

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 8, 2020

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

RE: CCN: 245591 Cycle Start Date: September 18, 2020

Dear Administrator:

On September 18, 2020, a survey was completed at your facility by the Minnesota Department of Health, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504 Email: nicole.osterloh@state.mn.us Office: 507-476-4230 Mobile: (507) 251-6264 Mobile: (605) 881-6192

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 18, 2020 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 18, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: <u>https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm</u>

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: <u>https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html</u>

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.

Feel free to contact me if you have questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 8, 2020

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

Re: State Nursing Home Licensing Orders Event ID: B3H411

Dear Administrator:

The above facility was surveyed on September 16, 2020 through September 18, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Nicole Osterloh, RN, Unit Supervisor Marshall District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 1400 East Lyon Street, Suite 102 Marshall, MN 56258-2504 Email: nicole.osterloh@state.mn.us Office: 507-476-4230 Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please 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.

Please feel free to call me with any questions.

Sincerely,

Kumalu Hiske Downing

Kamala Fiske-Downing Minnesota Department of Health

Good Samaritan Society - Pipestone October 8, 2020 Page 3 Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>kamala.fiske-downing@state.mn.us</u>

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	****ATTE	ENTION*****					
	NH LICENSING	CORRECTION ORDER					
	144A.10, this correction pursuant to a survi- found that the defini- herein are not corrected shall with a schedule of the Minnesota Dep Determination of w corrected requires requirements of the number and MN R When a rule conta comply with any of lack of compliance re-inspection with result in the asses	n Minnesota Statute, sect ection order has been iss ey. If, upon reinspection, ciency or deficiencies cite rected, a fine for each vio be assessed in accorda fines promulgated by rule partment of Health. whether a violation has be compliance with all e rule provided at the tag tule number indicated bel ins several items, failure the items will be conside e. Lack of compliance up any item of multi-part rule sment of a fine even if th luring the initial inspection	ued it is ed lation nce e of en en ow. to erred on e will e item				
	that may result fro orders provided th the Department wi	a hearing on any assessn m non-compliance with th at a written request is ma thin 15 days of receipt of ent for non-compliance.	nese .de to				
	survey was condu- with State Licensu NOT in compliance Please indicate in correction that you and identify the da	ITS: h 9/18/20, an abbreviated cted to determine complia re. Your facility was found e with the MN State Licer your electronic plan of have reviewed these ord te when they will be com	ance I to be Isure. Iers,				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVI ically Signed	DER/SUPPLIER REPRESENTATI	VE'S SIGNATURE		TITLE		(X6) DATE 10/20/20

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2 830	MN Rule 4658.052 Proper Nursing Ca		ite and	2 830		10/20/20	
	Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t resident must rema prefers to remain in	re and treatment, supervision base of preferences as resident assessor scribed in parts 46 ing home residen possible unless t he attending physian in bed or the residen	bersonal and d on identified in nent and 558.0400 and t must be out here is a ician that the				
/innesota D	This MN Requirem by: Based on observat review, the facility f supervision and ca residents (R1 and I falls. Findings include: R2's 9/10/20, State R2 fell on 9/8/20 at the floor. Prior to th	ion, interview, and ailed to ensure ap re plans followed R2) to prevent pot Agency (SA) repo 6:30 p.m. R2 wa	I document propriate for 2 of 2 ential future ort identified s found on		Statement of Compliance: Preparation and execution of this response and plan of correction doe constitute an admission or agreement the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan correction is prepared and/or execu- solely because it is required by the provisions of state and federal law.	ent by ne of ited	

