



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 9, 2025

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

RE: CCN: 245591
Cycle Start Date: May 21, 2025

Dear Administrator:

On May 21, 2025, 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
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 August 21, 2025 (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 November 21, 2025 (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>

Good Samaritan Society - Pipestone

June 9, 2025

Page 4

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
MN 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,

A handwritten signature in black ink, appearing to read 'M. Poepping', with a stylized, cursive script.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



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

Re: State Nursing Home Licensing Orders
Event ID: E81W11

Dear Administrator:

The above facility was surveyed on May 18, 2025 through May 21, 2025 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102 Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/30/2025
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 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 On 5/18/25 through 5/21/25, a survey for compliance with §483.73, Appendix Z, Emergency Preparedness Requirements for Long Term Care Facilities 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.	E 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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 000	INITIAL COMMENTS On 5/18/25 through 5/21/25, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55914327C (MN104519). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000			
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657			6/10/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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 657	Continued From page 1 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed revise the care plan when new physician orders were received for 1 of 3 sampled residents (R55) receiving oxygen therapy upon return from the hospital. Findings include: R55's 3/24/25, admission Minimum Data Set (MDS) assessment identified R55 cognition was intact, R55 had no behaviors. On 5/5/25, the MDS noted she and was receiving oxygen therapy. Observations on 5/19/25 identified at: 1) 8:25 a.m., R55 was noted to be awake lying in her bed. Her oxygen tubing was not applied to her person but was observed lying on the bed next to her. The oxygen concentrator was noted to be on and set to deliver oxygen at 3 liters/minute (L/min). 2) 8:35 a.m., nursing assistant (NA)-B was	F 657	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 federal and state law. For the purpose of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the state operations manual. F657 (SS=D) Based on observation, interview, and document review, the facility failed to revise the care plan when new physician orders were received for 1 of 3 resident's		

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F 657	Continued From page 2 assisting R55 with morning cares. NA-B ensured R55 had her oxygen on via nasal cannula (NC). NA-B then transferred R55. Following R55's transfer, NA-B switched R55 from her oxygen concentrator set at 3 L/min over to her portable oxygen tank and turned it on. The flow rate was pre-set at 2.5 L/min. 3) 11:06 a.m., of R55 while registered nurse (RN)-B performed a dressing change, identified R55's oxygen flow rate was set at 3 L/min. R55's 3/31/25, hospital discharge summary identified an order for oxygen at 2 L/min. per NC for 1 month. R55's current care plan identified a focus area of oxygen therapy initiated revised on 3/31/25 related to acute respiratory failure with hypoxia (lack of oxygen). R55 was to have no signs or symptoms of poor oxygen absorption through the review date. Staff were to monitor for signs and symptoms of respiratory distress and report to the provider. R55's head of her bed was to be elevated as she tolerated. R55 was to have oxygen at 2 L/min. per NC at rest and overnight to maintain her oxygen saturation above 92%. R55's 4/29/25, hospital discharge summary identified a new physician order was placed for R55 to receive oxygen at 1-2 L/min. per NC during the day, with titrating up to 2 L/min. per NC overnight. Further review of the above-mentioned care plan identified no changes were made when a new order was received to change the oxygen flow rate on 4/29/25. R55's 5/21/25, Order Summary Report (OSR)	F 657	(R55) receiving oxygen therapy upon return from the hospital. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? When alerted by the surveyor, residents oxygen was changed to physician ordered rate. Care plan updated to show physician ordered oxygen rate. Resident discharged 5/29 to other facility closer to home that she was on wait list. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents requiring oxygen therapy have the potential to be affected by this deficient practice. The DNS and Health information Specialist identified all residents utilizing oxygen therapy. Audit was completed to ensure anyone utilizing oxygen was using it at Physician prescribed amount. Care plans reviewed for current oxygen therapy orders. Oxygen therapy residents TAR's were updated to document residents oxygen saturations and flow rate BID. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, all nursing staff were educated to utilize the oxygen order template when transcribing oxygen orders. This will help ensure that parameters or monitoring		

