present on admission. (Did not identify location of pressure injury). Care plan initiated on 7/13/25, and revised on 10/20/25, indicated R13's pressure ulcer would show signs of healing and remain free from infection. (Did not identify location of pressure ulcer) Care plan initiated on 9/16/25, and revised on 10/17/25, indicated SDTI (suspected deep tissue injury) to bilateral buttocks. Care plan dated 10/20/25, indicated R13's pressure ulcer would show signs of healing and remain free from infection. Care plan dated 10/28/25, indicated weekly skin assessment to include measurement of each area of skin breakdown if applicable (width, depth, type of tissue/exudate, etc.). Provide wound/skin treatments as ordered. Nursing wound assessments provided by registered nurse (RN)-A who was also the nurse manager (continued on next page)

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	245390	A. Building B. Wing	12/15/2025

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

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included: 1. --9/20/25: Unstageable pressure injury to buttocks. 2. --10/17/25: No stage. Site was right and left buttocks. Type was pressure. 3. --10/28/25: No stage. Site was right and left buttocks. Type was pressure. 4. --11/21/25: Stage 2. Site was right and left buttocks. Type was pressure. Provider wound assessments provided by registered nurse (RN)-A for the following dates 8/26/25, 9/2/25, 10/14/25, 10/18/25, 10/28/25, 11/24/25, and 12/2/25, consistently identified R13's skin problem as incontinence associated dermatitis, buttocks, bilateral. Pressure injury or ulcer had never been used to describe R13's skin on his buttocks. 1. During an interview on 12/9/25 at 2:06 p.m., RN-A stated after reviewing nurse wound assessments and provider wound notes, realized R13's skin on his buttocks had been incorrectly identified; that R13 never had a pressure ulcer. RN-A stated she was aware nurses had documented both a stage 1 and stage 2 pressure ulcer to R13's buttocks, as well as deep tissue injury, but the provider had consistently identified the skin problem as incontinence associated dermatitis. During a telephone interview on 12/11/25 at 11:56 a.m., RN-D who was a MDS nurse for the facility stated she had coded R13's significant change MDS dated [DATE], section M (skin conditions) as R13 having a pressure ulcer. RN-D stated her decision was based upon skin assessments by nurses. RN-D stated she had been aware the provider diagnosed incontinence associated dermatitis to buttocks and thought it was possible R13 could have both pressure ulcer and dermatitis. During a telephone interview on 12/11/25 at 2:28 p.m., nurse practitioner (NP)-G stated she saw R13 for wound care; her last visit was 11/24/25. NP-G was informed nursing staff had documented R13 as having pressure ulcers of various stages to his buttocks, yet her documentation consistently indicated he had incontinence associated dermatitis of bilateral buttocks. NP-G stated she had not been aware nurses were documenting pressure. NP-G stated R13 did not have pressure wounds to his buttocks. During an interview on 12/11/25 at 4:12 p.m., the executive director (ED)-A was informed of findings related to inaccurate MDS coding of wounds on R13's buttocks due to inaccurate wound assessments by nurses. No additional information was provided. R55's 5-day MDS assessment dated [DATE], indicated R55 initial admit date was 12/30/2020, makes self-understood, ability to understand others, adequate hearing severely impaired vision, moderately impaired cognition, no hallucinations or delusions, no rejection of care, utilized a manual wheelchair, required substantial/maximal assistance with eating, shower, upper body dressing; dependent on toileting, lower body dressing, putting on footwear, and transfers; diagnoses included Non-Alzheimer's Dementia, depression, end stage renal disease with dialysis, and further section O - Special Treatments, Procedures, and Programs, indicated resident dialysis on admission, however did not indicate while a resident. R55's modification of MDS dated [DATE], indicated on 12/11/25 O - Special Treatments, Procedures, and Programs, indicated resident dialysis on admission, and while a resident. