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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y54L

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 **07/25/2018** (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 **90** (L18)
13.Total Certified Beds **90** (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 ___ 6. Scope of Services Limit
___ 3. 24 Hour RN ___ 7. Medical Director
___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size
___ 5. Life Safety Code ___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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 :
Nicole Osterloh, Supervisor 10/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2018 (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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245591

July 30, 2018

Ms. Crystal Ellefson, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

Dear Ms. Ellefson:

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 July 2, 2018 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

July 30, 2018

Ms. Crystal Ellefson, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

RE: Project Number S5591028

Dear Ms. Ellefson:

On June 11, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 23, 2018. 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 July 25, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 18, 2018 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 23, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 2, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 23, 2018, effective July 2, 2018 and therefore remedies outlined in our letter to you dated June 11, 2018, 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y54L

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(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 **05/23/2018** (L34)

8. ACCREDITATION STATUS: __ (L10)
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FISCAL YEAR ENDING DATE: (L35)
09/30

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

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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
	90			
(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 :
Pamela Manzke, HFE NE II 07/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/20/2018 (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)

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3. Both of the Above :
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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

Electronically delivered
June 11, 2018

Ms. Crystal Ellefson, Administrator
Good Samaritan Society - Pipestone
1311 North Hiawatha
Pipestone, MN 56164

RE: Project Numbers S5591028, H5591012

Dear Ms. Ellefson:

On May 23, 2018, 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. In addition, at the time of the May 23, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5591012 that was found to be unsubstantiated.

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 July 2, 2018, 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 July 2, 2018 the following remedy will be imposed:

- Per instance civil money penalty. (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 23, 2018 (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 23, 2018 (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 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. 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
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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 _____	C 05/23/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on May20 through May 23, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On May 20th, 2018 through May 23, 2018, a recertification survey was conducted and complaint investigation was also completed at the time of the standard survey by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. An investigation of complaint H#5591012 was completed and found not to be substantiated. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		7/2/18

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

Electronically Signed | 06/20/2018

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 _____	C 05/23/2018

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 585	Continued From page 1	F 585		

that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 585	Continued From page 2 be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation	F 585		

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 _____	C 05/23/2018

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 585	Continued From page 3 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their process to ensure prompt efforts occurred to resolve a grievance related to missing personal items for 1 of 1 resident (R71) reviewed for grievances. Findings Include: R71's brief interview for mental status (BIMS) score dated 5/1/18, was documented as 15/15 indicating no cognitive impairment. During interview on 5/20/18 at 3:09 p.m., R71 reported she'd been missing two pairs of crop pants and a pair of sweat pants for about two weeks. R71 said although she'd had reported this to staff, no one had followed up with her since the pants were reported missing. During interview on 5/21/18 at 2:03 p.m., nursing assistant (NA)-C stated if a resident reported an item missing, the NA staff would look for it. If the NA staff were unable to locate the item, they filled out a slip for the missing item. NA-C indicated she was aware of R71's missing pants and had been following up with R71.	F 585	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. F585 1. On 6/8/2018 the process was updated to reflect new forms which will be easier for staff to utilize for missing items. A spread sheet was created by the Administrator to track all the missing	

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F 585	Continued From page 4 During an interview on 5/22/18, at 8:30 a.m. laundry assistant (LA)-E indicated once laundry is notified of missing items, they would look for the item. LA-E stated laundry occasionally took unclaimed items to staff meetings to have staff help identify missing clothing. LA-E reported laundry staff had been notified yesterday (5/21/18) that R71 was missing some pants, but stated laundry staff did not keep a log of missing items as it had been unsuccessful in the past. During interview on 5/22/18, at 12:25 p.m. the licensed social worker (LSW) stated therapy staff had informed her that morning that R71 was missing clothing, but had not specified what was missing. The LSW provided a sample of a facility form called Procedure for Investigating Missing Items which instructed staff to turn a completed form into the charge nurse, who then was to give it to social services. The LSW said she had no prior knowledge of R71's missing clothing, and stated her expectation was for staff to fill out the form for reported missing items, and give the form to social services for follow up. The LSW indicated that if items were not found, the social worker contacted the resident's family to discuss resolution. During interview on 5/23/18, 10:50 a.m. R71 reported getting one pair of crop pants back, and stated she had just been informed the other pair of crop pants and black sweat pants were not found. Review of facility's policy Policy and Procedure for Missing Items last revised 4/16, included: "1) The facility will promptly report. 2) The facility will notify appropriate staff in charge."	F 585	items to be reported immediately. This form includes the date item went missing and if/when the item was found and the follow up of the missing item. 2. This has the potential to affect all residents with personal belongings. 3. The Licensed Social Worker will review the missing item forms that have been turned in and promptly will inform all departments of the missing item. Social Worker will then follow up with the resident that a missing items form was received. Social Worker will document whom they informed and if/when the item was found. Re-education will be provided to all staff by their department manager in regards to the updates on the missing items procedure and updated forms by July 2, 2018. 5. To monitor performance and ensure that solutions are sustained the Social Worker or designee will audit the use of the missing items form and spreadsheet. Audits will be conducted about missing items by interviewing residents. Audits will be completed as follows 1 x per week for 4 weeks, and then 1x per month for 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations. 6. Date: July 2, 2018	

