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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M5W1

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: **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 **06/19/2014** (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:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

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):
Post certification revisit (PCR) of Health and Life Safety Code Surveys completed on June 19, 2014. Refer to CMS form 2567B.

17. SURVEYOR SIGNATURE Date :
Pamela Manzke, HFE NE II 06/20/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/20/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
06/13/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245591

June 20, 2014

Mr. Joshua Hofmeyer, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, Minnesota 56164

Dear Mr. Hofmeyer:

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 May 31, 2014 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
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 20, 2014

Mr. Joshua Hofmeyer, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, Minnesota 56164

RE: Project Number S5591024

Dear Mr. Hofmeyer:

On May 16, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 1, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 19, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 10, 2014 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 1, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 1, 2014, effective May 31, 2014 and therefore remedies outlined in our letter to you dated May 16, 2014, 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.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245591	A. Building B. Wing	6/19/2014

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/31/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/31/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/31/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/31/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/31/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/31/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/30/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	06/20/2014	32978	06/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/1/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245591	A. Building 01 - MAIN BUILDING 01 B. Wing	6/10/2014

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).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	05/31/2014	ID Prefix Reg. # NFPA 101 LSC K0050	05/31/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/KFD	**Date:** 06/20/2014	**Signature of Surveyor:** 22373	**Date:** 06/10/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 5/1/2014		**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

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: M5W1

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 **05/01/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 05/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/11/2014 (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
Posted 06/10/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5591

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 16, 2014

Mr. Joshua Hofmeyer, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, Minnesota 56164

RE: Project Number S5591024

Dear Mr. Hofmeyer:

On May 1, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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

Informal Dispute Resolution - 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
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158 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 10, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 10, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 1, 2014 (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 1, 2014 (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
Division of Compliance Monitoring
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 electronic 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
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 _____	05/01/2014

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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 6 residents (R3) had been assessed for their safety to self administer medications, and failed to ensure their was a physician's order to self administer medications. Findings Include: During observation of medication administration on 04/30/14, at 7:32 a.m., trained medication assistant (TMA)-A was observed to administer medications to R3 while seated in the main dining room. TMA was observed to prepare the following medications for administration: levothyroxine 150	F 176	Response for F176: 1. Resident 3 had a self-administration assessment by the interdisciplinary team for medications completed on May 14, 2014, and was deemed safe at that time to self-administer medications. The physician was faxed and we received a signed physician order that the resident may self-administer Zyrtec. 2. The facility□s interdisciplinary team will review any requests made by residents to have a self-administration	5/31/14

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

Electronically Signed | 05/21/2014

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 _____	05/01/2014

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F 176	Continued From page 1 micrograms (mcg), furosemide 20 milligrams (mg), Verapamil 240 mg, metoprolol 100 mg, Losartan 50-12.5 mg, Fiber tab 1250 mg and docusate sodium 100 mg. TMA-A was observed to check R3's pulse as directed by physician orders prior to administering the medications and then left the medications on the dining room table in front of R3. TMA-A stated to the surveyor that R3 liked to take her medications at her own time preference and that was why she had left the medications on the table. TMA-A stated she would maintain observation of R3 to ensure she took the medications. At 7:44 a.m. TMA-A walked to a different table and administered medications to another resident. TMA-A was observed to have her back to R3 and was unable to visualize R3 from her position. The medications were observed to remain on R3's table until 7:54 a.m. at which time R3 was observed to self-administer the medications. During interview with TMA-A on 4/30/14, at 7:58 a.m. TMA-A verbalized R3 was able to take her medications and liked to have them left at her table so that she could take them as she ate. TMA-A stated R3 did not have a problem with taking her medications independently. On 5/1/14, at 10:00 a.m. R3's medical record was reviewed and failed to include an assessment for self-administration of medications and further lacked physician orders for self-administration of medications. On 5/1/14, at 10:40 a.m. the Director of Nursing (DON) was interviewed and verified R3 did not have physician orders or a self-administration assessment in her medical record. The DON further stated that medications should not have	F 176	order for medications and deem whether or not they are safe through the assessment process. Trained Medication Aides who complete the medication passes have been educated on this procedure and the importance of notifying the resident□s Nurse Manager if the resident is showing the desire or expressing the want to self-administer medications. This education was provided to the Professional Nurses on May 1, 2014, and to the Trained Medication Aides on May 13, 2014. All current residents who self-administer drugs have been reviewed to ensure physician order and self-administration assessment has been completed. 3. The policy and procedure for Self-Administration of medications was reviewed at the Trained Medication Aide meeting on May 13, 2014. This was also reviewed with the Professional Nurses at the meeting on May 1, 2014. 4. Audits will be done by the Director of Nursing or designee to observe compliance with the self-administration of medications policy and procedure. These audits will be completed weekly for a month and then monthly for two months. Audit findings will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	