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F 657	Continued From page 3 identified R55 had an order for oxygen to be administered at 2 liters (L) per nasal cannula (NC) at rest and overnight to maintain an oxygen saturation over 92 %, The order summary report identified diagnoses of a history of acute respiratory failure with hypoxia. There was no indication the OSR had been updated to the newer 4/29/25 physician order from the original order placed on 3/31/25, to show the change in flow rate to 1-2 L per min. during the day and 2 L/min at night. R55's May 2025, medication administration record (MAR) identified an order was documented for oxygen to be administered at 2 L/min. via NC at rest and overnight to maintain oxygen saturation above 92%. Staff were to check twice a day at 8:00 a.m. and again at 8:00 p.m.. Staff documented R55's oxygen saturations levels were identified to be 91% to 96%, however, there was no indication staff were checking the actual flow rate, nor had they verified the MAR with the correct physician order which was changed to 1-2 L during the day and 2 L/min. at night. Further observations on 5/20/25 identified at: 4) 5/20/25 at 8:43 a.m., R55 was noted to be seated at the breakfast table. Her portable oxygen tank was set at flow rate of 3 L/min. 5) 5/20/25 at 9:04 a.m., R55 noted to be in her room. Her oxygen was connected to the oxygen concentrator with the flow rate set at 3 L/min. Observation and interview on 5/20/25 at 10:11 a.m., of R55's oxygen flow rate with RN-C identified R55's oxygen was set at 3 L/min.. RN-C reviewed the MAR and noted R55's oxygen flow rate was supposed to be at 2 L/min. per NC at	F 657	expectations are made known to caregivers responsible for the administration of oxygen. Nursing Manager or designee will review all orders/changes in orders and verify care plan is updated. All nursing staff were educated on the deficiency during nurses meeting 6/10/25. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Daily audits x 5, then weekly audits x 4, and monthly audits x 2 will be completed by DNS or Designee to ensure the oxygen concentrators and oxygen tanks are at the physician ordered rate. Care plans on any new admissions with respiratory therapy and those with oxygen changes will be verified they contain physician prescribed amount. Audits will be brought to QAPI committee to ensure completion and follow is completed. 5. Date of completion? Initiated 5/21/25		

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F 657	Continued From page 4 rest and during the night. Direct care staff were not allowed to change the flow rate and only switch the oxygen tubing from the concentrator to the portable oxygen tank as needed for transfers. RN-C thought R55's family member "messed with the oxygen" at times. RN-C made no mention if in knowing R55's family member was known to adjust R55's physician ordered oxygen rate, the family member had been educated by staff not to adjust it, or to alert staff if they noticed R55 had any breathing difficulty requiring oxygen adjustment. RN-C also failed to verify the accuracy of the MAR with the updated physician order for 1-2 L per min during the day and 2 L/min at night that was changed on 4/29/25. Interview and document review on 5/21/25 at 10:31 a.m., with administrator identified her expectation was a resident's oxygen administration orders were to be followed, be consistent in the medical record, and appropriately documented and administered. The administrator reviewed the OSR. She confirmed that OSR (entered by staff) noted R55 was to receive oxygen at 2 L/min. There was no indication the administrator was aware R55's oxygen administration order had been changed on 4/29/25 for 1-2 L/min. via NC during the day and 2 L/min. at night. Review of the 7/8/24, Oxygen Administration policy identified oxygen was to be administered with a physician order. A licensed nurse was to be on duty and responsible for the proper administration of the oxygen for the resident. There was no mention of how staff were to appropriately document the amount of oxygen that was being administered.	F 657			

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F 657	Continued From page 5	F 657			
F 695 SS=D	There was no policy related to care plans provided by the end of survey. Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the correct physician order was followed and appropriately monitored for 1 of 3 sampled residents (R55) receiving oxygen therapy. Findings include: R55's 3/24/25, admission Minimum Data Set (MDS) assessment identified R55 cognition was intact, R55 had no behaviors. On 5/5/25, the MDS noted she and was receiving oxygen therapy. Observations on 5/19/25 identified at: 1) 8:25 a.m., R55 was noted to be awake lying in her bed. Her oxygen tubing was not applied to her person but was observed lying on the bed next to her. The oxygen concentrator was noted to be on and set to deliver oxygen at 3 liters/minute (L/min). 2) 8:35 a.m., nursing assistant (NA)-B was	F 695	F695 (SS=D) Based on observation, interview and document review, the facility failed to ensure the correct physician order was followed and appropriately monitored for 1 of 3 residents (R55) receiving oxygen therapy. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? When alerted by the surveyor, resident's oxygen was changed to be at the appropriate levels. A task was added to TAR to document resident's o2 saturations and flow rate (liters) BID. Resident discharged 5/29 to other facility closer to home that she was on wait list. 2. How will other residents, having the potential to be affected by the same	6/11/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/21/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164		
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F 695	Continued From page 6 assisting R55 with morning cares. NA-B ensured R55 had her oxygen on via nasal cannula (NC). NA-B then transferred R55. Following R55's transfer, NA-B switched R55 from her oxygen concentrator set at 3 L/min over to her portable oxygen tank and turned it on. The flow rate was pre-set at 2.5 L/min. 3) 11:06 a.m., of R55 while registered nurse (RN)-B performed a dressing change, identified R55's oxygen flow rate was set at 3 L/min. R55's 3/31/25, hospital discharge summary identified an order for oxygen at 2 L/min. per NC for 1 month. R55's current care plan identified a focus area of oxygen therapy initiated revised on 3/31/25 related to acute respiratory failure with hypoxia (lack of oxygen). R55 was to have no signs or symptoms of poor oxygen absorption through the review date. Staff were to monitor for signs and symptoms of respiratory distress and report to the provider. R55's head of her bed was to be elevated as she tolerated. R55 was to have oxygen at 2 L/min. per NC at rest and overnight to maintain her oxygen saturation above 92%. R55's 4/29/25, hospital discharge summary identified a new physician order was placed for R55 to receive oxygen at 1-2 L/min. per NC during the day, with titrating up to 2 L/min. per NC overnight. Further review of the above-mentioned care plan identified no changes were made when a new order was received to change the oxygen flow rate on 4/29/25. R55's 5/21/25, Order Summary Report (OSR)	F 695	deficient practice, be identified? All residents requiring oxygen therapy have the potential to be affected by this deficient practice. The DNS and Health Information Specialist identified all residents utilizing oxygen therapy. An audit was completed to ensure anyone utilizing oxygen was using it at Physician prescribed amount. Care plans were reviewed for current oxygen therapy orders. Orders for oxygen therapy in residents TAR's were updated to document residents oxygen saturations and flow rate BID. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, all nursing staff were educated to utilize the oxygen order template when transcribing oxygen orders. This will help ensure that parameters or monitoring expectations are made known to caregivers responsible for the administration of oxygen. All nursing staff were educated on the deficiency during nurses meeting held on 6/10/25. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Daily audits x 5, then weekly audits x 4, and monthly audits x 2 will be completed by DNS or Designee to ensure the oxygen concentrators and oxygen tanks are at the physician ordered rate. Audits will be brought to QAPI committee for further		