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F 585	Continued From page 5 Review of facility's policy Policy and Procedure for Suggestions or Concerns last revised 11/16, included: "1) The facility will document concerns, investigate and correct. 2) The facility will develop a systematic approach to resolve grievances. 3) The facility will make prompt efforts to resolve resident grievances."	F 585		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure nail care was provided for 1 of 2 residents (R37) reviewed for activities of daily living (ADL) who was dependent on staff for assistance with ADL care. Findings include: R37's resident face sheet identified a current admission date of 11/17/14, and a diagnosis of type 2 diabetes mellitus, cerebral infarction (stroke) and Alzheimer's disease. R37's annual Minimum Data Set (MDS) dated 3/17/18, identified R17 to have a severe cognitive deficit and indicated R71 required one person extensive assist with personal hygiene. R37's care plan dated 12/9/14, identified the need to have one person assist with personal hygiene, with an approach to have nail care with bathing.	F 677	F677 1. (R37) nails were cared for by CNA with an orange stick on 5/9/18. Entered nursing order to trim nails on bath day and as needed per licensed nurses for (R37). (R37)'s careplan has been updated with the task to clean under nails after meals and to be documented on Point of Care. Personal nail brush will be provided for this resident. 2. This has the potential to affect all residents that are dependent on staff for assistance with nail care after meals. 3. Personal nail brushes will be provided for all residents that are dependent on staff assistance for fingernail hygiene. The process will include having a scheduled nail care day for dependent residents weekly. All nursing assistants & nurses	7/2/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - PIPESTONE	1311 NORTH HIAWATHA PIPESTONE, MN 56164

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F 677	Continued From page 6 R37's treatment administration record (TAR) for 5/1- 5/31/18, revealed R17 received a bath every Friday evening with the last documented bath 5/4/18. Review of R37's personal hygiene task documentation from 4/10-5/9/18, indicated R37's fingernails were cleaned/trimmed on the following dates: 4/19/18, 4/29/18, and 5/5/18. During observation on 5/7/18 at 3:08 p.m., R37 was lying on her right side in bed and was observed to have dark colored debris caked underneath her long, red-painted fingernails. During observation on 5/8/18 at 10:01 a.m., R37 was in her room seated in her wheel chair. R37 was observed to have long red-painted fingernails on both hands, with brown debris packed under each finger's nails. During observation and interview on 5/9/18, at 7:51 a.m., R37 was seated in her wheelchair in her room. When asked, R17 stated she liked the length of her fingernails. R37's fingernails continued to have visible brown debris packed underneath all fingernails. During interview on 5/9/18 at 8:01 a.m., nursing assistant (NA)-A verified she helped get R37 with ADL cares this morning, stating R37 washed her own hands and face, and that she (NA-A) helped her with the rest of her cares. NA-A further stated R37 was diabetic and that as a NA she could not trim R37's nails, but could clean them. NA-A stated, "I know her nails get bad, sometimes they get caked with food, she has snacks in her bedside drawer." NA-A further stated, "I think it is chocolate under her nails."	F 677	will be re-educated on policy and procedure for ADL care/nail care including the new process by the Director of Nursing or Designee by June 29, 2018. 4. To monitor performance and ensure that solutions are sustained the Director of Nursing or designee will audit nail care on 3 dependent residents 1 x per week for 4 week, then 1x per month for 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations. 5. Date: July 2, 2018	