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	help, and staff assi After staff assisted found on the floor. after the fall, and in the emergency dep night, R2 develope transferred to the E non-displaced left further medical inte facility.	h her room. R2 called staff for isted R4 out of R2's room. R4 out of the room, R2 was R2 had no pain immediately hitially declined evaluation at partment (ED). Throughout the d increased hip pain and was ED. R2 was found to have a femur fracture. R2 declined ervention and returned to the		purposes of any allegation that the is not in substantial compliance wit federal requirements of participatio response and plan of correction constitutes the center s allegation compliance in accordance with sec 7305 of the State Operations Manu- plan of correction constitutes a writ allegation of substantial compliance Federal Medicare and Medicaid requirements.	h n, this of tion Ial. This ten
	identified her cogn included history of hemiparesis and h arm impairment), o anxiety, severe dej disorder, epilepsy, hip pain, and musc extensive assistan between surfaces, frequently incontine occasional bowel in toileting program. If 10 that affected he R2's 9/16/20, care pain in her left arm verbal ommunication mobility and used a brakes for transpool of one staff for tran- person cares and to implement 15-minu- was not aware of h impulsive. R2 was R2 to activate her of	plan identified R2 had chronic and leg. R2 had impaired on. R2 had limited physical a wheelchair with locking rtation. R2 required assistance sfers between surfaces, toileting. Staff were to ute checks when needed. R2 her limitations and was a fall risk. Staff were to remind call light for assistance and		 According to the deficiency states the facility failed to ensure proper supervision and care plans for 2 of residents. Surveyor observed no convithin reach of R (1). Call light was immediately given to R (1). R (1) of have a toileting program in place. 9/28/20 an every three hour schedure prompt to void was added to plan of R (1) is care plan did not identify n increased supervision to prevent far Care plan modified on 10/12/20 to need for increased supervision to prevent far Surveyor observed wheelchair on the side of room when R (2) was in bed Wheelchair was placed next to be commediately upon notification of observation. R (2) did not have a to prompt to void schedule. R (2) is of plan did not identify need for increased supervision to prevent far prompt to void schedule. R (2) is of plan did not identify need for increased supervision to prevent falls. Carep modified on 10/12/20 to include network of the supervision to prevent falls. 	2 all light s lid not On Jle to of care. eed for Ills. include prevent opposite d. I oileting 20 care our care sed lan ed for
		r brakes. Staff were to ensure as next to her bed. The care		increased supervision to prevent fa	lls.

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	Supervision require Observation on 9/1 identified R2 was I the head of the be- was located on the	ify the need for increased ed to prevent potential falls. 16/2020 at 9:52 a.m., of R2 ying in bed, eyes closed, with d elevated. R2's wheelchair e wall opposite and not kept care planned in case she		 This has the potential to affer residents with increased risk for Interdisciplinary review of reside high fall risk and/or major injury completed and care plans will be and modified by Case Manager, designee by 10/26/20. All Nursing Staff are educated 	falls. nts with will be e reviewed or	
	Interview on 9/16/2 R2 used a full body Prior to her last fall assistance of 1 sta since been angry. difficulty communion was easily frustrate R2's fall prevention strips by her bed, of her room. Falls we she refused to call had a history of tra and had self-transit today she was four bed. Staff try to po	20 9:56 a.m., NA-A identified y lift and assistance of 2 staff. I, R2 pivot transferred with aff. R2 had a stroke and had She was impulsive, and had cating. She fell frequently. R2 ed and frequently refused care. Ins included placement of grip call lights were placed all over ere difficult to prevent because for help and refused care. R2 Insferring without assistance ferred less after her fall, but ind sitting on the edge of her osition her as far from edge of 2 was unaccepting of her		 All Nursing Staff are educated orientation on where to find, read follow care plan/Kardex upon him Clinical Educator. All Nursing Sire-educated per the Director of M designee on importance to follow plans, communicate changes to plans and the vital role the care in ensuring residents are safe by Re-education was provided CNAs who were observed not for care plans on 9/17/20, education importance of following care plans to be in the safest pos environment to minimize fall risk Re-education will be provided to nursing staff regarding fall preverpolicies and care plan being following fall 	d, and e per taff will be Nursing, or v care care plan plays / 10/26/20. to three illowing n included n/Kardex allow ition/safe all	
	a.m., of R2's door to observe her ever self-transfer had d and fracture, howe the edge of the bee the edge of her be bed. R2 did not ha because of her fra self-transfer. R2 w in a nursing home.	nterview on 9/16/20 at 10:10 with NA-A identified staff were ery hour. R2 attempts to ecreased down since her fall ever, she continued to scoot to d. This am she was found at d and was assisted back into ave her wheelchair by her bed cture and reduced attempts to vas alert, and did not want to be She wanted to be with her ifficulty expressing her needs		 This will be completed by the Dir Nursing, or designee with mand- education. Professional Nursing were educated on 9/28/20 and 9 the Director of Nursing. Nursing Staff to be educated by 10/26/20 to their next scheduled shift. 5. To monitor performance and compliance the DON, or designed audit resident care plans with his falls. Four residents care plan 	rector of atory 9 Staff 1/30/20 by 1 Assistant 0 or prior I ensure ee, will story of	