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F 176	Continued From page 2 been left sitting on the table since R3 did not have an assessment identifying she could safely self administer medications. The DON stated that if a medication was being left at the table staff were responsible to keep the resident in view at all times to ensure the medication was taken by the resident. During review of the Good Samaritan Society (GSS) Policy for medication administration, revised 01/2011, included: "Purpose: a. To determine if the resident can safely self-administer medication and to assist the resident who is self-administering medications. b. To manage his or her prescribed medications in a safe manner. c. To provide residents who can do so safely with the opportunity to self-administer medications. Procedure: a. The interdisciplinary team must make a determination for each resident who expresses a desire to self-administer medications if the resident can do this safely. b. It is recommended that any resident teaching be documented on the interdisciplinary teaching record (GSS#217). This document was not found in medical record by surveyor or DON. c. The interdisciplinary team will determine the location where the medication will be self-administered. Medication cannot be left in common areas by nurses or residents (e.g.; at a dining room table). d. A physician's order must be obtained prior to the resident self-administering medications. The order must be specific to the medications being self-administered."	F 176		

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F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in a dignified manner during the breakfast meal on 4/30/14, for 4 of 18 residents (R113, R65, R70, R30) who failed to receive food service in a manner that promoted dignity. Findings include: R113's admission Minimum Data Set (MDS) dated 2/6/14, identified R113 had severe cognitive impairment and required extensive assistance with eating. In addition, the MDS identified R113 had a diagnosis of Alzheimer's disease and dementia. During continuous observation of breakfast in the main dining room on 4/30/14, at 7:53 a.m. R113 was assisted to her table in the dining room by the nursing assistant (NA)-E, who placed a glass of juice on the table in front of her, and walked away. NA-E made no attempts to assist R113 to drink, nor did R113 attempt to consume the juice. At 7:59 a.m. R113 looked around the dining room, leaned her head to her left side and closed her eyes. At 8:41 a.m. R113 continued to sit at the table without being offered assistance with her food or fluids. During this time, five staff persons were noted to be circulating throughout the dining	F 241	Response for F241: 1. Residents 113, 65, 70, 30 and all other residents in the assisted area are receiving services in a dignified manner during all meal times. 2. All residents are receiving care in a dignified manner and per their individual care plans. 3. Education was provided to all employees on May 8, 2014, and again to CNA□s and Trained Medication Aides on May 13, 2014, as to the importance of maintaining a dignified environment for all residents who are cared for. All residents will receive meals in a dignified manner. 4. Audits will be done by the Director of Nursing or designee to observe compliance that residents are not being placed in the dining room without food or beverage being offered in a timely manner that maintains a dignified environment. These audits will be completed weekly for a month and then monthly for two months. Audit findings will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for	5/31/14