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F 677	Continued From page 7 During observation on 5/9/18 at 8:04 a.m., NA-A asked R37 if she could clean her fingernails and R37 stated, "Oh are they bad again?" NA-A stated, "Yes." R37 stated, "You know it hurts when they do it." NA-A stated, "I will be gentle. Oh, were you eating chocolate?" (At this point NA-A is cleaning the debris underneath R37's fingernails with an orange stick). R37 allowed NA-A to clean her fingernails. During interview at 8:09 a.m. NA-A stated, "I think it was chocolate under her fingernails" and further stated R37 sometimes refused nail care which was reported to the nurse, and would be documented as a refusal in R37's chart. During interview on 5/9/18 at 11:14 a.m., registered nurse (RN)-A, the unit care coordinator, verified there had been no documented refusals of nail care in R37's chart and stated, "I would expect [R37] to have her nails checked after every meal to make sure they are clean." RN-A further stated R37 had been refusing showers and baths however weekly bed baths were provided. RN-A further indicated she would expect R37 to have her nails soaked prior to cleaning, so it does not cause pain. The facility policy Care of Fingernails/Toenails dated February 2011, included: "The purposes of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections. 1. Nail care includes daily cleaning and regular trimming."	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1)	F 679		7/2/18

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F 679	Continued From page 8 §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure individualized activities were provided for 1 of 3 residents (R60) reviewed for activities. The findings include: R60's care plan indicated diagnoses including: macular degeneration, osteoporosis, and unspecified dementia. In addition, the care plan indicated R60 had been admitted to the facility 8/28/13. Throughout the survey R60 was observed without participation in individualized activities. R60's care plan indicated a focus area "The resident has impaired cognitive function R/T (related to) E/B (evidenced by) forgetfulness and needing assist with decisions. A goal included: Resident will continue to receive daily opportunities or social contact through the review date." Approaches included: Bring to large group activities such as spiritual (devotions, worship, Bible Study, Methodist communion as available), bring to lounge area to watch TV (Hallmark [channel], game shows or DVDs [movies]). Give	F 679	F679 1. (R60) Care plan will be updated by Case Manager and Activities Assistant II to reflect her current interests based on families request by June 29th, 2018. 2. This has the potential to affect all residents whom are unable to express when they want to attend an activity. 3. Re-education will be given to CNA's and activity assistants on the policy and procedure on activity program and following the Kardex on resident preferences by Director of Nursing/Activities Assistant II or Designee by June 29th, 2018. 4. To monitor performance and ensure that solutions are sustained the Director of Nursing/Activities Assistant II or designee will audit the care plan focus of resident activities to ensure resident involvement of such 1 x per week for 4 week, then 1x per month for 3 months until compliance is sustained. The results will be brought to	

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F 679	Continued From page 9 1-1 attention with sensory stimulation using lotions and bright picture books in contacts or small group setting at least 3 x week expecting response of smiles/listening. Read and show cards received by mail from family...Reminisce with resident using photos of family and friends...Invite and assist resident to activities of known interests." The care plan also included a focus area of "The resident is dependent on staff for activities, cognitive stimulation, social interaction R/T cognitive deficits E/B staff assistance to attend and participate in activities." Interventions included: Provide 1 to 1 bedside/in-room visits and activities if unable to attend out of room events. Encourage ongoing family involvement. Invite resident's family to attend special events, activities, meals." An Activity Interest Data Collection Tool completed 5/2/18, indicated R60 enjoyed music, activities with children/youth, 1:1's, and TV. During interview with the activity assistant-A on 5/21/18 at 3:15 p.m., it was learned a game of Dominos and music had begun at 2:30 p.m. in the dining room. However, R60 was observed to be laying in bed during the afternoon from after lunch until at least 3:18 p.m. Although staff did provide care including positioning change, the resident was not provided any individualized activity during these observations and no staff were observed to have invited the resident to the activity that began at 2:30 p.m. On 5/22/18 at 7:11 a.m., R60 was observed in the day area in a reclining geriatric (geri) chair in front of the TV. R60 was awake and appeared to be watching people around her. At 7:49 a.m., R60 remained in the same location in the geri chair,	F 679	the monthly QAPI meeting for review and/or further recommendations. 5. Date: July 2, 2018	

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F 679	Continued From page 10	F 679		

but had her eyes closed and appeared to be sleeping. At 8:23 a.m., R60 was assisted by staff to the dining room for breakfast where she required staff assistance to eat. At 9:27 a.m., R60 was assisted back out to the day area where her geri chair was parked in front of the TV.

