



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 25, 2026

Administrator

GOOD SAMARITAN SOCIETY - PIPESTONE

1311 NORTH HIAWATHA

PIPESTONE, MN 56164

RE: CCN:245591

Cycle Start Date: August 5, 2026

Dear Administrator:

On August 5, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

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

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by November 5, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by February 5, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
OrigCertMN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA , PIPESTONE, Minnesota, 56164			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 8/3/26 through 8/5/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000				
F0000	INITIAL COMMENTS On 8/3/26 through 8/5/26, a standard recertification survey (S5591039-0) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.		F0000				
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -		F0812				

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

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

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F0812 SS = F	Continued from page 1 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control measures were followed during observation of 1 of 1 meal service. This had the potential to affect all 52 residents who dined in the facility. Findings include: Observation on 7/29/26 at 11:29 a.m., identified cook-A completed preparation of the noon meal consisting of chicken with mushroom gravy, noodles, and broccoli. Cook-A was placing the food items onto the steam table when she turned and went to the cabinet, opened the door, removed a saltshaker, and shook salt into her bare hand. After filling the palm of her hand with salt she returned to the stove, where she dumped the salt from her hand into the cooking noodles. When questioned as to her action, she replied she had measured the salt to add to the noodles. She then stated that was how she always did it. Cook-A then set the pot into the sink and prepared a fresh pot of noodles which were placed onto the steam table. As she was pouring the noodles into the steamtable pan several noodles landed on the counter in front of the pan. Cook-A used her bare hand and tossed the noodles from the counter back into the pan of noodles in the steamtable. At no time did cook-A perform hand hygiene in between tasks or put on gloves. Observation on 7/29/26 at 11:42 a.m. identified			F0812			

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F0812 SS = F	Continued from page 2 cook-A washed her hands and returned to the counter across from the steamtable where she picked up a tray containing 2 paper meal slips. She then picked up the slips and identified the resident meals, turned back to the steamtable, picked up 2 plates, and began placing food items onto the plates. She used a large, slotted spoon to scoop noodles onto the plates, then placed the slotted spoon on the side of the steamtable and went around the steamtable to a drawer which she opened with her bare hand. Cook-A then removed a green handle scoop spoon and returned to plating the meal without performing hand hygiene or donning gloves. As she was scooping noodles onto the plate, there were noted to be several noodles were noted to be hanging off the side of the plate. Cook-A then used her bare hand to scoop them back onto the plate. Cook-A then placed the filled plates onto the tray and pushed them into the window for staff to serve to residents in the dining room. Cook-A continued the same process of serving several plates and again used her bare hand to scoop noodles hanging off the side of the plate back onto the plate being served, without performing hand hygiene or putting on gloves. Interview on 7/29/26 at 12:05 p.m. with cook-A reported she had always measured seasonings using her hand and was not aware there was a problem doing it that way. When asked about serving of the noodles and handling them with her bare hands, reported she did not realize she had done that and reported she should have, tossed the noodles that landed on the counter Infront of the steam pan, and used the scoop to position noodles on to plates instead of her hand. Interview on 7/29/26 at 12:15 p.m. with the certified dietary manager (CDM) identified her expectation was for appropriate infection control practices to be followed in the kitchen. She reported she was not aware cook-A used her bare hand to measure spices, and she should have used measuring spoons, not her hand. Touching food with bare hands was not acceptable practice, and she expected staff to use utensils and appropriate hand hygiene practices. She identified anytime staff left the steam table area, staff needed to perform hand hygiene and/or don gloves before returning to serving food after changing tasks. Interview on 7/29/26 at 1:30 p.m., with the infection preventionist (IP) identified her expectation was for			F0812			

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F0552 SS = D	Continued from page 4 R4's current Order Summary Report indicated R4 was currently prescribed clonazepam (anti-anxiety) 1 milligram (mg) tablet by mouth daily every Monday, Wednesday, and Friday. Give on dialysis days started on 04/03/26 and Temazepam (hypnotic) 30 mg by mouth at bedtime started on 04/3/26. R4's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications. The director of nursing (DON) attempted to locate signed consent and was unsuccessful. During an interview on 08/05/2026 9:46 a.m., DON stated, any resident admitted with a psychotropic medication in use needed a consent form signed for that medication on admission day. Facility policy titled "Psychotropic Medications-Rehab/Skilled indicated, a consent form must be signed for use of an Antipsychotic medication. The Permission for use of Psychotropic Medications (GSS#478) will be used to obtain consent.			F0552			
F0582 SS = D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,			F0582			