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F 241	Continued From page 4 room assisting other residents. At 8:50 a.m. NA-E served R113 her breakfast and at 8:51 a.m. NA-E sat between R113 and her tablemate R65, and assisted R65 to eat. She then proceeded to roll around the dining table (on wheeled stool) to assist R30 and R70. NA-E made no attempts to assist R113 to eat, and R113 continued to sit at the table without assistance until 8:54 a.m. At 8:54 a.m. NA-E looked at R113 and asked, "Are you hungry?" R113 did not respond and continued to sit with her head leaning to the left. NA-E continued to assist other residents at R113's table; however R113 was not offered assistance to eat her food or drink her fluids and made no attempts to eat herself. At 9:03 a.m. (1 hour and 10 minutes after seated at the table) NA-E began to assist R113 with her food. At times during this period resident was observed to open eyes and look around room at other residents being served and eatting. During interview on 4/30/2014 at 8:37 a.m. dietary (D)-A stated, staff have a row they work with and they attempt to serve residents as they come into dining room. During interview on 5/1/14 10:00 a.m. the director of nursing (DON) stated there policy is that residents brought to the dining room by staff are served and assisted within 30 minutes at a maximum. At time only one NA could assist four residents at one table if one or two of the residents were able to feed themselves or needed minimal assistance/prompting. If more residents need assistance with eating at one table, then another person would need to assist at that table.	F 241	further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	
F 282	483.20(k)(3)(ii) SERVICES BY QUALIFIED	F 282		5/31/14

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F 282 SS=D	Continued From page 5 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 provide services as directed by the plan of care for 1 of 3 residents (R113) who had a history of pressure ulcers and 1 of 3 residents (R113) who was reviewed for incontinence. Findings include: POSITIONING R113's Care Plan, dated 4/23/14, identified a problem with potential impairment to skin integrity related to immobility evidenced by a history of a pressure ulcer to her to medial left heel region. The interventions included: education to family and resident of causative factors and measures to prevent skin injury; monitor location, size and treatment of skin injury; report abnormalities; monitor for signs and symptoms of infection, maceration, to R113's healthcare provider. The care plan further identified staff would reduce R113's risk factor for pressure ulcer development by repositioning her every two hours. During observation on 04/30/14 at 7:08 a.m. R113 was seated in her geri-chair in the small dayroom near the 200 wing nurses station. R113 remained seated in her geri-chair until 7:53 a.m.	F 282	Response for F282: 1. Resident 113□s Care Plan was reviewed and updated by the resident□s Nurse Manager to reflect repositioning every two hours and check and change for incontinence every two hours. This was updated on the Kiosk for the CNA□s to view and document cares provided. 2. All current residents requiring assistance with repositioning or requiring incontinent care are receiving timely care according to their care plan. 3. Education was provided to CNA□s on May 13, 2014, to review policies and procedures for repositioning and incontinence care. Nurse Managers and Professional Staff reviewed this May 1, 2014, and will review again with the Nurse Managers on May 27, 2014. 4. Audits will be done by the Director of Nursing or designee to observe compliance that resident care plans are being followed for repositioning and incontinence care. These audits will be completed weekly for a month and then monthly for two months. Audit findings	

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F 282	Continued From page 6 when she was wheeled from the day room to the dining room by nursing assistant (NA)-E. R113 remained seated in her geri-chair until 9:28 a.m. at which time NE-E wheeled R113 from the dining room back to the small day room by the 200 wing nurses station. R113 remained seated, and was not assisted to reposition by NA-E until 10:15 a.m. At 10:15 a.m. (3 hours and 7 minutes since R113 was observed seated in dayroom) NA-D was interviewed and confirmed she was responsible for R113 but had not repositioned or toileted her since arriving at work. NA-D stated R113 was assisted out of bed at 7:00 a.m., 3 hours and 15 minutes since R113 was last repositioned. At 10:24 a.m. NA-D wheeled R113 into her room and at 10:30 a.m. NA-C and NA-F transferred R113 out of the geri chair with a mechanical lift into bed. R113's left heel was slightly reddened in color. NA-C stated previously R113's heel was black and had a big blister, about 2 months ago. During interview at approximately 11:00 a.m. on 4/30/14 the case manager Registered Nurse (RN)-A, verified R113 was at risk for pressure ulcer development and should have been repositioned every two hours as the care plan directs. INCONTINENCE R113's Care Plan, dated 4/23/14, identified a problem with functional incontinence related to activity of daily living (ADL) dependence, impaired mobility and medications. R113 care plan identified she was to be toileted, checked and changed at least every 3 hours.	F 282	will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	