On 5/22/18 at 9:50 a.m., R60 was observed lying in bed on her right side. Her eyes were open. At 9:53 a.m., activity assistant-A stated "[R60] likes to go to music and church. I was going to take her to church but she is in bed now, so that probably won't happen." Activity assistant-A further stated, "she doesn't participate much in activities, I do 1:1's with her while I'm washing her hands before lunch, but she doesn't really respond. I also visit with her in the TV room every so often."

On 5/22/18 at 1:45 p.m., R60 was observed lying in bed on her right side again. There were no individualized activity interventions being provided for R60 while she was in her room. At 2:03 p.m., nursing assistant (NA)-E was interviewed and stated R60's family wanted her to lay down after meals so that's what they did. NA-E also stated, "[R60] gets her hair done on Thursdays, and if it is requested she get up for activities, we will get her up. When she was on hospice they would do her nails and such, but she really doesn't participate any more."

A review of the facility's activity schedule for 5/22/18 indicated the following activities were scheduled: - 9:35 a.m. manicures; 10:00 a.m. Bible study; 10:30 a.m. Peace United; 1:30 p.m. Teen Living Class visit; 2:15 p.m. coffee time; 2:30 p.m. Bubbles/Music - outdoors

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F 679	Continued From page 11 0n 5/23/18 at 8:51 a.m., R60 was observed in the dining room for breakfast. At 9:12 a.m., staff took her back to her room and used a Hoyer lift to transfer her to bed. NA-F stated, "She [R60] likes to go to church on Sundays and Bible study on Tuesdays and Thursdays. Activities will come and tell us if we should get her up or sometimes family will call and tell us if they want her out for something special." On 5/23/18 at 11:00 a.m., a movie was playing in the chapel, R60 was observed to be sleeping in her geri chair in the dining room by the aviary. During an interview with activity assistant-B on 5/23/18 at 11:32 a.m., she stated, "I haven't done her care plan yet, we do an assessment and ask her family what she likes to do. I'm only two weeks into my new position. The NA's have everything on file at the desk on the things that she likes to do and the NA's or I will grab her and ask her if she wants to do something. I always like to invite her to exercises because she loved to bat at the balls and noodles, it would make her smile. We can read her by her facial expressions as far as whether she wants to attend or not. " On 5/23/18 at 1:47 p.m., R60 was observed again lying in bed with her eyes closed. Although there was a CD (compact disc) player in room, it had not been turned on during any of the observations. The facility's Activity Program revised 9/17, included: "...The program of activities focuses on the cognitive, physical, spiritual, community, social and creative needs of each individual resident. Creating, supporting, developing and restoring the resident's appropriate lifestyle	F 679		

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F 679	Continued From page 12 through structured and spontaneous activity programming enables the resident to participate in opportunities that help achieve the highest practicable level of function..."	F 679		
F 680 SS=C	Qualifications of Activity Professional CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have a qualified activities director overseeing and directing the comprehensive assessment, care planning and activity program implementation in the facility. This had the potential to affect all 78 residents residing in the facility. Findings include:	F 680	F680 1. On June 5, 2018 the Administrator located a qualified Activity Director to oversee and direct the Activity Assistant II in the comprehensive assessment, care planning and activity program implementation in facility until those qualifications are met by the Activity Assistant II. 2. This has the potential to affect all	7/2/18

