DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 6, 2020

Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

RE: CCN: 245591
Survey Start Date: May 19, 2020

Dear Administrator:

On August 5, 2020 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of July 2, 2020. Per the CMS Memo QSO-20-20-All, enforcement remedies were suspended from March 23, 2020 to May 31, 2020 and will be evaluated at a later date.

The CMS Region V Office may notify you of their determination regarding any remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
June 3, 2020

Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

SUBJECT: SURVEY RESULTS
CCN: 245591
Cycle Start Date: May 19, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On May 19, 2020, the Minnesota Department of Health completed a COVID-19 Focused Survey at Good Samaritan Society - Pipestone to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable electronic plan of correction (ePOC) for the enclosed deficiencies that were cited during the May 19, 2020 survey. Good Samaritan Society - Pipestone may choose to delay

submission of an ePOC until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit an ePOC. 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. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- The date that each deficiency will be corrected.

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

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the May 19, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Health Regulation Division
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-308
Fax: 507-537-7194

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting

immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Good Samaritan Society - Pipestone may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted 5/18/20 through 5/19/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your 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 facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted 5/18/20 through 5/19/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		7/2/20

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

Electronically Signed | 06/11/2020

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

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F 880	Continued From page 1 infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and	F 880		

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F 880	Continued From page 2 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to implement isolation precautions on new admissions for 4 of 70 residents (R1, R2, R3, R4, R5), and appropriately social distance 30 residents in the dining room (R1, R4, R6, R7, R,8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R27, R28, R29, R30, R32, R33, R34, R35) in accordance with Center for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19. This had the ability to affect all 70 residents.	F 880	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction	

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F 880	Continued From page 3 Findings include: ISOLATION Interview on 5/18/20 at 12:07 p.m., with registered nurse (RN)-A identified when a resident returned from the hospital they were not required to quarantine or be placed on 14 days of precautions.The director of nursing (DON) advised residents readmitted following hospitalization required a COVID-19 test. If the test was negative, no precautionary isolation was required. Review of the facility admission record, hospital returns, and progress notes for the past month identified: 1) R5 was admitted on 4/22/20. The medical record made no mention R5 had been isolated with precautions upon admission to the facility. 2) R1 was admitted on 4/28/20. Further review of medical record revealed R1 was hospitalized on 5/5/20 for a seizure and returned to the facility on 5/8/20. The medical record lacked identification R1 had been quarantined with transmission-based precautions following return to the facility after either hospitalization. 3) R4 was admitted on 4/29/20. The medical record made no mention that R4 had been isolated with precautions upon admission to the facility. 4) R2 was admitted on 4/30/20. Further review of medical record revealed R2 was hospitalized on 5/9/20 for a seizure and returned to the facility on 5/11/20. The medical record made no mention R2 had been quarantined with transmission-based precautions following return to the facility after hospitalization. 5) R3 was admitted on 5/8/20. The medical record made no mention R3 had been isolated	F 880	constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. ISOLATION 1. According to the deficiency statement the facility failed to implement isolation precautions for four out of five new admissions/re-admissions R1, R2, R3, R4 and R5. On May 11, 2020 facility implemented guidelines to isolate, with transmission based precautions, all new admissions. On May 18, 2020 facility implemented guidelines to isolate, with transmission based precautions, all new admission and re-admissions which includes above referenced residents. 2. This has the potential to affect all residents admitted or re-admitted to the facility. On May 18. 2020 transmission based precautions were required for all admissions/re-admissions. Care plans were reviewed to ensure residents that were under transmission based precautions, at that time, had care plan items to reflect this. 3. All admissions and re-admissions to the facility will have isolation with transmission based precautions for a 14-day quarantine period. They will be placed in a private room on a separate wing reserved for admissions and re-admissions. The following will be	