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F 695	Continued From page 7 identified R55 had an order for oxygen to be administered at 2 liters (L) per nasal cannula (NC) at rest and overnight to maintain an oxygen saturation over 92 %. , The order summary report identified diagnoses of a history of acute respiratory failure with hypoxia. There was no indication the OSR had been updated to the newer 4/29/25 physician order from the original order placed on 3/31/25, to show the change in flow rate to 1-2 L per min. during the day and 2 L/min at night. R55's May 2025, medication administration record (MAR) identified an order was documented for oxygen to be administered at 2 L/min. via NC at rest and overnight to maintain oxygen saturation above 92%. Staff were to check twice a day at 8:00 a.m. and again at 8:00 p.m.. Staff documented R55's oxygen saturations levels were identified to be 91% to 96%, however, there was no indication staff were checking the actual flow rate, nor had they verified the MAR with the correct physician order which was changed to 1-2 L during the day and 2 L/min. at night. Further observations on 5/20/25 identified at: 4) 5/20/25 at 8:43 a.m., R55 was noted to be seated at the breakfast table. Her portable oxygen tank was set at flow rate of 3 L/min. 5) 5/20/25 at 9:04 a.m., R55 noted to be in her room. Her oxygen was connected to the oxygen concentrator with the flow rate set at 3 L/min. Observation and interview on 5/20/25 at 10:11 a.m., of R55's oxygen flow rate with RN-C identified R55's oxygen was set at 3 L/min.. RN-C reviewed the MAR and noted R55's oxygen flow rate was supposed to be at 2 L/min. per NC at	F 695	recommendation. 5. Date of completion? Initiated 5/21/25		

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F 695	Continued From page 8 rest and during the night. Direct care staff were not allowed to change the flow rate and only switch the oxygen tubing from the concentrator to the portable oxygen tank as needed for transfers. RN-C thought R55's family member "messed with the oxygen" at times. RN-C made no mention if in knowing R55's family member was known to adjust R55's physician ordered oxygen rate, the family member had been educated by staff not to adjust it, or to alert staff if they noticed R55 had any breathing difficulty requiring oxygen adjustment. RN-C also failed to verify the accuracy of the MAR with the updated physician order for 1-2 L per min during the day and 2 L/min at night that was changed on 4/29/25. Interview and document review on 5/21/25 at 10:31 a.m., with administrator identified her expectation was a resident's oxygen administration orders were to be followed, be consistent in the medical record, and appropriately documented and administered. The administrator reviewed the OSR. She confirmed that OSR (entered by staff) noted R55 was to receive oxygen at 2 L/min. There was no indication the administrator was aware R55's oxygen administration order had been changed on 4/29/25 for 1-2 L/min. via NC during the day and 2 L/min. at night. Review of the 7/8/24, Oxygen Administration policy identified oxygen was to be administered with a physician order. A licensed nurse was to be on duty and responsible for the proper administration of the oxygen for the resident. There was no mention of how staff were to appropriately document the amount of oxygen that was being administered.	F 695			

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F 842 F 842 SS=D	Continued From page 9 Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842 F 842			6/11/25

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F 842	Continued From page 10 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed accurately reconcile physician orders upon return from the hospital and update the electronic medical record for 1 of 3 sampled residents (R55) receiving oxygen therapy. Findings include:	F 842	F842 (SS=D) In review, the facility failed to accurately reconcile physician orders upon return from the hospital and update the electronic medical record for 1 of 3 sampled residents (R55) receiving oxygen 1. What corrective action will be accomplished for those residents found to		