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

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F 680	Continued From page 13 During an interview on 5/22/18, at 12:33 p.m. licensed social worker (LSW)-A reported the current activity director (AD)-A had "just started" her position within the past couple weeks, as the previous director had retired. LSW-A reported she was not aware of what training or qualifications AD-A had for the position, and added she was "watching over her" to make sure she completed her documentation and care plan(s) correctly. In addition, LSW-A explained there was an AD (from a neighboring faclity) that was supposed to be coming over once a week to assist AD-A with the new position, however LSW-A did not know whether that was happening or not. When interviewed on 5/22/18, at 1:42 p.m. AD-A stated she was not sure how long it would be to complete the certification process and be certified to lead the facility's activity program as she was "still starting the courses" to become certified. AD-A explained she was not currently licensed or registered as an activities professional, however, was "in progress" for doing so. AD-A stated she started at the facility in the Fall of 2016, and had worked in an "almost full time" basis in the activity department since then. AD-A stated her supervisor, whom she reports to, was the administrator of the facility. Further, AD-A expressed she had a total of four staff who report to her in the activity department and she was "still learning everything" regarding the activity's director position. A review of activity director (AD)-A's personnel file was completed and identified a facility letterhead, signed by AD-A on 10/25/16, which indicated AD-A was provided confirmation of a conditional offer of employment as, "...Part-time Activities	F 680	residents in this facility. 3. According to the contract the qualified Activity Director will oversee Activity Assistant II as per phone conversations, emails, punch reports and direct supervision weekly. 4. To monitor performance and ensure that solutions are sustained the Administrator will communicate with the qualified Activity Director weekly. This process will be monitored through the QAPI committee for review and/or further recommendations. 5. July 2, 2018	

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	245591	A. BUILDING _____ B. WING _____	C 05/23/2018

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

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F 680	Continued From page 14	F 680		

Assistant (Days/Evenings)" for the facility. In addition, another facility letterhead, signed by AD-A on 4/16/18, identified AD-A was provided with, " ... written confirmation of a Conditional Offer of Employment as a Full Time Activity Director with [the facility]." The letter explained since AD-A was not yet certified, their "temporary title" would be listed as activity assistant II with additional information explaining, "Once certified your title will change to activity director." No evidence was identified in the personnel file to otherwise demonstrate AD-A's competence to be the activity director for the facility.

On 5/22/18, at 2:58 p.m. the administrator and human resources director (HRD) were interviewed. They verified AD-A was originally hired in September 2016 and had a "few different roles" while working for the campus, including nursing assistant and activity assistant. They further stated she was in an "on-call" position for all of her roles, except for the nursing assistant position however, completed a full-time work load between all the different positions. The administrator stated the current, acting activity director was a different Good Samaritan Society (GSS) campus activity director (AD)-B, who visited the facility approximately once a month. Since AD-A was not currently certified or licensed for her position, AD-B was overseeing the activities program here at the Pipestone campus.

On 5/23/18, at 8:10 a.m. (AD)-B of the GSS Edgerton campus was interviewed. AD-B explained she was "not sure if she was the "acting activity director for the Pipestone campus or not" as she had only been asked to "help out with some things" recently. AD-B expressed again she was not sure what she was supposed

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F 680	Continued From page 15	F 680		

to be doing to help provide oversight of the Pipestone campus activity's program, nor what her exact role was with the Pipestone campus at this time adding she had not even been to the Pipestone campus for "a long long time." AD-B and the Pipestone administrator were supposed to meet a couple weeks ago however, there was a "lack of communication" and they were unable to touch base. AD-B expressed she had a meeting scheduled for the following week to meet with the administrator and see what she could do to "help out." When questioned about helping direct, supervise and implement activities program(s) for the residents' of the Pipestone campus, AD-B stated she was not helping do any of those things at this time adding, "nope, I'm not," and again reiterated she was "kind of lost" about what she should be doing to help AD-A in her role at the Pipestone campus. Further, AD-B stated she had not signed any agreements or contracts to act as the Pipestone campus interim activities director.

During subsequent interview on 5/23/18, at 8:51 a.m. the administrator stated she had called the Edgerton campus administrator on Monday (5/21/18) and asked AD-B then to oversee the activity's program for the Pipestone campus. AD-B had been in to visit the former activity director and AD-A, and the administrator expressed she wanted AD-B to give AD-A direction along with overseeing the activity calendar and to make sure she was doing them correctly. The administrator explained AD-A was currently gathering and "capturing the data" for resident' assessments and care plans, then LSW-A was entering the data into the computer and writing the Care Area Assessments (CAAs) as required. The administrator stated she felt

