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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: H3YY
Facility ID: 00455

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245591**

2. STATE VENDOR OR MEDICAID NO. (L2) **108042300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - PIPESTONE**
(L4) **1311 NORTH HIAWATHA**
(L5) **PIPESTONE, MN** (L6) **56164**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **6/24/2016** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

FISCAL YEAR ENDING DATE: (L35) **09/30**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 7/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 7/11/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245591

July 11, 2016

Mr. Michael Feltes, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

Dear Mr. Feltes:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 21, 2016 the above facility is certified for:

94 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 94 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 11, 2016

Mr. Michael Feltes, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

RE: Project Number S5591026

Dear Mr. Feltes:

On May 23, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 12, 2016. This survey found the most serious deficiencies to bea pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 24, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 30, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 12, 2016, effective NO DATA and therefore remedies outlined in our letter to you dated May 23, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245591		6/24/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 06/21/2016	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 06/21/2016	ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 06/21/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KS/kfd	DATE 7/11/2016	SIGNATURE OF SURVEYOR 03048	DATE 6/24/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245591	A. Building 01 - MAIN BUILDING 01 B. Wing	6/30/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 06/21/2016	ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 06/21/2016	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 06/21/2016
ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 06/21/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 7/11/2016	SIGNATURE OF SURVEYOR 35482	DATE 6/30/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 5/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: H3YY

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00455

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245591**

2. STATE VENDOR OR MEDICAID NO. (L2) **108042300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - PIPESTONE**
(L4) **1311 NORTH HIAWATHA**
(L5) **PIPESTONE, MN** (L6) **56164**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/12/2016** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **94** (L18)

13.Total Certified Beds **94** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	94			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Holly Kranz, HFE NE II 06/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/22/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 23, 2016

Mr. Michael Feltes, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

RE: Project Number S5591026

Dear Mr. Feltes:

On May 12, 2016, a standard 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

> <u>Informal Dispute Resolution</u> - **your right to request an informal reconsideration to dispute the attached deficiencies.**