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F 842	Continued From page 11 R55's 3/24/25, admission Minimum Data Set (MDS) assessment identified R55 cognition was intact, R55 had no behaviors. On 5/5/25, the MDS noted she and was receiving oxygen therapy. Observations on 5/19/25 identified at: 1) 8:25 a.m., R55 was noted to be awake lying in her bed. Her oxygen tubing was not applied to her person but was observed lying on the bed next to her. The oxygen concentrator was noted to be on and set to deliver oxygen at 3 liters/minute (L/min). 2) 8:35 a.m., nursing assistant (NA)-B was assisting R55 with morning cares. NA-B ensured R55 had her oxygen on via nasal cannula (NC). NA-B then transferred R55. Following R55's transfer, NA-B switched R55 from her oxygen concentrator set at 3 L/min over to her portable oxygen tank and turned it on. The flow rate was pre-set at 2.5 L/min. 3) 11:06 a.m., of R55 while registered nurse (RN)-B performed a dressing change, identified R55's oxygen flow rate was set at 3 L/min. R55's 3/31/25, hospital discharge summary identified an order for oxygen at 2 L/min. per NC for 1 month. R55's current care plan identified a focus area of oxygen therapy initiated revised on 3/31/25 related to acute respiratory failure with hypoxia (lack of oxygen). R55 was to have no signs or symptoms of poor oxygen absorption through the review date. Staff were to monitor for signs and symptoms of respiratory distress and report to the provider. R55's head of her bed was to be elevated as she tolerated. R55 was to have oxygen at 2 L/min. per NC at rest and overnight			F 842	have been affected by the deficient practice. When alerted by the surveyor, residents oxygen was changed to physician ordered rate. Order was updated to reflect orders received upon hospital return. Electronic record is reflective of the change. Care plan updated to show physician ordered oxygen rate. Resident discharged 5/29 to other facility closer to home that she was on wait list. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents requiring oxygen therapy have the potential to be affected by this deficient practice. The DNS and Health information Specialist identified all residents that had hospital returns in past 60 days. Audit was completed to ensure orders were reconciled upon the resident's return from the hospital. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are sustained, all nursing staff were educated on the process of reconciling orders upon a resident's return from the hospital. This was completed at nurses meeting 6/10/25 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or Designee will audit the orders of hospital returns. Audits of every return for		

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F 842	Continued From page 12 to maintain her oxygen saturation above 92%. R55's 4/29/25, hospital discharge summary identified a new physician order was placed for R55 to receive oxygen at 1-2 L/min. per NC during the day, with titrating up to 2 L/min. per NC overnight. Further review of the above-mentioned care plan identified no changes were made when a new order was received to change the oxygen flow rate on 4/29/25. R55's 5/21/25, Order Summary Report (OSR) identified R55 had an order for oxygen to be administered at 2 liters (L) per nasal cannula (NC) at rest and overnight to maintain an oxygen saturation over 92 %, The order summary report identified diagnoses of a history of acute respiratory failure with hypoxia. There was no indication the OSR had been updated to the newer 4/29/25 physician order from the original order placed on 3/31/25, to show the change in flow rate to 1-2 L per min. during the day and 2 L/min at night. R55's May 2025, medication administration record (MAR) identified an order was documented for oxygen to be administered at 2 L/min. via NC at rest and overnight to maintain oxygen saturation above 92%. Staff were to check twice a day at 8:00 a.m. and again at 8:00 p.m.. Staff documented R55's oxygen saturations levels were identified to be 91% to 96%, however, there was no indication staff were checking the actual flow rate, nor had they verified the MAR with the correct physician order which was changed to 1-2 L during the day and 2 L/min. at night.	F 842	2 weeks, then weekly x 4 and monthly x 3. to ensure electronic medical record is updated with the physician ordered rate. Audits will be brought to QAPI committee for further recommendation 5. Date of completion? Initiated 5/21/25		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 842	Continued From page 13 Further observations on 5/20/25 identified at: 4) 5/20/25 at 8:43 a.m., R55 was noted to be seated at the breakfast table. Her portable oxygen tank was set at flow rate of 3 L/min. 5) 5/20/25 at 9:04 a.m., R55 noted to be in her room. Her oxygen was connected to the oxygen concentrator with the flow rate set at 3 L/min. Observation and interview on 5/20/25 at 10:11 a.m., of R55's oxygen flow rate with RN-C identified R55's oxygen was set at 3 L/min.. RN-C reviewed the MAR and noted R55's oxygen flow rate was supposed to be at 2 L/min. per NC at rest and during the night. Direct care staff were not allowed to change the flow rate and only switch the oxygen tubing from the concentrator to the portable oxygen tank as needed for transfers. RN-C thought R55's family member "messed with the oxygen" at times. RN-C made no mention if in knowing R55's family member was known to adjust R55's physician ordered oxygen rate, the family member had been educated by staff not to adjust it, or to alert staff if they noticed R55 had any breathing difficulty requiring oxygen adjustment. RN-C also failed to verify the accuracy of the MAR with the updated physician order for 1-2 L per min during the day and 2 L/min at night that was changed on 4/29/25. Interview and document review on 5/21/25 at 10:31 a.m., with administrator identified her expectation was a resident's oxygen administration orders were to be followed, be consistent in the medical record, and appropriately documented and administered. The administrator reviewed the OSR. She confirmed that OSR (entered by staff) noted R55 was to receive oxygen at 2 L/min. There was no	F 842			