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	and became easily identify her needs. Observation on 9/ R2's wheelchair co opposite R2's bed Observation, inter- on 9/16/20 at 12:4 nurse (LPN)-A ide against the wall op R2's care plan incl next to the bed for anti-back brakes to back. R2 was not at this time, and w self-transfer. The I wall because she self-transfer since if R2's current care wheelchair away fi R2's current care p wheelchair was to LPN-A identified si the care plan until Any charge nurse plan and notify the managers and dire care plan were up team (IDT) would interventions were notify the director of placing the wheelc identified she was R2's second fall. F shift prior to the st	y agitated if staff were unable to 16/20 at 12:40 p.m., identified ontinued to be against the wall view, and docuement review, 7 p.m., with licensed practical ntified R2's wheelchair was oposite her bed. Before her fall, luded to keep the wheelchair safety. The wheelchair had o prevent the chair from rolling able to transfer independently as not currently at risk to NAs put the wheelchair by the had not attempted to her last fall. LPN-A was unsure e plan was to place the rom R2's bedside. Review of plan with LPN-A identified R2's be placed at the bedside. taff were to continue to follow the care plans were reviewed. was able to modify the care e registered nursed, case ector of nursing (DON) when dated. The interdisciplinary review care plans to determine appropriate. LPN-A planned to of nursing (DON) to review chair at the bedside. LPN-A the nurse on duty at the time 82 had also fallen earlier in the art of LPN-A's shift. Staff		reviewed; that have a risk for falls a observation will occur that care plan being followed weekly for 4 weeks, 1x per month for 3 months until rest sustained. Results will be reviewed monthly at Quality Assurance/Performance Improveme meetings by the Interdisciplinary Test	i is then ults are ent
		d on R2 because of her n. R2 was difficult to redirect.			
nesota D	R2's fall incident re	eports identified the following			
TE FOR			6899	B3H411 I	f continuation sheet 5