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 21, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 12, 2016 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. 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.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, 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:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		6/21/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/02/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a care plan was developed for 1 of 3 residents (R110) reviewed for pressure ulcers. Findings include: R110 was admitted on 4/12/16. The diagnoses noted from the physician history and physical dated 4/14/16, included: musculoskeletal weakness, paraplegia (one sided weakness), sacral sore and pain. The Minimum Data Set (MDS) assessment Care Area Assessment (CAA) worksheet dated 4/22/16, indicated R110 was admitted with a stage 2 pressure ulcer (PU) located on the coccyx (open area on buttocks). The CAA further indicated the pressure ulcer would be care planned for actual PU and risk for development. R110's Positioning Assessment and Evaluation dated 4/12/16, also indicated R110 has an open area to bottom. R110's Braden Scale for Predicting Pressure Sore Risk dated 4/12/16, indicated a mild risk for PU development with recommended intervention guide. R110's care plan initiated 4/12/16, does not include a focus area related to a pressure ulcer, areas of risk or interventions to promote healing of current PU and/or prevention of developing PU's.	F 279	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. On 5/12/2016 for resident R110 a pressure ulcer focus was developed in resident 's care plan along with appropriate interventions. 2.On 5/12/2016 all other residents who may have been affected by the deficiency were reviewed to ensure that care plan focus and appropriate goals and interventions were in place. For each resident who has a pressure ulcer at admission, a pressure ulcer focus will be developed upon admission and a repositioning schedule implemented by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 2 When interviewed on 5/12/16, at 9:01 a.m. registered nurse (RN)-B verified the PU was present upon admission and not been identified on the care plan, including identification, risks and interventions. RN-B developed the pressure ulcer care plan/interventions during the interview. The Pressure Ulcer Practice Guidelines, revised 12/15 indicated identified areas of risk should be identified and interventions care planned.	F 279	admitting nurse. The Director of Nursing or designee will also educate professional staff at meeting on 6/2/2016 on revised admission checklist. 3.To monitor and ensure that solutions are sustained, the Director of Nursing or designee will conduct audits of careplans for each resident admitted with a pressure ulcer as follows: one audit per week for four weeks and if compliant, monthly for the following three months. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care as directed for 1 of 2 residents (R 72) reviewed who was incontinent of bladder and did not receive timely toileting. Findings include: R72 was admitted with diagnoses obtained from the most recent plan of care dated 9/17/15, which included: Parkinson's disease, Type II diabetes, hypertension and edema.	F 282	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance	6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 Review of the most recent care plan dated 9/17/15, identified R72's needed to be toileted every (Q) two (2) hours(H) and as needed (PRN). The care plan further identified the potential for impairment to skin integrity related to moisture from bowel and bladder incontinence and pressure secondary to limited mobility. During an interview on 5/10/16, at 2:32 p.m. nursing assistant (NA)-B indicated R72 requires extensive assistance with toileting and is incontinent of bowel and bladder most of the time. NA-B further confirmed that R72 wears an incontinent brief and is toileted Q2H. During continuous observation on 5/11/16 from 7:00 a.m. until 9:58 a.m. (a time frame of two hours and 58 minutes) R72 remained seated in a wheelchair (w/c), and was transported by staff from the television/lounge area to the dining room and back to the lounge area. R72 was not assisted to toilet at any time. When interviewed on 5/11/16, at 9:27 a.m. NA-A verified R72 is toileted Q2H and is frequently incontinent of both bowel and bladder. At 9:58 a.m. NA-A reported that R72 was already up and dressed when she began her shift and as a result she was not aware of the time R72 had last been toileted. NA-A then transported R72 into the tub room via the w/c where he was transferred onto the toilet. R72 voided a large amount. NA-A indicated R72 was frequently incontinent of bladder when toileted on the 2 hours schedule. NA-A further indicated documentation of the most recent toileting of R72 would have been documented on the Kiosk (computer terminal for NA documentation). Review of documentation on	F 282	with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. On 5/11/2016 at 09:58, resident R72 was assisted to toilet and voided at that time. R72 toileting schedule is being followed according to plan of care. 2. For all other residents with scheduled toileting, their toileting schedule is being followed, according to care plans. Education will also be provided to the nursing assistants during the CNA skills fair June 6-10, 2016. At shift change, all residents with scheduled toileting will also have their last time of toileting communicated between shifts. 3. To monitor and ensure that solutions are sustained, the Director of Nursing or designee will conduct audits on toileting in accordance with plan of care for five residents weekly for four weeks and then two residents weekly for three weeks thereafter. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 4 the Kiosk with NA-A indicated R72 should have been toileted at 8:00 a.m. and was confirmed toileting had not occurred at that time and the last documented toileting time had been at 6:00 a.m. When interviewed on 5/11/16, at 12:59 p.m. registered nurse (RN)-B indicated R72's most recent Care Area Assessment (CAA) and care plan indicated R 72 was to be toileted on an Q2H during the day and Q3H during the night. RN-B further indicted the expectation was for toileting to be documented in the task section of the electronic record (Kiosk) each time if was completed. The physician progress note dated 3/24/16, indicated R 72 had a hydrocele which contributes to R72's inability to control bladder function. The most recent Minimal Data Set (MDS) assessment dated 4/7/16, also indicated R72 was frequently incontinent of bladder. This was verified by review of the bowel and bladder task sheets obtained from the task documentation.	F 282		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 5 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement procedures to minimize the spread of infection during a dressing change to a wound for 1 of 3 residents (R70) observed with pressure ulcers and failed to ensure urinary collection drainage bags were changed and stored in a sanitary manner for 2 of 2 residents (R110, R21) reviewed who utilize urinary collection bags. Findings include: On 5/11/16, at 7:45 a.m. registered nurse (RN)-A	F 441	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 6 was observed to apply a dressing to R70's left buttock/sacrum wound. R70 had been identified in the medical record to have a stage 3 pressure ulcer to the left buttock/sacral area. R70 had just had a bath and it was noted that clear fluid was draining from the wound. RN-A proceeded to place a tube of Santyl (collagenase) ointment inside the wound and squeezed the ointment throughout the wound bed. Clear fluid continued to drain from the wound. The tip of the tube along with the edges of the tube, touched the inside of the wound bed during the application of the ointment (the tube had not been cleaned after the application). RN-A then proceeded to pack the wound with gauze and covered the wound with an ABD pad. When interviewed on 5/11/16, at 8:00 a.m. RN-A indicated that by using the Santyl ointment in a tube application, it worked better for wound coverage. RN-A further indicated the clear fluid draining from R70's wound bed was water retained after her morning bath. When interviewed on 5/11/16, at 9:00 a.m. the director of nursing (DON) confirmed RN-A had not followed facility practices/policies for wound care related to infection control practices and would require-re-education. The DON indicated all nursing staff have had annual training on infection control procedures and practices Review of the facility policy/procedure for Wound Dressing Change, revised 5/16, indicated the purpose of the procedure is to promote wound healing and for wounds to remain free of infection. The steps included; to cleanse the wound thoroughly with normal saline using gauze wipes, wound cleanser or ordered antiseptic	F 441	this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. According to the deficiency statement, the facility (a) failed to implement infection control practices for 1 of 1 resident during a dressing change to a wound and (b) failed to ensure the urinary collection drainage bags were changed and stored in a sanitary manner for 2 of 2 residents. On 5/11/2016 for Resident R70 the Director of Nursing along with RN-A discarded Santyl Tube that was contaminated, the Director of Nursing re-educated RN-A on correct wound dressing change procedure, and then proceeded to clean and redress wound in a manner that minimized the spread of infection through use of a new tube of Santyl. On 5/9/2016 for R110, the Director of Nursing replaced leg bag for resident and reinforced education with NA-C. On 5/11/2016 for Resident R21, the Director of Nursing replaced overnight bag and obtained sterile cups for storage of urinary collection drainage bag caps for both R110 and R21. In addition, education was placed in the staff communication book on 5/11/2016. 2. (a) For all residents who have a wound with dressing change, appropriate infection control practices have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7	F 441		