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's care plan dated 9/22/25, indicated R55 risk for complications related to dialysis secondary to renal failure. receives dialysis Mon-Wed-Fri. R55's progress note dated 12/11/25 at 10:43 a.m., RN-E, MDS coordinator, 5D (day) MDS with an ARD (assessment reference date) of 11/26/25, was requested by primary site MDS d/t (due/to) potential oversight identified, this review found that both dialysis and hemodialysis were coded on his initial 5D in the on admission column, however, there was an oversight in checking this in the secondary since admission column. The service was correctly identified on the initial 5D as occurring within days 1-3 of the stay. A correction was made by writer to include dialysis in the since admission column as well to indicate that it was also received while a resident of the facility during the review period. In PN (progress note) review to confirm services, emesis was also noted that was excluded from the initial 5D. This was also modified with the correction. These corrections will not result in a service level or [NAME] (health insurance prospective payment system) code change for this resident. Appropriate care planning for hemodialysis was resumed upon reentry to the facility. On 12/9/25 at 1:06 p.m., R55 was seated in a recliner in his room and stated he went to an outside dialysis facility three days a week on Monday, Wednesday and Friday, and stated he has been going to dialysis for years. On 12/9/25 at 4:21 p.m. licensed practical nurse (LPN)-A confirmed R55 was on dialysis. On 12/11/25 at 10:14 a.m., RN-E, stated she was a MDS coordinator, and confirmed on 12/2/25, she had completed R55's MDS and failed to indicate R44 received dialysis as a resident on the MDS. RN-E stated that was overlooked and was an error and should have included R55 dialysis while a resident marked. RN-E stated a correctio was done today [12/11/25], that indicated R55 received dialysis while a resident. On 12/11/25 at 4:09 p.m., the executive director (ED)-A stated MDS assessments were expected accurate. Facility Comprehensive Assessments Policy dated 10/23, indicated: Comprehensive MDS assessments are conducted to assist in developing person-centered care plans. Policy Interpretation and Implementation 1. The facility conducts comprehensive, accurate, standardized, reproducible assessments of each resident's functional capacity using the Resident Assessment Instrument specified by CMS. 2. The comprehensive assessment process includes direct observation and communication with residents, as well as communication with licensed and non-licensed direct care staff members on each shift. 3. A comprehensive assessment includes: a. completion of the Minimum Data Set (MDS); b. completion of the care area assessment (CAA) process; and (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R46) reviewed for colostomy care.Findings include: R46's face sheet provided on 12/15/25, included diagnoses of malignant neoplasm (cancer) of rectum, rectosigmoid junction (where the S-shaped sigmoid colon joins the rectum) and anus (the exit point for feces [stool] from the body). R46's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could usually understand. R46 had an ostomy, specifically a colostomy (an opening in the abdomen connecting the large intestine to the outside of the body), required supervision or was dependent upon staff for activities of daily living (ADLs). R46's Care Area Assessment (CAA) dated 10/27/25, did not identify an ostomy or colostomy. R46's physician orders and TAR (treatment administration record) dated 12/1/25, included change colostomy bag twice a week on Mondays and Fridays. 1) Use stoma cleanser and adhesive remover, 2) Apply no sting barrier film, 3) Ensure area is DRY, 4) Use Ostomy Powder around ostomy, 5) Apply moldable ring, 6) Apply new ostomy bag, 7) Apply elastic barrier strips and as needed.R46's care plan reviewed on 12/9/25, did not include R46's colostomy; nothing about ostomy care, skin observations, family member (FM)-A tips for an effective seal, and reporting problems.During an interview on 12/8/25 at 4:21 p.m., FM-A stated R46's colostomy bag was often not placed correctly and separated from his skin and leaked stool. FM-A stated she had talked to many staff about it and had trained nursing staff on her own. FM-A stated she told them the biggest thing was, they did not let the skin prep dry -- I think they hurry too much. FM-A stated at home she applied a new colostomy bag every