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F 880	Continued From page 4 with precautions upon admission to the facility. Interview on 5/18/20 at 2:45 p.m., RN-B identified new admissions to the facility were required to be tested for COVID-19 and have negative results. RN-B identified residents returning to the facility from the hospital had not required COVID-19 testing or to be placed on precautions as they were screened for signs and symptoms at the front door. Interview on 5/18/20 at 3:22 p.m., with the DON identified every new admission required a COVID-19 negative test result or they were not admitted to the facility. The facility policy for new admissions with a negative COVID-19 test did not require any type of quarantine or precautions. The DON identified R1, R2, R3, R4, and R5 had not been placed on quarantine or precautions when admitted to the facility. Residents who returned to the facility following hospitalization did not require a COVID-19 test unless they were hospitalized for three days. The DON was aware of CDC guidance, however facility policy differed. Interview on 5/18/20 at 4:00 p.m., with the administrator identified the facility policy for new admissions required a negative COVID-19 test result prior to admission. New admissions with a negative test result did not require isolation. The administrator identified both the hospital and the facility were considered to be clean environments and as a result when a resident was readmitted/returned there was not a need for isolation or full PPE as staff wore masks and face shields at all times. The admin was aware of CDC guidance, however agreed facility policy differed from CDC guidelines requiring additional 10 days of protective isolation after a negative	F 880	entered into the care plan: a. Focus The resident is on admission/re-admission isolation precautions R/T potential for COVID-19 b. Goal The resident will remain free from adverse psychological effects of isolation through isolation period c. Interventions 1. TRANSMISSION BASED PRECAUTIONS FOR 14 DAYS POST ADMIT/RE-ADMIT 2. Monitor for s/s of COVID-19 3. Provide independent or 1:1 activities as tolerated by the resident 4. Educate resident regarding the importance of handwashing Education was provided to all staff immediately at daily huddle. Education was provided to all professional nursing staff on June 8, 2020 to include isolation with transmission based precautions for 14 days to the care plan for all new admission/re-admissions. This was completed by Director of Nursing, Infection Preventionist and Nursing Case Manager. Education will be provided to all facility staff on the importance of isolation of new admission/re-admissions for 14 day quarantine period, this will be completed by the Director of Nursing or Infection Preventionist at the mandatory virtual staff meetings on June 17/18/19, 2020. Those who are unable to attend the scheduled virtual meeting times will need to view recording of education by July 2, 2020, or prior to their next scheduled shift.	

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F 880	Continued From page 5 COVID-19 test. Review of the 5/11/20, Guidance on Accepting Hospital Admissions policy, identified residents were to be tested for COVID-19 with negative results prior to admission. No transmission-based precautions were necessary, however facility was to adhere to local guidance and individual state regulations. For residents who test negative but had a prior positive test would need a second negative test prior to admission. Following the second negative COVID test no transmission-based precautions would be necessary however, facilities should follow state regulations and local guidance. If a resident tested positive for COVID-19, the facility was not admit unless they had adequate staffing and ability to manage COVID positive residents. If the facility admitted a COVID positive resident facility would implement transmission-based precautions. The facility could discontinue transmission-based precaution after two negative test results that were twenty four hours apart or ten days if fever free for three days. There was no mention the facility should follow current CDC guidance on isolation after admission. Review of the 4/16/20, Emerging Threats-Acute Respirator Syndromes Coronavirus (COVID) policy identified residents with respiratory illness were educated on COVID, evaluated and appropriate precautions were to be implemented. Control recommendations and infection prevention included transportation of a resident out of the long term care (LTC) facility that was symptomatic. The policy lacked identification process of admissions or hospital returns to the LTC facility per CDC guidance.	F 880	4. To monitor performance and ensure compliance the Director of Nursing, or designee, will audit care plans and resident rooms for presence of isolation with transmission based pre-cautions on new admissions/re-admissions weekly for four weeks, then once per month for three months (or until guidance is revised by CDC/CMS/MDH, whichever is sooner) DINING 1. According to the deficiency statement the facility failed to appropriately social distance 30/30 residents in need of assistance and/or supervision in the dining room. Interdisciplinary Team screened residents that were seated in the dining room for continued necessity. Those determined no longer in need of assistance and/or supervision, and were deemed safe to eat independently in their rooms, were removed. The remaining residents will be seated individually at separate tables, in main dining room and 200 dining room, not to exceed the number of tables available. 2. This has the potential to affect all residents by having a large number of residents in communal dining setting. On June 8, 2020 residents eating meals in large dining room were screened to determine if they continued with need for assistance and/or supervision. Each resident will be reviewed on an ongoing basis.	