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F 282	Continued From page 7 During observation on 04/30/14 at 7:08 a.m. R113 was seated in her geri-chair in the small dayroom near the 200 wing nurses station. R113 remained seated in her geri-chair until 7:53 a.m. when she was wheeled from the day room to the dining room by nursing assistant (NA)-E. R113 remained seated in her geri-chair until 9:28 a.m. at which time NE-E wheeled R113 from the dining room back to the small day room by the 200 wing nurses station. R113 was not assisted to have her incontinent product checked or changed. At 10:15 a.m. (3 hours and 7 minutes since R113 was observed seated in dayroom) NA-D was interviewed and confirmed she was responsible for R113 but had not checked or changed her incontinent product since arriving at work. NA-D stated R113 was assisted out of bed at 7:00 a.m., 3 hours and 15 minutes since R113 was last checked or changed for incontinence. At 10:24 a.m. NA-D wheeled R113 into her room and at 10:30 a.m. NA-C and NA-F transferred R113 out of the geri chair with a mechanical lift into bed, 3 and 1/2 hours since R113 last checked for incontinence. R113 had a disposable brief on which was removed while lying in bed. The brief was saturated with urine. During interview with R113's Registered Nurse (RN), case manager at approximately 11:00 a.m. on 4/30/14 the RN verified R113 was incontinent of urine and stated R113 should be checked and changed at a minimum of every 3 hours as directed by the care plan.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		5/31/14

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F 314	Continued From page 8 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow pressure ulcer interventions to decrease risks of pressure ulcer development for 1 of 3 residents (R113) who was identified at risk of pressure ulcers. Findings Include: R113's Care Plan, dated 4/23/14, identified her as having a potential impairment to skin integrity related to immobility evidenced by a history of a pressure ulcer to her medial left heel region. The interventions developed for pressure ulcer risk reduction in the Care Plan included: education to family and resident of causative factors and measures to prevent skin injury; monitor location, size and treatment of skin injury; report abnormalities; monitor for signs and symptoms of infection, maceration, and etc. to R113's healthcare provider. The care plan further identified staff would reduce R113's risk factors for pressure ulcer development by repositioning her every two hours. R113 had a Braden Scale assessment (scale for determining risk for pressure ulcer development) conducted with her quarterly Minimum Data Set	F 314	Response for F314: 1. Resident 113 is being repositioned according to the care plan and the pressure ulcer interventions in place. 2. All current residents who are at risk for pressure ulcers are receiving timely repositioning. 3. Education was provided to CNA□s on May 13, 2014, to review the policy and procedure for repositioning. Professional Staff were educated on monitoring for this on May 1, 2014. Nurse Managers will be reeducated on this on May 27, 2014, to help monitor for compliance of the care plan interventions. 4. Audits will be done by the Director of Nursing or designee to observe compliance that resident care plans are being followed for repositioning. These audits will be completed weekly for a month and then monthly for two months. Audit findings will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for	