STATEMENT OF DEPICIENCIES [X10] PHONODERSUPPLIENCUM [X20] MALTIPLE CONSTRUCTION [X20] MALTIPLE CONSTRUCTION MAD PLAN OF CORRECTION 00455 INVINO C 09/18/2020 NUME OF PHONODERI OR SUPPLIENT STREET ADDRESS, CITY, STATE, ZIF CODE C 09/18/2020 INVINO STREET ADDRESS, CITY, STATE, ZIF CODE STREET ADDRESS, CITY, STATE, ZIF CODE CONDERNO FAX OF CORRECTION C 09/18/2020 INVIE OF PHONODERI OR SUPPLIENT SUMMARY STREMENT OF DEPIDENCES PROTICE TO SUPPLIENT CONDERNO FAX OF CORRECTION CONDERNO FAX OF CORRECTION <th>Minnesota Department of Health</th> <th></th> <th></th> <th></th> <th></th>	Minnesota Department of Health				
Odd5 IP WING Odd5 NAME OF PROVIDER ORSUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE COOD SAMARITAN SOCIETY - PIPESTONE 1311 NORTH HAWATS Implement REACH DEPICIENCY MUST ER EPRECEDED BY FULL, PRESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ADDRESS, CITY, STATEL COUNT CONSTRUCT ON ECONFECTION (EACH CORRECTIVE ADDRESS, CITY, STATEL 2 830 Continued From page 5 2 830 2 830 EACH CORRECTION (EACH CORRECTION ECONFECTION (EACH CORRECTION (EACH CORECTION (EAC					
Build North HulwArtha prestore. 1311 NORTH HUWATHA prestore. MM soids (M) ID FREE M. SUMMARY STATEMENT OF DEFICIENCIES ERACH DEFICIENCY MUST BE PRECEDED BY FULL FREE MEDIATION OF DESIDENTIFYING INFORMATION) ID PREFIX PHOVIDER'S PLAN OF CORRECTION ERACH ZORRECTING ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETE UNITE 2 830 Continued From page 5 2 830 2 830 1 0 ns 8/1/20 at 7:30 p.m., R2 was found on the floor on her buildoks after attempting to reposition herself in the wheelchair. R2 kays found on the floor on her buildoks after attempting to reposition herself in the wheelchair. R2 forgot to lock the wheelchair brakes. No flury occurred. Anti-back brakes were added to R2's wheelchair. 3) On 8/27/20 at 1:245 p.m., R2 was found on the floor on her stomach with her right arm out to the side. R2 attempted to self-transfer without locking the wheelchair brakes, and had not used the call light. R2 was offered the toliet at 11:50 a.m., and had not voided. A) On 8/27/20 at 1:245 p.m., R2 was found on the floor after an attempt to self-transfer without locking the wheelchair brakes, and had not used the call light. R2 was offered the toliet at 11:50 a.m., and had not voided. A) On 8/27/20 at 1:15 p.m., R2 was found on the floor after an attempt to self-transfer form the bed to the wheelchair. R2 was uninjured. R2's fall incident report made momention R2 had fallen twice on 9/8/20. Attent the transfer form the bed to fallen twice on 9/8/20. Attent for the floor documentation was requested. No documentation was requested. No documentation was requested. No documentation was enviced. Herevice No 1/6/2020 at 1:36 p.m., with occupational theragist (CT)	00455	B. WING			
Guod SAMARHAR SOCIE IT - PIPESTONE ppestone, MN 56164 Image: Provide Research of the second se	NAME OF PROVIDER OR SUPPLIER STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE Convict The DEFICIENCY 2830 Continued From page 5 2830 2830 2830 2830 Continued From page 5 2830 1) On 8/1/20 at 7:30 p.m., R2 was found on the floor following an attempt to self-transfer from the wheelchair to the bed. R2 was not injured. 2) On 8/14/20 at 12:40 p.m., R2 was found on the floor on her buttocks after attempting to reposition herself in the wheelchair. R2 forgot to lock the wheelchair brakes. No Injury occurred. Anti-back brakes were added to R2's wheelchair. 3) On 8/27/20 at 12:45 p.m., R2 was found on the floor on her studied. 4) On 8/30/20 at 1:15 p.m., R2 was found on the floor after an attempt to self-transfer without locking the wheelchair brakes. And had not used the call light. R2 was offered the toilet at 11:50 a.m., and had not voided. 4) On 8/30/20 at 1:15 p.m., R2 was found on the floor after an attempt to self-transfer from the bed to the wheelchair. R2 was uninjured. F2's fall incident report on 9/8/20, identified R2 fell at 6:30 p.m. The report made no mention R2 had fallen twice on 9/8/20. Additional fall documentation was provided. R2's 9/9/20, SA report made no mention R2 had fallen twice on 9/8/20. Additional fall documentation was provided. R2's 9/9/20, SA report made no mention R2 had fallen twice on 9/8/20. Additional fall. R2 was alert but had difficulty with verbal expression. OT-A's interview widentified R2 was agitated and 1 1 1	GOOD SAMABITAN SOCIETY - PIPESTONE				
falls during the past month: 1) On 8/1/20 at 7:30 p.m., R2 was found on the floor following an attempt to self-transfer from the wheelchair to the bed. R2 was not injured. 2) On 8/14/20 at 12:40 p.m., R2 was found on the floor on her butcoks after attempting to reposition herself in the wheelchair. R2 forgot to lock the wheelchair brakes. No injury occurred. Anti-back brakes were added to R2's wheelchair. 3) On 8/27/20 at 12:45 p.m., R2 was found on the floor on her stomach with her right arm out to the side. R2 attempted to self-transfer without locking the wheelchair brakes, and had not used the call light. R2 was offered the toilet at 11:50 a.m., and had not voided. 4) On 8/30/20 at 1:15 p.m., R2 was found on the floor after an attempt to transfer off the toilet without assistance R2 had not used the call light. The investigation report made mention whether staff remained in the bathroom according to R2's care plan. 5) On 9/1/20 at 7:10 a.m., R2 was found on the floor after an attempt to self-transfer from the bed to the wheelchair. R2 was uninjured. R2's fall incident report on 9/8/20, identified R2 fell at 6:30 p.m. The report made no mention R2 had fallen twice on 9/8/20. Additional fall documentation was requested. No documentation was requested. No documentation was provided. R2's 9/8/20, SA report made no mention R2 had fallen twice on 9/8/20. Interview on 9/16/2020 at 1:36 p.m., with occupational therapist (OT)-A identified she interviewed R2 on 9/8/20. Interviewed R2 on 9/8/20, atter her first fall. R2 was alert but had difficulty with verbal expression. OT-A's interview identified R2 was agaited and	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
	 falls during the past month: 1) On 8/1/20 at 7:30 p.m., R2 was found on the floor following an attempt to self-transfer from the wheelchair to the bed. R2 was not injured. 2) On 8/14/20 at 12:40 p.m., R2 was found on the floor on her buttocks after attempting to reposition herself in the wheelchair. R2 forgot to lock the wheelchair brakes. No injury occurred. Anti-back brakes were added to R2's wheelchair. 3) On 8/27/20 at 12:45 p.m., R2 was found on the floor on her stomach with her right arm out to the side. R2 attempted to self-transfer without locking the wheelchair brakes, and had not used the call light. R2 was offered the toilet at 11:50 a.m., and had not voided. 4) On 8/30/20 at 1:15 p.m., R2 was found on the floor after an attempt to transfer off the toilet without assistance R2 had not used the call light. The investigation report made mention whether staff remained in the bathroom according to R2's care plan. 5) On 9/1/20 at 7:10 a.m., R2 was found on the floor after an attempt to self-transfer from the bed to the wheelchair. R2 was uninjured. R2's fall incident report on 9/8/20, identified R2 fell at 6:30 p.m. The report made no mention R2 had fallen twice on 9/8/20. Additional fall documentation was provided. R2's 9/8/20, SA report made no mention R2 had two falls on 9/8/20. Interview on 9/16/2020 at 1:36 p.m., with occupational therapist (OT)-A identified she interviewed R2 on 9/8/20, after her first fall. R2 was alert but had difficulty with verbal expression 				