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F 842	Continued From page 14 indication the administrator was aware R55's oxygen administration order had been changed on 4/29/25 for 1-2 L/min. via NC during the day and 2 L/min. at night. Review of the 7/8/24, Oxygen Administration policy identified oxygen was to be administered with a physician order. A licensed nurse was to be on duty and responsible for the proper administration of the oxygen for the resident. There was no mention of how staff were to appropriately document the amount of oxygen that was being administered.	F 842			
F 880 SS=F	There was no policy related to reconciling physician orders provided by the end of survey. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an 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	F 880			6/26/25

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F 880	Continued From page 15 arrangement based upon the facility assessment conducted according to §483.71 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 (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	F 880			

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F 880	Continued From page 16 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 interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employee would be able to return to work after an illness, dependent upon their symptoms for 3 of 5 sampled staff (trained medication aide (TMA)-A, nursing assistant (NA)-A, and dietary aide (DA)-B). In addition, the facility failed to ensure 1 of 5 sampled staff (dietary aide) had completed tuberculosis testing (TST) upon hire. This had the potential to affect all 62 residents in the facility. Findings include: Employee Surveillance Review of the December 2024 through April 2025 Monthly Report of Infections in Location-Employees, Children, Family and Visitors logs identified the following columns: 1) Name 2) ID Code 3) Assigned Unit 4) Date of onset 5) Type of Infection 6) Antibiotic Treatment 7) Cautionary Measures 8) Culture Results (if taken). The following randomly selected staff were identified to have absences from work: NA-A, TMA-A, and DA-B.	F 880	F880 (SS-F) Based on interview and document review, the facility failed to ensure employee illnesses were traced to identify when employee would be able to return to work after an illness, dependent upon their symptoms for 3 of 5 sampled staff. In addition, the facility failed to ensure 1 of 5 sampled staff (dietary aide) had completed (TST) upon hire. This had the potential to affect all 60 residents in the facility. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Infection preventionist educated by DNS regarding utilization GSS#362 Monthly report of Infections in Location Employees, children, family and Visitors. Also educated the Infection Preventionist on GSS #426 Absence/Tardy Report. Education completed on 5/21/25. The practice in place is to contact employees and provide return to work instructions prior to their return to work. All employees are tracked monthly. Dietary aide completed 2 step TB screening 5/30/25		

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F 880	Continued From page 17 Review of Absence/Tardy Report sheets and matching timecards from February 2025 to April 2025 identified the following corresponding information: Name, date, time, called in, scheduled shift, reason for absence, illness and symptoms, and return to work date. On: 1) 2/21/25, nursing assistant (NA)-A was noted to have called in sick from work with symptoms of diarrhea (loose watery stool) and vomiting. NA-A returned to work on 2/23/25. There was no mention when or if NA-A symptoms resolved prior to returning to work. 2) 3/14/25, trained medication aide (TMA)-A was noted to have called in sick from work with symptoms of diarrhea and had left early from her shift. TMA-A timecard identified on 3/14/25, TMA-A had worked from 6:30 a.m. to 4:13 p.m. On 3/16/25, she had worked 1 hour and returned to work for a full day (8 hours) on 3/18/25. There was no mention when or if TMA-A symptoms resolved prior to returning to work. 3) 4/29/25, dietary aide (DA)-B was noted to have called in sick from work with symptoms of vomiting and fever. DA-B returned to work on 5/02/25. There was no mention when or if DA-B symptoms resolved prior to returning to work. Interview on 5/19/25 at 3:58 p.m., with director of nursing (DON) and registered nurse (RN)-A identified TMA-A had reported her illness on 3/14/25 had not felt well and left work early on 3/14/25 and again on 3/16/25. The DON identified the Absence/Tardy report sheets was to track employee illnesses, by the infection preventionist (IP) to identify when employees was eligible to return to work and was not updated, accurately. RN-A identified processes to monitor staff illnesses was not consistent and would need to be evaluated for improvement.	F 880	2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by this deficient practice. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Infection preventionist/DNS will complete GSS#362 Monthly tracking on all employee absences. Infection preventionist/DNS will be given GSS#426 Absence/Tardy report and will contact all employees and provide return to work instructions based on illness prior to returning. All department heads notified to provide this report to infection preventionist on any absence and day of call in. All staff will be reeducated on the process of the Absence/Tardy forms and return to work process at all staff meeting 6/26/25. All new employees are directed to Infection preventionist for Initial TB screening/start of TST first step. IP will provide instructions to employee on reading of TB in 48-72 hours and set up dates for return in 1-3 weeks for 2nd TST. All department heads were educated to direct new employee to Infection preventionist on day 1 of General Orientation. IP will track and update department heads on employees completion. 4. How will the corrective action be monitored to ensure the deficient practice		