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F 314	Continued From page 9 (MDS) assessment on 4/3/14. R113's Braden score was identified as 14, which indicated a high risk for development of pressure ulcers. Risk factors identified on the assessment included: Immobility, incontinence, disease process, history of deep tissue injury to left heel and above left heel. During observation of R113's cares on 04/30/14 at 7:08 a.m. R113 was observed to be seated in her geri-chair in the small dayroom by the 200 wing nurses' station. R113 remained seated in her geri-chair in the small day room until 7:53 a.m. at which time she was wheeled in the geri-chair from the day room to the dining room by nursing assistant (NA)-E. R113 remained seated in her geri-chair in the dining room until 9:28 a.m. at which time NE-E wheeled R113 back to the small day room by the 200 wing nurses station. R113 remained seated in the small dayroom until 10:15 a.m. At 10:15 a.m. on 4/30/14, (3 hours and 7 minutes since R113 had originally been viewed seated in the dayroom), NA-D was interviewed and asked what time R113 had last been toileted or repositioned. NA-D stated she was working with R113 and had not provided R113 with repositioning or toileting since she'd assisted the resident out of bed at 7:00 a.m.. On 4/30/14 at 10:24 a.m., R113 was observed to be wheeled to her room in her geri-chair by NA-D for cares. At 10:30 a.m. NA-C and NA-F were observed to transfer R113 with the use of a mechanical lift from her geri-chair to bed. During the observation R113's left heel was viewed and noted to be slightly reddened in color but not open. NA-C stated during the observation that	F 314	further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	

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F 314	Continued From page 10 R113's heel had been black with a big blister about 2 months ago. NA-C stated R113 was checked and changed every 3 hours. During interview with R113's Registered Nurse (RN), case manager at approximately 11:00 a.m. on 4/30/14 the RN verified R113 was at risk for pressure ulcer development and verified she was scheduled to be repositioned every two hours. During interview with the Director of Nursing (DON) on 4/30/14 at approximately 1:30 p.m., the DON stated R113 should be repositioned every 2 hours and that 3 1/2 hours was too long between repositioning attempts. The DON verified R113's risk for pressure ulcer development and stated staff should follow the care plan as written when providing cares. The facility's Pressure Ulcer Practice Guidelines, Section III. Prevention Strategies, revised 9/2010, identified the following: "The nurse aide is an important team member in the management and prevention of pressure ulcers. It is recommended that there be a communication process between the nurse and the nurse aide for concerns that the nurse aide may identify during care delivery. The nurse aide is also responsible for implementing certain preventative interventions for the resident based on the residents plan of care and should be educated by the nurse how to perform these interventions."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		5/31/14

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F 315	Continued From page 11 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide services in a manner to maintain current bladder status or prevent decline for 1 of 3 residents (R113) who was reviewed for incontinence. R113's Care Plan, dated 4/23/14, identified she has functional incontinence related to activity of daily living (ADL) dependence, impaired mobility and medications. R113 care plan identified she was to be toilet checked and changed at least every three hours. During observation on 04/30/14 at 7:08 a.m. R113 was seated in her geri-chair in the small dayroom near the 200 wing nurses station. R113 remained seated in her geri-chair until 7:53 a.m. when she was wheeled from the day room to the dining room by nursing assistant (NA)-E. At 9:28 a.m. NE-E wheeled R113 from the dining room back to the small day room by the 200 wing nurses station. R113 remained seated, and her incontinent product was not checked or changed. At 10:15 a.m. NA-D was interviewed and confirmed she was responsible for R113 but had	F 315	Response for F315: 1. Resident 113 is receiving timely incontinence care per the care plan. 2. Care plan interventions will be implemented as needed to ensure appropriate incontinence care is provided. This information is then entered on the care plan and carried over to the Kiosk for the CNA□s to view to provide and document cares. 3. Education was provided to CNA□s on May 13, 2014, to review policies and procedures for incontinence care. Nurse Managers and Professional Staff reviewed this May 1, 2014, and will review again with the Nurse Managers on May 27, 2014. 4. Audits will be done by the Director of Nursing or designee to observe compliance that resident care plans are being followed for incontinence care. These audits will be completed weekly for a month and then monthly for two months.	