solution. Allow the skin to dry completely before applying the dressing.

R110 had diagnoses listed on the face sheet which included: neuromuscular dysfunction of the bladder (unable to empty bladder on own) and required the use of a urinary drainage collection bag at night and a leg drainage bag during the day.

On 5/9/16, at 7:07 p.m. nursing assistant (NA)-C was observed to provide evening cares for R110 which included changing the urinary leg bag system from daytime use to the night time urinary collection bag. NA-C obtained the overnight urine collection bag from the bottom drawer of a night stand located in the bathroom. It was noted to be stored in the drawer without a cap over the connector tip of the catheter. NA-C disconnected the leg bag and laid it directly on the bedroom floor with the connector tip touching the floor (the end that goes into the catheter tubing which goes directly into the bladder). NA-C proceeded to clean the connector tip with an alcohol wipe, connect the overnight collection bag to the urinary catheter and then transported the leg bag into the bathroom. NA-C stored the leg bag directly on the floor with the connector tip touching the floor. The connector tip was then wiped with an alcohol wipe, instilled vinegar and water (per facility protocol) and hung the leg bag over a bar in the bathroom. The connector tip was not capped.

When interviewed on 5/09/16, at 7:20 p.m. NA-C indicated they usually don't have caps for the catheter connector ends stating, "There never seems to be a cap for these when we get new bags".

implemented in order to minimize the spread of infection. (b) For all residents who have catheters that utilize leg bags during the day and bed bags at night, proper infection control practices for storage and changing of urinary collection drainage bags have been implemented. Education will be provided by the Infection Control Preventionist or designee to nurses at professional staff meeting on 6/2/2016 regarding the proper wound dressing change procedure. Sanitary storage and changing of urinary drainage bags will be provided to nursing assistants by the Infection Preventionist or designeee during the CNA skills fair June 6-10, 2016 and to professional staff at the 6/2/2016 professional staff meeting. Plastic containers will be provided to all residents with catheters to store their supplies in as well.