Minneso	ta Department of H	ealth					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00455		B. WING		(09/1) 8/202 <u>0</u>
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDED LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE INCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	which caused R2 a frustrated nothing resident. OT-A ide move the residents had an extensive f opinion of R2's fall self-transferring w Changes to reside communicated tho that was provided nurses and the DC Observation on 9/ R1 was sitting in h her room. Her hea were closed. Her R1's bed was unm within R1's reach. person was in the R1's 9/8/20, quarte R1 had severe cog diagnoses included degeneration, hea diarrhea, bladder of infections (UTIs), of weakness, impaire history of multiple required extensive transfers, toileting had frequent blado incontinence. R1 w R1's 9/16/20, care R1 was non-ambu	allow her to express a lot of frustration. I was being done ab entified the best opt s away from each of all history. OT-A ide s and history of ere "cries for attent nt care plans were bugh a communicat to case managers, DN. 16/20 at 12:56 p.m. er wheelchair in the ad was down, and h feet were resting of ade. No call light w An unidentified ma room fixing the air erly MDS assessme gnitive impairment. d, Dementia, macu rt disease, constipat disorder, history of bateoporosis, music ed balance and gait falls with fractures. e assistance of one and personal cares der and occasional was not on a toiletin th an injury since he plan fall interventio	R2 was also out the loud ion was to other. R2 entified her ion". ion sheet charge , identified e middle of her eyes n the floor. vas observed intenance conditioner. ent identified R1's lar ation, urinary tract cle , and a R1 staff for s. R1 was bowel ng program. er prior	2 830		DEFICIENCY)	
	arm rest when in h	t was to be placed her recliner, and on					
STATE FOR	N			6899	B3H411	If continuat	on sheet 7 of 11

Minneso	ta Department of He	ealth					
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		_
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2 830	Continued From pa	age 7		2 830			
	railing when in bed call light was within all times. Staff were decision making. T required increased potential falls. R1's fall incident re- falls: 1) On 1/30/20 at 7: on the floor near he uninjured. 2) On 3/3/20 at 2:0 floor next to her re- without using a wa walker was not beso occurred. 3) On 5/5/20 at 7:4 floor lying on her ri- with her head restit table. R1 attempter recliner. R1 had no 4) On 8/6/20 at 8:4 floor. R1 believed i attempted to walk	I. Staff were to ensure reach and on her leter to assist and cue R here was no mention supervision to prever eports identified the for 00 a.m., R1 was four er roommate's bed. If 5 p.m., R1 was found cliner. R1 attempted lker or staff assistance side the resident. No 5 p.m., R1 found R1 ght side covered in a ng on the metal foot of the to walk from her charts.	ft side at 1 for n R1 nt ollowing nd sitting R1 was d on the to walk ce. Her injuries on the blanket of the side nair to her d on the and and nt side at R1 was				
	hematoma and ski	n tear on her left leg. v-up urinalysis was o	R1 had a				
	leg pain at 3:00 a.r	port identified R1 repo n. R1 was transferre to have a non-displa la fractures.	d to the				
Minnesota D	identified changes were communicate stand-up meetings	20 at 10:19 a.m., with in residents' plans of ed during shift report a . Staff could look at o nal communication w	care and during electronic				