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	245591	A. BUILDING _____ B. WING _____	05/01/2014

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

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F 315	Continued From page 12 not checked or changed her incontinent product since arriving at work. NA-D stated R113 was last assisted out of bed at 7:00 a.m., 3 hours and 15 minutes since R113 was last checked or changed for incontinence. At 10:24 a.m. NA-D wheeled R113 into her room and at 10:30 a.m. NA-C and NA-F transferred R113 out of the geri chair with a mechanical lift into bed, 3 and 1/2 hours since R113 was last checked for incontinence. R113 had a disposable brief on which was removed while lying in bed. The brief was saturated with urine. During interview with R113's Registered Nurse (RN), case manager at approximately 11:00 a.m. on 4/30/14 the RN verified R113 was incontinent of urine and stated R113 was supposed to be checked and changed at a minimum of every 3 hours.	F 315	Audit findings will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		5/31/14

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F 329	Continued From page 13 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide routine laboratory services recommended by the pharmacist for 1 of 5 residents (R5) reviewed for unnecessary medications. Findings include: R5 was admitted to the facility on 8/16/10 with diagnoses including hyperlipidemia (an increased amount of lipids/fat in the blood), hypothyroidism (a condition where the thyroid gland does not make enough thyroid hormone), and history of deep vein thrombosis with embolism (a blood clot that forms in a vein and travels through the blood vessels until it reaches a vessel that is too small to let it pass). Review of R5's physician orders dated 3/20/14 included the following medication orders: Zocor 20 milligrams (mg) by mouth (po) at bedtime for hyperlipidemia, Synthroid 112 micrograms (mcg) po at bedtime for hypothyroidism, and Coumadin 2.5 mg po one time a day every Wednesday and Coumadin 5 mg po one time a day every Sunday, Monday, Tuesday, Thursday, Friday, and Saturday for personal history of deep vein	F 329	Response for F329: 1. Physician for resident 5 was contacted on April 30, 2014, to review the pharmacy recommendation for labs and to obtain reasoning for not ordering new labs for this resident. Physician responded She is on a different blood draw schedule and limiting to minimum venipuncture and patient desire. Physician is still reluctant to draw new labs. Director of Nursing or designee will be readdressing this with the physician again during physician rounds on May 22, 2014, to determine if additional labs can be ordered during the resident□s next PT/INR lab draw to minimize venipunctures . 2. The facility□s pharmacy consultant reviews all residents□ medications that need pertinent labs to go along with them on a monthly basis and communicates suggestions to the physicians when needed for future lab orders. This is being completed currently on all residents. 3. Nurse Managers follow-up on all	

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F 329	Continued From page 14 thrombosis with embolism. During a review of the consulting pharmacist's consultation report dated 2/24/14 included the comment: "R5 receives Synthroid 112 mcg daily and simvastatin (Zocor) 20 mg daily. Her most recent TSH (thyroid stimulating hormone) was checked in January 2013 and lipid panel in November 2012." The recommendation indicated: "Would it be a consideration to monitor a TSH and free T4 (FT4) and fasting lipid panel on the next convenient lab day and annually thereafter?" The response from the physician dated 3/13/14 indicated the recommendations were declined and the rationale given was: "different sched." (schedule). During interview on 4/30/14 at 12:06 p.m., the director of nursing (DON) confirmed there was not a current TSH, Free T4, or lipid panel in R5's record. The DON further confirmed that the the last lipid panel for R5 was drawn on 11/13/12 and last TSH and FT4 on 1/22/13. The DON stated she would follow up with the physician regarding the rationale for declining the laboratory testing recommendations by the pharmacist. During subsequent interview at 12:35 p.m. the DON revealed a fax received by the physician on 4/30/14 at 12:18 p.m. indicating, "she's on a different blood schedule and limiting to minimum venapucture and patient desire." The DON stated that the physician wanted to keep R5's blood draws to a minimum. The DON confirmed that R5 had blood drawn a minimum of once a month to check the PT/INR related to Coumadin use and over the past month these labs were ordered and drawn every two weeks.	F 329	pharmacy consult reports with abnormalities and work with the physicians to get timely acceptance or denial of the recommendation. Nurse Managers are being educated on May 27, 2014, on how to properly handle pharmacy recommendations that have not been addressed or received incomplete justification not to accept the recommendation of the pharmacy consultant by the residents□ physicians. 4. Audits will be completed by Nurse Managers each month in conjunction with the tracking of pharmacy lab recommendations being sent to the physicians to ensure they are being addressed timely and appropriately. These audits will be completed monthly with the pharmacy consultant report for three months. Audit findings will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		5/31/14