three day, and they changed it three times yesterday (12/7/25) because it kept falling off. FM-A pointed to hand-written instructions for R46's colostomy care taped to his closet door for nursing staff to review.During an interview on 12/10/25 at 1:46 p.m., licensed practical nurse (LPN)-G stated she was aware of R46's colostomy and was aware his bag came off quite a bit. LPN-G stated FM-A posted instructions in R46's room and they were also in his electronic medical record (EMR). LPN-G stated she was not sure if all nursing staff used binders - sticky things that went on either side of the ostomy, supplied by FM-A. During an interview on 12/10/25 at 1:50 p.m., registered nurse (RN)-A, who was also the nurse manager for the unit on which R46 resided, stated she had talked with staff about how FM-A would like R46's colostomy care done. RN-A stated R46 had reported staff have had to replace the ostomy bag three times in one day, but that had not happened. RN-A stated R46 had memory issues and could exaggerate. RN-A stated she went through the instructions with LPN-G with the intent that LPN-G would teach each nurse. RN-A did not ask LPN-G to keep track of who she had trained and who still needed training so was not able to say if all nurses who changed R46's ostomy bag had the training. RN-A acknowledged ostomy care should be on R46's care plan to ensure nursing staff knew how to manage his colostomy. During an interview on 12/10/25 at 2:33 p.m., RN-A stated there was nothing in R46's care plan pertaining to his colostomy, adding he came from short term stay and it should have been added there. RN-A stated she didn't catch it (the omission) when he came to long term care. RN-A stated it would be important to have ostomy care on R46's care plan to make sure instructions and care were not overlooked. During a telephone interview on 12/11/25 at 9:12 a.m., FM-A again verbalized concerns with how staff applied R46's colostomy bag. FM-A stated it had been a couple of months since she showed staff and could not recall whom she told. FM-A stated she looked at R46's stoma when she came to visit to see if it looked okay and taped correctly, adding the big thing was, staff did not let the prep dry before they proceeded with next step -- they try to rush it which made the bag loosen and leak stool. FM-A stated, Not long ago there was stool all over. Inquired about staff needing to change R46's bag three times on 12/7/25, and FM-A stated, I'm not sure he's [R46] right about that, he gets confused at times.During an interview on 12/11/25 at 9:41 (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., nurse practitioner (NP)-H who had just seen R46 and his colotomy stated R46 had no skin issues related to his stoma and that his skin around it looked fine. NP-H was informed of FM-A's concerns and stated she would write more specific orders to make sure staff let R46's skin prep dry completely.During a telephone interview on 12/11/25 at 11:56 a.m., RN-D who was a MDS nurse for the facility stated ostomy care should have automatically pulled to the care plan from the MDS and it was likely a system error that it did not.During an interview on 12/11/25 at 12:46 p.m., the assistant director of nursing (ADON) who was also responsible for staff education, was informed of findings and stated nurse managers were responsible for making sure staff were trained on ostomy care and acknowledged ostomy care should be on the care plan to ensure consistent care.During an interview on 12/11/25 at 4:12 p.m., the executive director (ED)-A, was informed of findings related to FM-A's concerns regarding ostomy care and ostomy care not identified on the care plan. No additional information was offered.Facility Colostomy/Ileostomy Care policy with revised date of October 2010, indicated the purpose of the procedure was to provide guidelines that will aid in preventing exposure of the resident's skin to fecal matter. Staff were to review the resident's care plan to assess for any special needs of the resident. The policy included step by step instructions for replacing an ostomy bag, documenting and reporting findings.A policy on accuracy of care plans was requested and not provided.