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

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F 680	Continued From page 16 AD-A was capable of doing the job, despite not being certified, and added she thought AD-B just "wasn't understanding" what she needed to help AD-A with when she last spoke with her. The Activity Director job description was signed by AD-A on 4/13/18. The document identified AD-A to be in a supervisor role and listed a summary of: " ... develops activity programming for residents and assures activities are led in a safe and effective manner by staff." A section of "Essential Duties and Responsibilities" identified the position would assess resident' needs, and develop programming to meet identified needs; along with evaluating program effectiveness and completing documentation timely. In addition, the position description listed "Qualifications" and directed the person must be eligible for certification as a Therapeutic Recreation Specialist or an Activities Professional by a recognized accrediting body, " ... or ability to satisfactorily complete an accredited training program approved by the state [sic] in which the center/campus is located ..." The policy did not direct or identify a need to be licensed and/or any of the other regulatory guidance as identified in 483.24(c)(2) (F680).	F 680		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		7/2/18

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F 880	Continued From page 17 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 18 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper hand hygiene and glove use during pericare for 3 of 3 residents (R30, R21 and R25) observed during personal cares. Findings include: 05/22/18, at 9:45 a.m. nursing assistant (NA)-A was observed entering R30's room with gloves on. R30 required use of a standing lift with 1 assist to transfer from bed to bathroom. NA-A exited room with gloves on, go the standing lift, and returned to the room with the same gloves on. Using the same gloves, NA-A applied stockings, pants, shoes, and R30 was assisted to a seated position in bed. R30's hair was combed, styled, and put into a ponytail, secured with an elastic band. NA-A proceeded to remove night gown put on shirt, and positioned a medium lift	F 880	F880 1. Re-education and a corrective action were given on June 14, 2018 by Staff Development/Infection Prevention to the direct CNA's involved in not following the policy on hand hygiene properly. Re-education included reviewing the policy and procedure on hand hygiene along with proper glove use. 2. This has the potential to affect all residents in this facility. 3. Re-education will be given to all nursing assistants on June 26 & 28, 2018 by reviewing the policy and procedure on hand hygiene along with proper glove use and will be verified with a competency validation on hand washing. 4. To monitor performance and ensure that solutions are sustained the Director of Nursing or designee will audit hand	

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F 880	Continued From page 19 sling on the resident, and assisted to transfer from bed to bathroom, and to the toilet. While on the toilet, NA-A started water, locked lift brakes, and stepped out of bathroom for privacy. NA-A continued to wear the same gloves and proceeded to gather supplies, wet washcloth, and hand it to R30. NA-A cued to R30 to wash face and hands with washcloth. NA-A again stepped out out of bath room while R30 washed face and hands, and started to clean R-Jane's wheelchair pad which was pad caked with crusty, red debris. NA-A next cleaned a dice and chair alarm pad which was also on wheelchair. NA-A re-entered the bathroom, while wearing same gloves, assisted R30 to standing position in lift and performed perineal cares. NA-A began washing resident from the back side first and used front to back wiping wiping technique. Following wiping the perineum, NA-A cleansed R30's front groin folds with the same washcloth, and patted R30's perineum with towel, pulled up pants, removed gloves, and assisted R30 to the wheelchair with the lift. After transferring R30 to the chair, NA-A brought R30 to the dining room for breakfast. NA-A did not wash hands following pericare and did not wash hands prior entrance to kitchen area. NA-A entered the kitchen, opened refrigerator to retrieve milk, and approached the steam cart. During interview at this time, NA-A stated she was a "germophobe" and preferred to wear gloves all the times to avoid spreading germs. NA-A stated she donned gloves before entering R30's room, and carries gloves in pockets so they are always available. NA-A stated she washed her hands before and after cares, after using the bathroom, after eating and also after pericare of residents. NA-A stated her hands should be washed after wearing gloves. NA-A verified that gloves are not a substitute for	F 880	hygiene compliance by monitoring 5 employees 1 x per week for 4 week, then 1x per month for 3 months until compliance is sustained. The results will be brought to the monthly QAPI meeting for review and/or further recommendations. 5. July 2, 2018	