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F 441 SS=E	Continued From page 15 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 (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.	F 441		

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide cares in a manner to promote good infection control standards for 1 of 6 residents (R3) during medication administration, for 3 of 19 residents (R30, R65, R113) during food service, and for 1 of 3 residents (R113) observed for incontinence care. Findings include: MEDICATION ADMINISTRATION Observation 04/30/14 7:44 a.m. trained medication aide (TMA)-A was passing medications to R3 and asked R3 if she would like assistance with her banana. R3 handed TMA-A her banana which she peeled and handed back to R3 with her bare hand. TMA-A then returned to medication cart and continued preparing medications without first washing her hands or using hand sanitizer. FOOD SERVICE Observation 4/30/14 8:50 a.m. food items were brought to the dining table where they were served by NA-E. NA-E placed gloves on and assisted R65 to eat. NA-E while sitting on a rolling stool, rolled herself to R30 to assist the resident to eat. NA-E picked up toast with her soiled gloved hands and handed the toast to R30. NA-E proceeded to wheel self around the table to other residents R65 and R113 offering assistance	F 441	Response for F441: 1. Facility is providing care in a manner to prevent good infection control standards during medication administration, during meal service, and during all resident cares, including incontinent care. 2. All residents have the potential to be affected by this if proper infection control is not provided per policy and procedure. 3. Education was provided on infection control policies and procedures for medication administration, food service, and incontinence cares at the CNA and TMA meetings on May 13, 2014. 4. Audits will be done by the Director of Nursing or designee randomly to observe compliance that infection control policies and procedures are being followed for medication administration, food service, and incontinence care. These audits will be completed weekly for a month and then monthly for two months. Audit findings will be submitted in a report by the Director of Nursing Services or a designee to the QA Director monthly for further recommendations by the QA Committee. 5. Completion Date: May 31, 2014	

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F 441	Continued From page 17 to them with the same soiled gloves. NA-E continued in this same manner, rolling herself around table, touching residents, toast and assisting them to eat without first changing her soiled gloves or washing her hands. INCONTINENCE CARES During observation of person cares on 4/30/14 at 10:24 a.m. R113 was transported to her room and assisted with person cares by NA-C and NA-F who were both wearing gloves. R113 was transferred from geri-chair to bed via sling lift to check and change her incontinent product. NA-C removed R113's soiled incontinent product which was saturated with urine, and placed it at the foot of the bed on the bed linens. NA-C used disposable wipes to cleanse R113's perineal area and placed these on top of the soiled incontinent product. NA-C stated that she would have used the trash can to place the pad in while changing R113 if she had had it available. She stated they are not to place soiled incontinent pads on the floor so she placed them at the foot of the bed. When NA-C and NA-F were finished with personal cares, they moved the soiled incontinent product and wipes to a bag, and removed their gloves. The bed linen that had been in contact with the soiled incontinent product was not changed. R113 was then transferred from bed to chair with the use of a mechanical lift. The facility policy for handwashing requested and received on 5/1/14, Title, Hand Hygiene and Handwashing Function/ Infection Control, revised 11/201, identified the following standards:	F 441		

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F 441	Continued From page 18 Purpose: To ensure appropriate hand hygiene technique Hand Hygiene Product Selection Bullet #1 Wash hands with plain soap and water or with anti-microbial soap and water: If hands are visibly soiled (dirty) If hands are visibly contaminated with blood or body fluids before eating after using the restroom Bullet #2. If hands are not visibly soiled or contaminated with blood or body fluids, use an alcohol-based hand rub for routinely cleaning your hands: Before having direct contact with residents; After having direct contact with a resident's skin; after having contact with body fluids, wounds or broken skin; after touching equipment or furniture near the resident; after removing gloves Note: Alternatively, hands may be washed with an anti-microbial soap and water in clinical situations described above. page 1 of 2. Page 2 is procedure for handwashing using soap and water and Use of alcohol-Based Hand Rub.	F 441		