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F 880	Continued From page 6 DINING Interview on 5/18/20 at 9:45 a.m., with dietary aide (DA)-A identified there were some residents who continued to eat meals in the dining room. D-A identified residents who were at risk to choke and required assistance to eat, continued to eat meals in the dining room. Tables were placed six feet apart. Interview on 5/18/20 at 10:25 a.m., with activities director (AD) identified residents continued to eat in the dining room. One or two residents sat at each table. Observation on 5/18/20 at 12:00 p.m., identified the main dining room contained 16 tables. Two residents sat at 15 out of 16 of the tables. Staff were in the dining room assisting residents to eat or provide oversight for those at risk for choking. At times 4 people would have been at a single table. Two residents and two staff were seated at a 4 foot square table. Interview on 5/18/20 at 1:15 p.m., with dietary manager (DM)-C identified she assisted nursing staff with seating arrangements in the dining room. Residents were to sit 6 feet apart. Tables had been removed from the dining room to ensure social distancing occurred between tables. The tables were four feet by four feet wide. The DM-C identified 2 residents were seated per table across from each other. Interview on 5/18/20 at 1:30 p.m., with register nurse (RN)-C identified the DM-C set up the initial seating arrangement. Interview and observation on 5/18/20 at 2:20 p.m., director of environmental services (DES)-A	F 880	3. On June 8, 2020 the following plan was developed: a. Residents eating in the dining room were screened for continued supervision and/or assistance needed, resident that were no longer in need of supervision and/or assistance are now allowed to eat in their rooms independently as they have been deemed safe to do so. b. Additional dining area opened in 200 wing. c. Placement of only one resident per table. Education was provided to all direct care staff on June 9, 2020 during daily huddle. Education will be provided to all facility staff regarding dining arrangements and appropriate social distancing. This will be completed by the Infection Preventionist and/or Director of Food and Nutrition at the mandatory virtual staff meetings on 6/17, 6/18 and 6/19/20. Those who are unable to attend the scheduled virtual meeting times will need to view recording of education by July 2, 2020, or prior to their next scheduled shift. 4. To monitor performance and ensure compliance the Infection Preventionist, or designee, will audit dining and social distancing along with continued need for assistance/supervision weekly for four weeks, then once per month for three months (or until guidance is revised by CDC/CMS/MDH, whichever is sooner).	

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F 880	Continued From page 7	F 880		

had been aware of the 6 foot distancing. Observation of the DES measured a round table and a square table. He identified that each table measured four feet by four feet across. He identified he was not involved in seating arrangements in the dining room.

Interview on 5/18/20 at 2:49 p.m., with RN-B identified table distance was measured to ensure residents were socially distanced. RN-B confirmed the dining room contained 16 tables and verified 2 residents were seated at each table except one during meal service.

Interview on 5/18/20 at 3:22 p.m., with the DON and RN-B/IP identified residents at risk for choking, required cues or eating assistance ate in the dining room. They attempted to seat residents who shared a room at the same table. The DON verified residents sat at four feet by four feet tables facing each other while dining, to enable staff to assist two residents and speed up the dining process. She agreed residents sat four feet apart and were not appropriately socially distanced.

Interview on 5/18/20 at 4:09 p.m., with the administrator identified she was aware six feet was the accepted length for social distancing practices during resident dining. CMS guidelines identified six feet was the recommended length for social distancing. She interpreted CMS guidelines to keep residents six feet apart by spacing tables. Residents seated two at a four by four feet square tables were six feet apart during meals. The administrator agreed residents who sat at a 4 x 4 table were not socially distanced at the same table.

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F 880	Continued From page 8 Review of the 4/21/20, Food and Nutrition Services Considerations for Pandemic/Epidemic Outbreaks Coronavirus (COVID-19) policy identified residents at risk for choking, had difficulty swallowing, or required assistance to dine were able to dine in a congregate setting. Residents were to be seated one resident per table, six feet apart.	F 880		