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure residents received assistance with meals for 1 of 2 resident (R5) reviewed for nutrition who required staff assistance and/or supervision with meals.Findings include:R5's five-day Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, no behaviors or rejection of care, use of wheelchair, substantial/maximal assistance for eating and oral hygiene, dependent for shower/bath, dressing, and toileting hygiene, and diagnoses of Alzheimer's disease, depression, and pressure ulcers.R5's care plan revised 10/27/25, indicated self-care performance deficit related to cognitive and physical limitations with intervention of supervision/touch assistance of one helper for eating. Helper to provide verbal cues, touch/steady, and/or contact guard assist intermittently.R5's physician orders dated 10/15/25, indicated regular diet, soft and bite sized texture, thin liquids.Facility chart progress note dated 12/7/25 at 2:28 p.m., indicated R5 choked on dessert and juice while unsupervised and was supposed to have assist of one helper and supervision for all meals. Daughter and provider notified, chest xray ordered for tomorrow. Daughter in agreement with plan.During interview on 12/8/25 at 5:30 p.m., R5's family member (FM)-F stated she often came to the facility and found R5 with no teeth in, which made it difficult for him to eat. FM-F further stated she was worried the facility would leave R5 unsupervised during meals and had put several signs up in his room prior to the choking episode to remind staff to supervise him during all meals.During observation on 12/8/25 at 6:45 p.m., four hand-written signs were observed posted in R5's room. All signs indicated the following: assist him from start to finish with each meal.During interview with registered nurse (RN)-F on 12/8/25 at 6:59 p.m., stated she heard about a choking incident when she came to work today, R5 was eating alone, choked, and was supposed to supervised while eating all meals. RN-F stated she did not know who had been working, who left R5 unsupervised, and had not investigated the incident further. RN-F further stated she had done some education with a few staff today and did an audit at one mealtime to make sure he was supervised while eating.During interview on 12/10/25 at 11:08 a.m., nursing assistant (NA)-M stated R5 would eat breakfast in the common area, lunch in his room, and supper in the common area. NA-M stated sometimes she would have to step away when feeding him to help other residents. NA-M stated she knew R5 was supposed to be supervised during all meals.During interview on 12/10/25 at 11:11 a.m., NA-N stated she was working at the time of R6's choking episode when he was left unsupervised on 12/7/25. NA-N stated she had been assisting R5 with eating lunch. R5 had completed most of his meal and had ice cream and juice left. NA-N stated some other call lights were on in the hallway, and she had to answer them because she did not want someone to fall. NA-N stated she left R5 alone, assisted another resident with toilet use, and when she returned R5 had choked, another NA had heard him, and a nurse was already in the room. NA-N stated she was aware R5 needed to be supervised for all meals.During interview on 12/9/25 at 2:20 p.m., RN-G stated she was working during R5's choking episode while unsupervised. RN-G stated she assessed R5 after the choking episode and provided education to NA-N to not leave R5 unattended while eating. RN-G stated she updated R5's family of the choking incident while unsupervised.During interview on 12/9/25 at 1:12 p.m., RN-F stated R5 was supposed to be supervised with all meals from start to finish. RN-F stated R5 was left unattended, ate ice cream without supervision, and had a choking episode. RN-F stated she would have expected R5 to be supervised, and that was indicated on his care plan.During interview on 12/9/25 at 2:15 p.m., executive director (ED)-A stated she filed a report with the state agency on 12/8/25 in the evening regarding R5's choking incident and lack of supervision and further stated she would have expected R5 to be supervised while eating if that is what his care plan directed.Facility Activities of Daily Living, Supporting policy dated 3/2018, indicated the following: Residents who are unable to carry out (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out activities of daily living independently, with the consent of the resident and in accordance with the care plan, including appropriate support and assistance with: Dining (meals and snacks).