3. To monitor and ensure that solutions are sustained, the Infection Control Preventionist or designee will conduct audits of (a) wound changes once per week for four weeks and if in compliance, once per month for three months and (b) urinary collection drainage bag and storage once per week for four weeks and if in compliance, one per month for three months. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8 When interviewed on 5/09/16, at 7:29 p.m. the director of nursing (DON) and registered nurse (RN)-A verified the connector tip should never touch the floor. They both observed the above urinary drainage bag and further verified it was not stored in a sanitary and appropriate manner. The DON replaced the leg bag. R21 had diagnoses listed on the face sheet which included: obstructive and reflux uropathy (blockage of urethra) and required the use of a urinary drainage collection bag at night and a leg drainage bag during the day. During an observation and interview on 5/11/16, at 11:37 a.m. the DON verified the catheter for R110 was laid loose in the bottom drawer of the night stand with the connector tip touching the inside of the drawer (uncapped). In addition, the DON observed R21's overnight urine collection bag hung on the inside of the cabinet storage door in the bathroom. The urinary tubing was coiled and the connector tip was exposed to the back of cabinet and other items in the cabinet. The collection bag contained approximately 20 millimeters (ml) of bloody urine. The DON further verified the urinary collection bag had not been rinsed with vinegar and water per facility protocol. Upon further interview on 5/11/16, at 11:41 a.m. the DON indicated the urinary collection bags had not been stored appropriately when not in use; stating, "I'm disappointed". The DON confirmed she was unaware that staff had improperly stored these items. The DON indicated these items will be stored in a sanitary manner from now on. The procedure titled Leg Bags for Catheter Drainage directed the following: (6) After wiping	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING ______ B. WING ______	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9 cap with alcohol pad, disconnect catheter and drainage tubing and do not allow ends to touch anything; (7) Place cap over the end of the drainage tubing. Do not let drainage tubing touch floor; (8) Store cap in designated bag or container; and (11 a. & b) Wash bag (leg bag and straight catheter bag) with vinegar and water solution or an appropriate commercial solution. The procedure did not direct how to store the drainage bags when not in use.	F 441		