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F 880	Continued From page 18 Review of May 2024 Employee Health Conditions Reporting and Managing-Infection Control policy identified employees was to communicate with department supervisors, such as the IP, nurse, or DON before returning to work. TB Review of employee health file of DA-A identified DA-A was hired on 3/17/25. DA-A had a baseline TB symptom screening on 3/24/25 and received the first step TST series on 3/14/25. The form lacked evidence of a second TST. Interview on 5/19/25 at 4:11 p.m. with director of nursing (DON) and registered nurse (RN)-A had voiced in agreement that new hires should have TB screening and testing completed upon hire and noted there was no documentation to support DA-A had received a 2nd TB test as required. Review of January 2025 Tuberculosis Control Plan and Screening for Employees, Senior Living, Rehab/Skilled, Home Health, Child Day-Enterprise policy identified new employees was to have a baseline TB screening and testing, prior or upon hire. If, the facility was to provide a two-step Mantoux TST, the first step was to be read within 48 to 72 hours and the second step should be given in 1 to 3 weeks.	F 880	is being corrected and will not recur? DNS/Designee will audit all Absence/Tardy reports weekly x 4 weeks, monthly x 2 to assure return to work instructions have been provided. DNS/Designee will audit all new employees TST test weekly x 4 weeks and Monthly x 2 months. Audit results will be brought to QAPI committee for further recommendations 5. Date of completion? 5/21/25 initiated		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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:	F 881			6/11/25

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F 881	Continued From page 19 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive assessment for continued use of antibiotics for 1 of 3 sampled residents (R16) reviewed for antibiotic stewardship. Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an "antibiotic time-out [ATO]". Review of Monthly Infection Summary reports from December 2024 through March 2025 identified the columns for resident's name, infection date, date symptoms resolved, infection, medication, source of the infection and if the criteria was met.	F 881	F881 (SS=D) Based on interview and document review the facility failed to complete a comprehensive assessment for continued use of antibiotics for 1 of 3 residents (F16) reviewed for antibiotic stewardship. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. The identified resident (R16'S) antibiotic usage was reviewed by DNS. UA and Culture were obtained and reviewed by DNS. Education provided to nursing staff 6/10/25 to alert Infection preventionist of any antibiotic starts. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have the potential to be affected by this deficient practice. All residents currently receiving antibiotics were reviewed by the DNS/IP to ensure appropriate indication and monitoring. Completed 5/22/25 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? To ensure systemic changes are		

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F 881	Continued From page 20 May 2025 infection control log identified R16 had been prescribed Bactrim sulfamethoxazole-trimethoprim (antibiotic medication) 800-160 milligrams (mg) for 7 days for a urinary tract infection (UTI). The onset of the infection occurred on 5/1/25 and had met criteria for the continuation of use. R16's current, undated diagnosis sheet identified R16 had a diagnoses of urinary tract infection (UTI) and sepsis (infection of tissues and organs). R16's, May 2025 Medication Record identified R16 had taken the Bactrim 800-160mg, one tablet twice a day from 5/02/25 to 5/09/25. R16's, progress note identified, on: 1)4/30/25 at 11:06 a.m., identified R16 arrived at the facility from an appointment with orders to start Bactrim medication therapy for UTI. 2)5/02/25 at 19:14 p.m., identified Bactrim was prescribed by R16's physician. 3)5/9/25 at 14:50 p.m., identified R16 had completed the antibiotic therapy with no adverse effects. R16's medical record lacked evidence of an ATO after the initiation of the Bactrim therapy between 48-72 hours after initiation. Interview on 5/19/25 at 3:50 p.m., with director of nursing (DON) identified R16 did not exhibit any signs or symptoms according to McGreer's (infection surveillance tool criteria) the facility normally would use to begin an evaluation for potential infection. Since R16 had shown no signs or symptoms while living at the facility and had only received the medication as a result of a physician outpatient visit at the clinic, the facility	F 881	sustained, the DNS/IP or designees will review and follow GSS antibiotic stewardship program protocols, utilize GSS standardized tracking tool : The infection and Antimicrobial Tracking tool, established criteria for antibiotic use review. Licensed nursing staff were educated by DNS on antibiotic stewardship plan, monitoring requirements, documentation expectations and communication protocols 6/10/25. Any initiation of antibiotics is to be communicated to DNS/IP to endure appropriate indication and monitoring is completed. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? To ensure compliance, the DNS/Infection Preventionist or designee will audit all new antibiotic orders weekly for 4 weeks, then monthly for 2 months. Audit results will be brought to the monthly QAPI committee for further recommendations. 5. Date of completion? 5/21/25 initiated		

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F 881	Continued From page 21 had not performed an ATO as would be the normal process. The DON agreed the facility was responsible for ensuring antibiotic stewardship, even if a medication was not initiated or ordered by the facility staff or attending physicians. Review of January 2025 Identification and Reporting of Suspected Infection AL, R/S, LTC, Home Health, Hospice policy identified the nurse manager, or infection preventionist (IP) was to identify infections, collect data related to the infection, record indication of use of antibiotic therapy, and maintain infection surveillance on a continued basis.			F 881			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza			F 883			6/11/25

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F 883	Continued From page 22 immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 5 sampled residents (R7) was offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC).	F 883			
			F883 (SS=D) Based on interview and document review, the facility failed to ensure 1 of 5 sampled residents (R7) was offered and/or provided updated vaccinations for pneumococcal disease, in accordance		