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F 880	Continued From page 20 hand hygiene. NA-A stated that she was planning to wash her hands before she assisted residents with their meals. During observation on 05/22/18, at 12:18 p.m. NA-A was providing peri care to R21. NA-A was in the bathroom, wearing gloves. R21 was on the toilet. After toileting was completed, NA-A cued R21 to stand. While R21 was standing in the bathroom, NA-A provided pericare as R21 had a bowel movement. When peri care was completed, NA-A removed her gloves, turned on the sink and placed her hands under the running faucet water. NA-A did not use use soap, and did not use friction to cleanse hands. NA-A shook the water off her hands, and quickly dried with a paper towel. NA-A pulled up R21's pants, and verbally cued R21 to wash his hands. NA-A wiped her hands on her uniform to finish drying them, pulled a paper towel from the dispenser, and cued R21 to dry his hands with the paper towel. NA-A assisted R21 out of his room, and continued to assist other residents to the dining table. No hand sanitizer or hand hygiene was performed prior to assisting other residents to the dining table. During observation on 05/22/18, at 1:33 p.m. NA-B assisted R25 to the toilet. and when NA-B donned gloves, and when R25 was done on the toilet, NA-B provided peri care, removed gloves and assisted R21 out of the bathroom with the standing lift. NA-B did not wash her hands, removed her gloves, applied R25's wheelchair foot rests, an alarm tab on the wheelchair, and assisted R21 out of their room to the main commons area, then NA-B cleansed her hands with hand sanitizer located on the wall outside the nurse station.	F 880		

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F 880	Continued From page 21 During interview on 05/22/18, at 1:40 p.m. NA-B stated hand hygiene was important to prevent spreading infections. Hand washing was completed before and after peri cares, before and after feeding residents, between feeding residents, and when hands are soiled. NA-B stated staff were trained on hand washing once a year and during NA class, and were also observed on the floor at times. NA-B stated gloves are worn during meals to avoid direct contact with food. NA-B stated hands are washed before and after assisting residents at the dining table. Gloves are removed and hands are washed after physically touching residents, handling mouth wear, and providing pericare. NA-B-B stated "I usually take them off as soon as I am done, I did not do that after I was in [R25's]room," and added she was, "not sure why." Infection preventionist, clinical manager (CM)-A was interviewed on 05/23/18, at 09:03 a.m. CM-B, a new staff member taking over the role of infection control preventionist, was also present. Both CM-A, and CM-B stated the expectations for staff were to follow the facility hand hygiene policy, which included to wash hands before entering a resident room, to don gloves to provide peri care, to perform hand hygiene following peri care before touching other items in rooms and before before leaving room. CM-A indicated staff just completed a training competency last summer on peri care. New staff received hand hygiene training with orientation, which included return demonstrations prior to working on the floor. Yearly competency check involved observing skills on the floor and also unannounced "spot checks" of handwashing if	F 880		

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F 880	Continued From page 22 indicated. NA certification training included hand washing to ensure staff had met the correct qualifications. Document review of the facility peri care procedure, revised 3/16, revealed step 7 in the pericare procedure stated "...wash rinse and dry anal area. After removing soiled gloves, use hand sanitizer or wash with soap and water to cleanse hands, and put on clean gloves to put on clean pad and/or clothing.	F 880		

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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. At the time of this survey, Good Samaritan Society Pipestone was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 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		06/20/2018

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 <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 83 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324	Cooking Facilities	K 324		7/2/18

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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**

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K 324 SS=F	Continued From page 2 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview the Facility did not ensure that the cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. This deficient practice could effect 79 of the 79 residents. Cooking Facilities	K 324	Statement of Compliance: Preparation and execution of the 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	

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 _____	**05/21/2018**

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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K 324	Continued From page 3 Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 05/21/2018, during the inspection, a carbon monoxide detector was activated near the cooking appliances (oven, stove, fryer and steamers). The ventilation hood was observed to be turned off. This deficient practice was verified by the Facility Director.	K 324	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. K324 1. On 5/21/18, the hood exhaust fan on/off switch was covered by the Maintenance director so that the switch could not be shut off. 2. The Maintenance Director/designee called the gas company and the appliance company to verify that there is no longer a carbon monoxide concern. Both companies gave approval to use the kitchen. One appliance was locked out/tagged out and sent for repair. A new exhaust hood was ordered on 6/15/18. 3. To monitor performance and ensure that solutions are sustained, the facility Maintenance Director/designee will conduct audits 1 per week X4 weeks, and 1 per month for 3 months. The results will be reported and reviewed at the monthly quality meeting for further review and recommendation. Date:7/2/18	