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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 1, 2014. 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	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/21/2014

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 By eMail to: Marian.Whitney@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 91 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		5/31/14

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K 038	Continued From page 2 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to notify building occupants that a delayed-egress lock was installed on an exit discharge door, and by which method the door could be opened. This deficient practice was not in accordance with the requirements at NFPA 101 (00) Chapter 19, Section 19.2.2.2 and Chapter 7, Section 7.2.1.6.1(d). In an emergency evacuation situation for scenarios other than fire, this deficient practice could adversely affect 20 of 94 residents, staff and visitors. FINDINGS INCLUDE: On 05/01/2014 at 1:40 PM, observation revealed an exit discharge door on the west side of The Chapel which was locked against egress, yet equipped with delayed-egress panic hardware, and no sign was posted on the door indicating "Push Until Alarm Sounds - Door Can Be Opened in 15 Seconds." This finding was verified with the chief building engineer at the time of discovery.	K 038	Response for K038: 1. The door referenced in this deficiency has a sign posted now that states Push Until Alarm Sounds □ Door Can Be Opened in 15 Seconds. 2. All other doors in the building were checked for proper signage where needed by the Maintenance Department and were found to be in compliance with the Life Safety Code. 3. Education was provided to all personnel regarding this door being a delayed egress door at the All-Staff meeting on Thursday, May 8, 2014. Maintenance personnel have been educated on the proper Life Safety Codes for egress doors as well as of this date. 4. Maintenance personnel or other designated staff will monitor weekly for one month and then monthly for two months to ensure the proper signage is on the doors throughout the building and has not been removed by anyone. Audit findings will be submitted in a report by the Director of Environmental Services or a designee to the QA Director monthly for further recommendations by the QA Committee.	

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K 038	Continued From page 3	K 038	5. Date of Completion: May 31, 2014	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it was confirmed that facility staff failed to properly conduct one or more fire drills during the previous year. This deficient practice was not in accordance with the requirements at NFPA 101 (2000) Chapter 19, Section 19.7.1.2, and CMS policy. In a fire emergency, this deficient practice could adversely affect 94 of 94 residents, staff and visitors. FINDINGS INCLUDE: On 05/01/2014 at 12:15 PM, during a review of the facility's fire drill reports for the previous year, it was confirmed that fire drills conducted on the PM-Shift during the previous four quarters were not sufficiently varied. Specifically, these fire drills were commenced not greater than 25 minutes apart, as follows: 1st Quarter - 02/26/2014 @ 15:30 hours 2nd Quarter - 05/30/2013 @ 15:28 hours	K 050	Response for K050: 1. The Director of Environmental Services has been educated on the importance of varying fire drills for the facility on all 3 shifts and holding them at different times throughout those shifts. 2. The Director of Environmental Services will make sure fire drills vary on all 3 shifts for the time frame they are conducted in. 3. Education was provided to the Director of Environmental Services, other Maintenance Personnel, and designees on the importance of varying fire drills on the day of the Life Safety Code Survey. 4. Maintenance personnel or other designated staff will monitor monthly for 3 months to ensure all fire drill times are	5/31/14

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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 050	Continued From page 4 3rd Quarter - 08/28/2013 @ 15:40 hours 4th Quarter - 11/20/2013 @ 15:15 hours This deficient practice was confirmed with the chief building engineer.	K 050	varied across all 3 shifts and across different times of the 3 shifts to be in accordance with the Life Safety Code. Audit findings will be submitted in a report by the Director of Environmental Services or a designee to the QA Director monthly for further recommendations by the QA Committee. 5. Date of Completion: May 31, 2014	