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F0582 SS = D	Continued from page 5 including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) to 1 of 3 sampled residents (R1) when their Medicare Part A skilled services with days remaining. Findings include: R1's CMS-10123 Notice of Medicare Non-Coverage (NOMNC) form identified R1's services ended on 7/17/26. R1 was not provided with the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) that identified the estimated cost of services if R1 would have chosen to continue with the skilled services on her own.			F0582			

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F0582 SS = D	Continued from page 6 Interview on 8/4/26 at 10:30 a.m., with the director of nursing (DON) identified that she had taken over providing the beneficiary notices after a recent staffing change. The DON stated she did not think that she needed to provide the CMS-10055 notice as R1 had Medicaid pending so she had only provided the CMS-10123 notice. Review of the 5/12/26, Advance Beneficiary Notice of Non-Coverage (ABN) policy identified the ABN informed the beneficiary of potential non-coverage and shift of financial liability for those items or services if Medicare denies the claim. The ABN notice was evidence that the beneficiary had knowledge about the likelihood of Medicare denial, and for purpose of determining financial liability for expenses incurred for services which Medicare does not pay.			F0582			
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and			F0755			

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F0755 SS = D	Continued from page 7 §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to monitor controlled narcotic medications in 1 of 1 emergency kit (E-kit) to prevent potential diversion. Findings include: Observation and interview on 8/5/26 at 2:45 p.m., with trained medication aide (TMA)-A and registered nurse (RN)-A of the 400/500 wing medication room and medication cart identified the E-kit was stored in the medication cart. Inside the locked box was a small plastic E-kit box that housed the controlled narcotic medications. When asked about monitoring the plastic numbered tags that secured the E-kit, RN-A stated the nurses did not monitor the tag of the E-kits daily. The plastic numbered tag was not documented anywhere that would confirm the correct tag remained in place in order to easily identify potential diversion. Both TMA-A and RN-A stated there would be no way to know if someone had opened it and took narcotics out until the nurse accessed the E-kit for medication that was needed. RN-A agreed that the E-kit and E-kit small box with narcotics inside the locked box on the medication cart was not opened on a regular basis so medication could be missing for quite some time before anyone would notice. Review of the E-kit medication list identified that the kit contained controlled narcotic medications of Tramadol 50 mg: 6 tablets, Hydrocodone/APAP 5/325 mg: 6 tablets, Lorazepam 0.5 mg: 6 tables, and Morphine solution 20mg/ml (unknown amount). Interview on 8/5/26 at 3:19 p.m., with director of nursing identified that the staff should have been monitoring the number of the plastic tag on the E-kit and the E-kit located inside the locked box on the medication cart with the narcotics. A policy on monitoring controlled narcotic medications to prevent diversion was requested but not provided.			F0755			

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F0867 SS = D	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(1)-(4)d)(1)(2)(e)(1)-(3)(g)(2)(ii)(iii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.71 and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.			F0867			

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F0867 SS = D	Continued from page 9 §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.71. Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body,			F0867			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/05/2026	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA , PIPESTONE, Minnesota, 56164			
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F0867 SS = D	Continued from page 10 or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to provide evidence of 1 of 1 required Performance Improvement Project (PIP), which focused on high-risk or problem-prone areas with identified interventions and analysis to track performance to ensure improvement after implementing actions. Findings include: Review of the QAPI meeting minutes provided identified on: 9/23/25, the current PIP project was pressure ulcers. The goal was to decrease their percentage to be at or less than 2%. Last year’s August report was used for comparison at 4.4%. Actions were to monitor and report monthly and reviewed by wound nurse weekly. There was no mention of what the current rate was, nor how the facility planned to reach their goal, if they were auditing, etc. 12/16/25, QAPI meeting minutes identified pressure ulcers were listed, but not as a PIP , with goal of zero new facility acquired pressure ulcers, with current data listed as “0”. The plan was to “continue with prevention”. The current PIP section was completely blank on the form, so it was unclear if the facility had dropped the current PIP and replaced it with another or had not addressed it at all. 3/30/26, QAPI meeting minutes Appendix IV 2026 Performance Improvement Priorities listed a PIP project for pressure ulcers. The facility was at 10.6%, with national and state comparisons at 5.7% and 6.1% respectively. The target was reported to be at or less than 5.97%, however, there were no actions noted as to how the facility would reach this goal, analysis of			F0867			