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F 883	Continued From page 23 Findings include: Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV 21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV 21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV 21) at any age and a PPSV23 at or after the age of 65 years old. R7's 5/05/25, 5-day Minimum Data Set (MDS) identified R7 was 98 years old and had a diagnoses of diabetes, heart failure and pneumonia. Section O-Special Treatments and Programs identified R7 was reported to be up to date with the pneumococcal vaccine (PCV). R7's current, undated immunization report indicated R7 had received PCV 13 on 3/17/15 and PPSV-23 on 3/17/09. R7's 4/15/25, Vaccine Consent form identified R7 consented for an updated PCV dose. Interview on 5/19/25 at 4:08 p.m., with registered nurse (NA)-A and director of nursing (DON) voiced in agreement that R7 had not received the PCV vaccine after the consent was obtained. Review of November 2024 Immunizations/Vaccinations for Residents, Pneumococcal influenza, COVID-19, Other AL, R/S, LTC, HBS-Enterprise policy identified the	F 883	with Centers for Disease Control (CDC) 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice. Immediate education was provided to the Infection Control Nurse. Consultant Pharmacist (Lewis Drug) administered PCV 20 on 6/2/25. Consultant available on Mondays to administer immunizations. This was the next available day due to Memorial Holiday. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? Potential to affect any new admissions or those that come into the time frame of meeting Centers for Disease Control: Pneumococcal Vaccine recommendations. DNS audited all residents' immunization records 5/22/25 and determined all current residents have been offered eligible immunizations and have received or declined those immunizations. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? All new admissions will have medical record and or MIIC reviewed for eligible immunizations at time of admission by DNS/IP. Residents/POA will be given VIS information and offered said immunizations. GSS#691 Vaccine consent form multiple vaccines will be		

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F 883	Continued From page 24 facility was to provide residents with the PCV, per Centers for Disease Control and Prevention guidelines.	F 883	signed for consent or decline. Lewis Drug will be notified of request and immunization to be given on next available date. Mondays have been set up with Lewis Drug for Consultant to come and give any immunizations. Infection Prevention Nurse was educated on our Policy and Procedure for Resident Vaccinations by DNS 5/21/25. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or Designee will audit all new admissions weekly x 4 and Monthly x 2 that they were offered eligible immunizations and have signed for consent or have declined. The audit will include date resident received immunization. Audit results will be reported to QAPI committee for further recommendations. 5. Date of completion? 5/22/25 initiated		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/20/2025. 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.			K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/16/2025

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 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 The facility has a capacity of 71 beds and had a census of 60 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by:			K 000			