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

F5591025

PRINTED: 06/07/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING 01 - **MAIN BUILDING 01** B. WING	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 11, 2016. At the time of this survey, Good Samaritan Society Pipestone was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 06/02/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Pipestone is a one-story building with no basement. The original building was constructed in 1971, with one building addition constructed in 1976, and both were determined to be of Type II (000) construction. The 1991 and 1999 building additions were determined to be of Type II (111) construction. The entire facility is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 94 beds and had a census of 79 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and	K 025		6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on May 11, 2016, between the hours of 11:30 AM and 3:00 PM, observation revealed that the smoke barrier in the 300 Wing near the Patio Door has a penetration around some cables above the lay-in ceiling. Also, it was observed that above the lay-in ceiling the smoke barrier at the entrance to the 200 Wing has some fire proof caulking that has dried and has pulled away from around some cables causing a penetration.open penetrations around cables were observed above the lay-in ceiling on the North Wing Smoke Barrier. This was also observed by the Facility Maintenance Director.	K 025	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. On 5/27/2016, the penetrations in the 300 wing near the patio door as observed by the fire marshal were repaired by the Facility Maintenance Director so that there is no longer any penetration around the cables above the lay-in ceiling. On 5/27/2016, new fire caulk was applied by the Facility Maintenance Director above the lay-in ceiling/smoke barrier at the entrance to the 200 wing that had dried caulk around some of the cables. On	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING **01 - MAIN BUILDING 01** B. WING ___	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 3	K 025	5/27/2016, the penetrations around the cables above the lay-in ceiling on the North Wing Smoke Barrier were sealed with new fire caulk by the Facility Maintenance Director. 2. The Facility Maintenance Director has checked and verified all fire walls and made sure that all penetrations have been sealed appropriately with fire rated caulk. 3. To monitor performance and ensure that solutions are sustained, the Facility Maintenance Director or designee will conduct monthly audits of fire penetrations x 6 months. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: One hour fire rated construction (with o hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 4 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 FINDINGS INCLUDE: During Facility Inspection on May 11, 2016, between 11:30 AM and 3:00 PM, observation during the inspection revealed the following discrepancies with Hazardous Areas: a.) Mechanical Room #25 in the 100 Wing has a penetration in wall above the door. b.) The Soiled Utility Room door in the 100 Wing does not latch into the door frame when closed. c.) The new Storage Room (Nurse Conference Room) door in the 300 Wing has a door without a self-closing device and the door has two penetrations through the door. This Storage Room exceeds 50 sq. ft. NOTE: All Hazardous Areas need to be checked to ensure compliance. These deficient practices were observed by the Facility Maintenance Director.	K 029	correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. Mechanical Room #25 in the 100 wing no longer has a penetration in the wall above the door as it has been sheet rocked and taped by facility maintenance technician on 5/20/2016. The Soiled Utility Room door in the 100 wing has been fixed by the Facility Maintenance Director on 5/18/2016 so that it does now latch into the door frame when closed. The New Storage Room (Nurse Conference Room) door in the 300 Wing had a self-closing device installed on it on 5/23/2016 and a new lockset was installed on 5/18/2016 by the Facility Maintenance Director so that there are no penetrations through the door. 2. For all storage room doors in the facility, which in total is 16 doors, the facility maintenance supervisor has checked and verified on 5/23/2016 that they do not have any penetrations through the doors and if they exceed 50 sq. ft, a proper self-closing device is in place and operating correctly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 5	K 029	3. To monitor performance and ensure that solutions are sustained, the Facility Maintenance Director or designee will a) Record monthly x 6 months any outside contractor work that has been completed in the facility that takes place on a smoke barrier wall and make sure that penetrations are filled with fire rated caulk, b) Conduct monthly audits x 6 months on all soiled utility room doors to ensure that they latch into the door frame when closed and c) Conduct monthly audits x 6 months that all storage room doors do not have penetrations through them and self-closing devices on rooms over 50 sq ft. are operating correctly. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper	K 056	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 6 switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 FINDINGS INCLUDE: During Facility Inspection on May 11, 2016, between 11:30 AM and 3:00 PM, observation during the inspection revealed 3 fire sprinkler escutcheon plates missing on sprinklers in the 100 Wing. This deficient practice was observed by the Facility Maintenance Director.	K 056	alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. The 3 fire sprinkler escutcheon plates missing on the sprinklers in the 100 wing as observed by the fire marshal were ordered on 5/17/2016 and installed on 5/31/2016 by the Facility Maintenance Director. 2. The Facility Maintenance Director checked and verified on 5/27/2016 that all sprinkler heads on all 5 hallways in facility have fire sprinkler escutcheon plates in place. 3. To monitor performance and ensure that solutions are sustained, the Facility Maintenance Director or designee will conduct monthly audits x 6 months of all five hallways to ensure that every fire sprinkler head has an escutcheon plate in place. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 FINDINGS INCLUDE: During the Facility Inspection on May 11, 2016, between the hours of 11:30 AM and 3:00 PM, an extension cord was observed in the Chapel being used as a source of fixed wiring. This deficient practice was observed by the Facility Maintenance Director.	K 147	Statement of Compliance: Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of state and federal law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. This plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements. 1. The extension cord in the Chapel being used as a source of fixed wiring has been removed on 5/11/2016 by the Facility Maintenance Director. 2. The Facility Maintenance Director checked and verified on 5/12/2016 that no extension cords are being used as a source of fixed wiring in any of the facility common areas. 3. To monitor and ensure that solutions are sustained, the Facility Maintenance	6/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245591	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**05/11/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - PIPESTONE	**1311 NORTH HIAWATHA** **PIPESTONE, MN 56164**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 8	K 147	Director or designee will conduct monthly audits x 6 months of all common areas (Chapel, Activity Room, 100/300 lounge, 500 lounge, 200 lounge, Dining Room) to make sure that extension cords are not being used as a source of fixed wiring. The results will be reported and reviewed at monthly quality committee meeting for further review and recommendation.	