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F0867 SS = D	Continued from page 11 current facility practices, or any resident data supplied to identify what was the cause of the increased PU percentage in their facility. 6/26/26, QAPI meeting minutes identified new or worsening pressure ulcers and there was noted to be an increase in pressure ulcers. The current intervention was “Great work team!” with a goal of NA and 2.3% and current data was listed as “0%”. There was a note for short stay residents at 0% but longer stay residents or the facility as a whole was not mentioned. The follow up was listed as “ongoing each meeting”. No analysis or data was included with the minutes in that section. Further down as another section for pressure ulcers/trends. The goal listed was “6 residents triggered for pressure ulcers”, and at 14.6% with an average of 5.7%. The action was to “continue with prevention” however, there was no identified actions as to how the facility would accomplish their goal. They had another section labeled “Current PIP-Pressure Ulcers” in their short stay residents at a goal of 0% but current data was also 0%. There was no mention why the facility was separating out their facility into short term or long term stay residents. They listed the current PIP as “going well” however there was no action to identify what the facility had implemented to reach their goal, or if this was an accurate portrayal of how the facility was doing overall, etc. Interview on 8/5/26 at 3:51 p.m., with the director of nursing (DON) and the administrator identified the DON stated there had been some staff turnover and a new person had started “taking care of the minutes” and had not put the data in. The committee was reviewing information and having discussion; however, she was unable to show that information was included in the minutes. The DON confirmed the facility PIP project of pressure ulcers had no identified interventions and the facility had no documentation that they had analyzed any data related to the PIP project. The DON was only able to identify that the facility was completing some audits as interventions for reducing long stay pressure ulcers. She stated, “We have nothing laid out in a plan such as what were are going to do and how we are going to do that... we need to work on our PIP and documentation of our meetings”. Review of the November 2025, QAPI plan identified The Quality Assurance Performance Improvement (QAPI) Plan was designed to outline a comprehensive and data driven QAPI program that focused on improving the outcomes and experiences			F0867			

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F0867 SS = D	Continued from page 12 of those served. The QAPI program was to address the complexity and uniqueness of the care and services provided. The QAPI Committee was responsible to track and trend performance, systematically analyze, prioritize quality deficiencies, develop action plans, and monitor for its effectiveness.			F0867			

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA , PIPESTONE, Minnesota, 56164			
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 08/04/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Pipestone was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/28/2026

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 08/04/2026	
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1.A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society Pipestone is a one-story building with no basement. The original building was constructed in 1971, with one building addition constructed in 1976, and both were determined to be of Type II (000) construction. The 1991 and 1999 building additions were determined to be of Type II (111) construction. The entire facility is fully fire sprinkler protected. The facility has a capacity of 71 beds and had a census of 54 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			08/28/2026
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing			K0918	Deficiency tag K0918 (Electrical Systems - Essential Electrical System Maintenance and Testing) 1) What corrective action(s) will be accomplished for those residents found to have been affected by the		08/17/2026

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K0918 SS = F Bldg. 01	Continued from page 2 The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 7.3.1. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 08/04/2026 at 10:29 AM, it was revealed by observation that the emergency generator transfer switch room was not provided with a battery powered emergency light. An interview with the Supervisor of Ancillary Services verified this deficient finding at the time of discovery.			K0918	Continued from page 2 deficient practice. A battery powered emergency light was installed 8/17/26. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected. 3) What measure will be put in place or what systemic changes will you make to ensure that the deficient practice does not reoccur. Maintenance team educated by State Fire Marshall during inspection on the requirement of a battery powered light near the emergency generator transfer switch. 4) How the corrective actions will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. A one time audit was completed to ensure installation and function of the emergency battery powered light. 5) The date for correction and the tile of the person responsible for correction of deficiency. The date of compliance 8/17/26, Administrator or designee.		08/17/2026

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K0761 SS = E Bldg. 01	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.3, 8.3.3.1 and, NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, sections 5.1.3.2 and 5.2.4.2 (8). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 08/04/2026 at 11:02 AM, it was revealed by observation that the fire doors located in the 100 wing did not shut completely when tested. An interview with the Supervisor of Ancillary Services verified this deficient finding at the time of discovery.			K0761	Deficiency tag K0761 (Maintenance, Inspection & Testing - Doors) 1) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. The fire door identified was repaired on 8/5/26. 2) How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected. 3) What measure will be put in place or what systemic changes will you make to ensure that the deficient practice does not reoccur. Maintenance team educated by Administrator on fire doors. 4) How the corrective actions will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Audits will be completed weekly x 4 and monthly x 2 on all fire doors to ensure proper closure. 5) The date for correction and the tile of the person responsible for correction of deficiency. The date of compliance 8/18/26, Administrator or designee.		08/18/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 23, 2026

Administrator
GOOD SAMARITAN SOCIETY - PIPESTONE
1311 NORTH HIAWATHA
PIPESTONE, MN 56164

RE: CCN: 245591
Cycle Start Date: August 5, 2026

Dear Administrator:

On September 16, 2026, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