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K 291 K 291 SS=F	Continued From page 2 Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 at 10:49 AM , it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested annually for 90 minutes within the last year. This deficient finding was confirmed by the Supervisor of Ancillary Services at the time of discovery.	K 291 K 291	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 federal and state law. For the purpose of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the state operations manual. K 291 Emergency Lighting 1. By 06-24-25 all emergency lights will have the required annual 90-minute test of the emergency lighting completed. 2. The maintenance staff will be educated on the compliance for battery powered emergency lighting on (insert date). 3. The Maintenance Director/Designee will conduct inspections to ensure that all emergency lights are tested to meet NFPA regulations.	6/24/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025																
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K 291	Continued From page 3	K 291																			
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 <table><tr><td>Area</td><td>Automatic Sprinkler</td></tr><tr><td colspan="2">Separation N/A</td></tr><tr><td colspan="2">a. Boiler and Fuel-Fired Heater Rooms</td></tr><tr><td colspan="2">b. Laundries (larger than 100 square feet)</td></tr><tr><td colspan="2">c. Repair, Maintenance, and Paint Shops</td></tr><tr><td colspan="2">d. Soiled Linen Rooms (exceeding 64 gallons)</td></tr><tr><td colspan="2">e. Trash Collection Rooms (exceeding 64 gallons)</td></tr><tr><td colspan="2">f. Combustible Storage Rooms/Spaces</td></tr></table>	Area	Automatic Sprinkler	Separation N/A		a. Boiler and Fuel-Fired Heater Rooms		b. Laundries (larger than 100 square feet)		c. Repair, Maintenance, and Paint Shops		d. Soiled Linen Rooms (exceeding 64 gallons)		e. Trash Collection Rooms (exceeding 64 gallons)		f. Combustible Storage Rooms/Spaces		K 321	4. The Maintenance Manager or designee will complete audits of emergency lighting weekly x 4, monthly x 2 and quarterly x 2. Audits will be monitored on the TELs system for compliance and will report the results to the Monthly QAPI committee for review. 5. Date of Substantial Compliance 06/24/25.	6/30/25	
Area	Automatic Sprinkler																				
Separation N/A																					
a. Boiler and Fuel-Fired Heater Rooms																					
b. Laundries (larger than 100 square feet)																					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 321	Continued From page 4 (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.6.3.5. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 05/20/2025 at 11:46 AM, it was revealed by observation that vacant resident rooms were being used to store combustible items and did not have a self-closing device on the door in the 200 wing. This deficient finding was confirmed by the Supervisor of Ancillary Services at the time of discovery.	K 321	K321 Hazardous Areas 1. By 06/30/25 all hazardous areas will be fit with closures to meet NFPA requirements. 2. The maintenance staff will be educated on the compliance of hazardous areas on (insert date) 3. The Maintenance Director/Designee will conduct inspections to ensure that all hazardous areas are checked to meet NFPA regulations. 4. The Maintenance Manager or designee will complete audits of hazardous areas weekly x 4, monthly x 2 and quarterly x 2. Audits will be monitored on the TELs system for compliance and will report the results to the Monthly QAPI committee for review. 5. Date of Substantial Compliance 06/30/25.		
K 325 SS=F	Alcohol Based Hand Rub Dispenser (ABHR) CFR(s): NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of	K 325		6/17/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 325	Continued From page 5 fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install Alcohol Based Hand Rub (ABHR) in accordance with the requirements of NFPA 101, section 19.3.2.6.8. These deficient findings could have a widespread impact on the residents. Findings include: 1. On 05/20/25 at 12:15 PM, it was revealed by observation that ABHR dispensers were installed directly above electrical switches in resident rooms in the 400 wing. 2. On 05/20/25 at 12:27 PM, it was revealed by observation that ABHR dispensers were installed directly above electrical switches in resident rooms in the 500 wing. These deficient findings were confirmed by the Supervisor of Ancillary Services at the time of discovery.	K 325	K325 Alcohol Base Hand Rub Dispensers (ABHR) 1. By 06/17/25 all alcohol-based hand dispensers will be adjusted to meet NFPA requirements. 2. The maintenance staff will be educated on the compliance for alcohol-based hand sanitizer dispensers on (insert date) 3. The Maintenance Director/Designee will conduct inspections to ensure that all alcohol-based hand sanitizers dispensers are installed to meet NFPA regulations. 4. The Maintenance Manager or designee will complete audits of alcohol-based hand sanitizer dispensers weekly x 4, monthly x 2 and quarterly x 2. Audits will be monitored on the TELs system for compliance and will report the results to the Monthly QAPI committee for review. 5. Date of Substantial Compliance		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164		
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K 325	Continued From page 6	K 325			
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain their sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.1.1 and 9.7.5, NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 4.3, 4.4, 4.7 and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 26.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include:	K 353	06/17/25		6/13/25
			K353 Fire sprinklers 1. By 06/13/25 all sprinkler heads will be inspected to meet NFPA requirements. 2. The maintenance staff will be educated on the compliance with fire sprinkler requirements on (insert date) 3. The Maintenance Director/Designee will conduct inspections of fire sprinkler systems to meet NFPA regulations. 4. The Maintenance Manager or designee will complete audits of the fire sprinkler systems weekly x 4, monthly x 2 and quarterly x 2. Audits will be monitored		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 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	
K 353	Continued From page 7 1. On 05/20/2025 at 10:45 AM, it was revealed by a review of available documentation that the facility could not provide current documentation for an annual sprinkler inspection. 2. On 05/20/2025 at 12:35, it was revealed by a observation that the sprinkler heads in the dishwashing area were covered in dust. These deficient findings were confirmed by the Supervisor of Ancillary Services at the time of discovery.	K 353	on the TELs system for compliance and will report the results to the Monthly QAPI committee for review. 5. Date of Substantial Compliance 06/13/25		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates	K 363		6/27/25	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2025	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164			
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K 363	Continued From page 8 of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 05/20/2025 at 12:17 PM, it was revealed by observation that the door to resident room 406 would not latch. This deficient finding was confirmed by the Supervisor of Ancillary Services at the time of discovery.			K 363	K 363 Corridors 1. By 06/27/25 all corridor doors will be adjusted to meet NFPA requirements. 2. The maintenance staff will be educated on the compliance for corridor doors on (insert date) 3. The Maintenance Director/Designee will conduct inspections of corridor doors to meet NFPA regulations. 4. The Maintenance Manager or designee will complete audits of the corridor doors weekly x 4, monthly x 2 and quarterly x 2. Audits will be monitored on the TELs system for compliance and will report the results to the Monthly QAPI committee for review. 5. Date of Substantial Compliance 06/27/25		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245591	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 5/20/2025
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 920	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 05/20/2025 at 11:49 AM, it was revealed by observation that a air conditioner was plugged into a power strip in the case managers office in the 200 wing. The Supervisor of Ancillary Services removed this deficient practice at the time of discovery. 2. On 05/20/2025 at 12:21 PM, it was revealed by observation that a microwave and refrigerator were plugged into a power strip in the Therapy room located in the 500 wing. The Supervisor of Ancillary Services removed this deficient practice at the time of discovery. These deficient findings were confirmed by the Supervisor of Ancillary Services at the time of discovery.			

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

The above isolated deficiencies pose no actual harm to the residents



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 10, 2025

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

RE: CCN: 245591
Cycle Start Date: May 21, 2025

Dear Administrator:

On July 7, 2025, 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.

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 10, 2025

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

Re: Reinspection Results
Event ID: E81W12

Dear Administrator:

On July 2, 2025 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 21, 2025. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'M. Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us