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide incontinence care for 1 of 1 resident (R12) reviewed who was dependent upon staff for assistance with activities of daily living (ADL). Findings include: R12's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated: severe cognitive impairment, no rejection of care, dependent on staff for toileting hygiene, shower/bath, lower body dressing, personal hygiene, and transfers, utilized a wheelchair, current toileting program, always incontinent of urine, frequently incontinent of bowel; diagnoses included cerebrovascular accident (CVA), transient ischemic attack (TIA), or stroke, anxiety, depression, history of falling.R12's Care Area Assessment (CAA) dated 8/29/25, requires assist x2 staff for toileting tasks, including assistance with transfers, peri cares, and clothing management, as well as the use of an EZ Stand (mechanical lift) for transfers, not aware of the need to toilet, so staff anticipate needs, on a toileting program, staff check resident every 2 hours and assist with toileting as needed, as well as providing toileting between 1900-2100 (7:00 p.m.-9:00 p.m.) daily and offering toileting upon waking, after meals and at HS (bedtime).R12's care plan dated 8/29/25, R12 ADL self-care performance deficit r/t (related to) weakness, impaired endurance and limited mobility; interventions include dependent A2 (assist of two) with Hoyer stand (mechanical lift) for toileting, bowel incontinence r/t immobility, check resident every two hours and assist with toileting as neededOn 12/8/25 at 11:24 a.m., nursing assistant (NA)-H was observed in R12's room. R12 was lying in bed, and NA-H stated she was going to assist R12 into her wheelchair and take her to lunch. The room had a noticeable odor. NA-H stated they had just checked R12's brief, reported it was dry and not soiled, and stated it did not need to be changed. NA-H further stated she did not smell any odor but would recheck the brief. Upon rechecking, NA-H observed R12's brief was saturated with urine, with bowel movement present. NA-H donned gloves and was observed cleansing R12's buttocks and providing a brief change. NA-H confirmed the brief was urine soaked and R12's bottom was soiled with bowel. NA-H stated R12 required staff assistance with toileting hygiene and reported R12 was last provided toileting care at approximately 10:00 a.m.On 12/8/25 at 1:55 p.m., R12 was observed lying in bed and stated she needed staff assistance to change her brief. R12 stated that prior to lunch, the nursing assistant working with her had not checked her brief until someone prompted the nursing assistant to do so, at which time the brief was changed.On 12/8/25 at 2:01 p.m., NA-H confirmed R12's brief had not been checked or changed as expected prior to lunch. NA-H stated R12 was expected to have her brief checked and changed every two hours and prior to being assisted to meals. NA-H further stated that R12 would have gone to lunch soiled with urine and bowel if they had not been prompted to check and change R12's brief. NA-H stated nursing assistants get busy and do not always have time to check and change all residents' briefs or provide toileting care prior to meals.On 12/9/25 at 1:12 p.m., registered nurse (RN)-C, nurse manager, stated staff were expected to check and change R12's brief every two hours and anytime it was saturated with urine or soiled with bowel. RN-C stated staff were not expected to require prompting to provide toileting or hygiene care and confirmed R12 was dependent on staff for toileting.On 12/9/25 at 2:57 p.m., the interim director of nursing (DON) stated staff were expected to check and change residents' briefs prior to meals and residents were not to be transferred to meals wearing urine-soaked or soiled briefs.Facility Activities of Daily Living (ADLs), Supporting Policy Statement dated 3/2018, indicated: Residents will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs).Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Policy Interpretation and Implementation1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate thatdiminishing ADLs are unavoidable.2. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, includingappropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, and oral care);b. Mobility (transfer and ambulation, including walking);c. Elimination (toileting);d. Dining (meals and snacks); ande. Communication (speech, language, and any functional communication systems).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide services to maintain and/or prevent loss of range of motion (ROM) for 1 of 3 residents (R4) reviewed for limited range of motion. In addition, the facility failed to ensure a hand splint was properly applied to ensure palmar protection. Findings include:R4's face sheet provided on 12/15/25, indicated diagnosis of hemiplegia (paralysis affecting one side of the body) following stroke and affecting his left side. R4's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was usually understood and was usually able to understand. R4 required substantial assistance or was dependent upon staff for help with most activities of daily living (ADLs). R4 did not walk.R4's provider orders dated 12/2/25, indicated the following: 1) PT/OT (physical therapy/occupational therapy evaluation and treatment every shift. 2) Apply resting hand splint when in wheelchair, at HS (bedtime) and in the morning. Remove when resting in bed. R4's care plan for ROM (range of motion) and hand splint:--Dated 12/9/24, indicated R4 had a restorative nursing program and R4 would allow staff to assist with restorative exercises. Care plan intervention with revised date of 2/28/25, indicated staff were to perform restorative exercises and the instructions were in black ROM book located at the nurse's station. --Revision date of 5/27/25, indicated R4 had an ADL self-care performance deficit related to left sided hemiplegia and would maintain flexibility of joints through review date. Care plan intervention with revision date of 11/8/24, indicated R4 would be encouraged to participate in ROM exercises. Instructions located in black book at nurse's station.--Revision date of 11/7/24, indicated R4 had limited physical mobility related to stroke with hemiplegia. Goal updated on 10/20/25, indicated would remain free of complications related to immobility, including contractures. Intervention dated 5/20/24, indicated left hand splint. Off for meals only. Complete gentle finger stretching prior to applying.R4's POC (point of care) TASK tab in the electronic medical record (EMR) utilized by NAs for documentation, reviewed on 12/11/25, indicated the following tasks to be completed by NAs: --Complete ROM per instructions in ROM binder. Documentation indicated task had been done only twice in the past 30 days. --Left hand splint. Off for meals only. Complete gentle finger stretching prior to applying. Notify therapy if assistance is needed to apply. Documentation indicated task had been done only 12 times in the past 30 days. During a telephone interview on 12/9/25 at 7:42 a.m., family member (FM)-A stated R4 no longer received therapy and did not receive ROM to his joints. FM-A stated R4 used to wear a splint on his hands so fingers wouldn't curl, But they [nursing staff] have given up on that.During an observation on 12/9/25, at 8:30 a.m., observed R4 in his wheelchair at the nurse's station with a splint noted on left hand. The splint did not appear to be applied correctly as the palmar padding had not been positioned in R4's left palm.During an interview and observation on 12/9/25 at 9:36 a.m., with R4 and occupational therapist (OT)-I, OT-I looked at R4's hand splint and stated had not been positioned correctly. OT-I removed the splint and replaced it, stating the [NAME] protector had not been placed into R4's palm. As OT-I replaced the splint, she carefully and slowly opened R4's fingers and slid the palmar support into his palm. In addition, OT-I stated R4 was on a restorative nursing program and ROM instructions should be posted in his room. During an observation on 12/10/25 at 8:41 a.m., observed nursing assistant (NA)-J apply a splint to R4's left hand. NA-J did not open the fingers on R4's left hand to place the [NAME] protector in his palm. Instead, NA-J set the [NAME] protector under R4's clenched fingers and wrapped the strap around his fist. During an observation and interview on 12/10/25 at 1:02 p.m., together with OT-J and the director of nursing (DON) in R4's room, observed R4's left hand splint laying on the bed. OT-J applied the splint by gently pulling back R4's fingers and placing the [NAME] pad in palm of his hand, then securing it with Velcro straps. NA-J entered the room as OT-J had been applying the splint and stated no one had ever showed her how to apply R4's hand splint and stated (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	12/15/2025

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.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she had not noticed the enlarged photos on his closet door with visual instructions. The DON stated NA's working with R4 should be utilizing the instructions on R4's closet door to correctly apply R4's splint. The DON did not know if NAs had received training on proper placement of R4's splint. During an interview on 12/10/25 at 5:01 p.m., registered nurse (RN)-A, who was also the nurse manager for the unit on which R4 resided, stated R4 was on a restorative program and NAs were responsible for performing ROM exercises utilizing instructions posted in R4's room. RN-A stated ROM exercises should be incorporated into R4's daily routines. RN-A looked in R4's EMR and verified ROM had been documented as being done only twice in the past 30 days. RN-A stated she had not been aware of this. RN-A stated she had trained NAs in applying R4's hand splint but did not document the training to determine which NAs had received the training and who had not. During an interview on 12/11/25 at 10:49 a.m., NA-K stated she thought NA staff performed R4's ROM at night when they put him to bed. NA-K stated she thought the paper sheets of exercises posted on R4's closet was for therapy staff to use. During an interview on 12/11/25 at 11:47 a.m., NA-J, who had been caring for R4, stated she did not perform ROM exercises with R4 - that he went to group exercise class. NA-J stated the ROM exercises posted on R4's closet was for therapy staff. During an interview on 12/11/25 at 12:46 p.m., the assistant director of nursing (ADON) who was also responsible for staff education, was informed of findings and stated it was the responsibility of the NA caring for a resident to perform ROM, and it was the responsibility of the nurse managers to monitor this. ADON stated nurse managers trained NA's in applying splints and performing ROM. ADON stated she would expect ROM to be completed on R4 since he was on a restorative program. During an interview on 12/11/25 at 4:12 p.m., executive director (ED)-A, was informed of findings regarding lack of ROM being done and incorrect placement of R4's hand splint. ED-A stated the facility tried to schedule NAs to work with the same residents to get used to their routines and had also been working on NA training. ED-A stated she would expect staff to carry out orders as directed by the provider. Facility Restorative Nursing Services policy with revised date of July 2017, indicated residents would receive restorative nursing care as needed to help promote optimal safety and independence. Restorative nursing care consisted of nursing interventions that may or may not be accompanied by formalized rehabilitative services (e.g., physical, occupational or speech therapies). Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care. Restorative goals may include but are not limited to supporting and assisting the resident in adjusting or adapting to changing abilities; developing, maintaining or strengthening his/her physiological and psychological resources; maintaining his/her dignity, independence and self-esteem; and participating in the development and implementation of his/her plan of care.

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	12/15/2025

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview and document review, the facility failed to ensure required nursing staffing information was posted for residents, staff and visitors. This had the potential to affect all 61 residents residing in the facility and their visitors.Findings include: During an interview and observation on 12/9/25 at 2:02 p.m., after being unable to locate the Daily Staffing Posting, the executive director (ED)-A, escorted surveyor to the location it had been posted. ED-A handed over a documented from a Plexiglas sign holder located on first floor by other resident information and the fish tank. The Daily Staffing Posting had not been recognizable among other documents and was a four-page, estimated seven font, six column, 35 row, electronically generated document from their scheduling software UKG (Ultimate Kronos Group), titled Daily Headcount for the time frame of 12/4/25 through 12/10/25. Only the dates of 12/4/25, 12/6/25, and 12/9/25, were identifiable as other dates had been cut off. Column headings included: shift, current resident census, staff category, actual hours worked, number of staff scheduled, total hours by shift. While the document included required information, it was not in a reader-friendly format due to small font and the amount of information displayed. No census information had been added, and the document did not include up-to-date staff adjustments by shift when indicated. The ED-A declined to comment if residents and visitors would be able to understand the information as posted.During an interview on 12/9/25, at 4:30 p.m., ED-A stated the Daily Staffing Posting had always been generated automatically with a week of dates at a time and that the census had never been included, nor staffing adjustments identified by shift. ED-A stated this had been how the Daily Staffing Posting had been since she started at the facility in 2024. ED-A stated she had not been aware of regulatory requirements related to the Daily Staffing Posting.Facility Posting Direct Care Daily Staffing Numbers policy undated, indicated the facility would post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. Within two (2) hours of the beginning of each shift, the number of licensed nurses (RNs [registered nurses] LPNs [licensed practical nurses] and LVNs [licensed vocational nurse]) and the number of unlicensed nursing personnel (CNAs [certified nursing assistants] and NAs) directly responsible for resident care would be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The information recorded on the form would include the following: name of the facility, current date (the date for which the information was posted), resident census at the beginning of the shift for which the information is posted, twenty-four (24)-hour shift schedule operated by the facility, the shift for which the information is posted, type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift who are paid by the facility (including contract staff), the actual time worked during that shift for each category and type of nursing staff; and total number of licensed and non-licensed nursing staff working for the posted shift. Within two (2) hours of the beginning of each shift, the charge nurse or designee computes the number of direct care staff and completes the Nurse Staffing Information form. The charge nurse completes the form and posts the staffing information in the location(s) designated by the administrator. The form may be typed or handwritten. If completed electronically, the recorded information will be a minimum font size of 12 points. If the information is handwritten, it must be legibly printed in black ink and written so that staffing data can be easily seen and read by residents, staff, visitors or others who are interested in our facility's daily staffing information.