Minnesota Depart	<u>ment of H</u>	ealth					
STATEMENT OF DEFIC		(X1) PROVIDER/SUP		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PROVIDER C	R SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAI	N SOCIETY	- PIPESTONE		TH HIAWAT			
PREFIX (EAC	H DEFICIENC	ATEMENT OF DEFICIEN Y MUST BE PRECEDEL _SC IDENTIFYING INFO) BY FULL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE FO THE APPROPRIATE	(X5) COMPLETE DATE
2 830 Continue	ed From pa	age 8		2 830			
	ge nurses	se station. Staff co if they had question					
identified recently issues w for follow plans of commun was uns ensure of	I R1 had a fractured I ith transfe ving the ca care were ication bo ure who en are plans	20 at 10:21 a.m., w a history of falls. Siner leg. R1 had we rring. NAs were r are plan. Changes communicated th ok at the nurse stansured staff were were followed or e rision was maintain	he had eakness and esponsible in residents' e ation. She monitored to ensure				
was in the confusion she was was uns assistan to be vis just gotte the room placed h unsure it assistan the time maintens agreed r care of r thier nee	ne hallway n daily. NA not usuall ure if R1 u ce. Staff v ible and a en up, and n. NA-B pu er call light R1 used ce. NA-B f the light w ance man naintenen esidents a eds.	20 at 12:57 p.m., w and identified R1 A-B was unsure ho y scheduled on R' ised her call light t were to ensure cal ccessible to reside the maintenance illed back R1's bla t within reach. Sh her call light to cal elt R1 was not un vas out of reach be was present in the ce was not respon- nd would be unfar	had by R1 was as 1's unit. She o call for I lights were ents. R1 had man was in nkets and was I for supervised at e room. NA-B usible for the miliar with				
and adm complete to update the IDT of for IDT to	inistrator i ed initial fa e care plan of interven o review. S ns until the	20, at 4:04 p.m., w dentified charge n Il investigations an ns. The charge nu tions on the fall in Staff were to contin ey were updated a	urses nd were able rse updated cident report nue to follow				

Minnesc	ta Department of H	ealth				-	-
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE S COMPL	
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NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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2 830	Continued From pa	age 9		2 830			
	educated of chang resident care plans daily stand-up, at s needed. The staff the facility at this ti documentation wa followed care plans The May, 2016, Fa policy and procedu policy was to deve management prog approach to fall pro- identify risk factors before falls occur, falls; to prevent fur guidance for docur staff were to docur Management Mod post fall huddle an identify risk factors safety. Updates to were to be commu- report. Fall investi and investigated u SUGGESTED ME The director of nur review/revise polic falls, accidents and proper assessment implemented and to of a change in con staff on the policies for evaluating and implementation of developed, with the	les to care plans. Cha s was communicated shift change report, and development nurse we me. She was unsure s available to ensure s a safter they were revise all Prevention and Mar ure identified the purpor lop a fall prevention and ram; implement a pro- evention and manage and implement intervi- give prompt treatment ther injury, and provide mentation. The policy ment falls in the Risk ule. Staff were to con- d use the Falls Tool U s and assist in planning o care plans to preven inicated in the 24 hour gations were to be sys- sing Root Cause Anal THOD OF CORRECT rsing or designee, cou- ies and procedures re- d resident supervision at and interventioins and the provider is prompt dition. They could re- s and procedures. A s- monitoring consistent these policies could b e results of these audi- lity's Quality Assurance	during id as vas not in what staff sed. nagement ose of the nd active ment; ventions t after le r identified nplete a DA to g resident t falls r shift stematic ysis. TION: Id elated to to assure re being ly notified educate system				
Minnesota D	epartment of Health						

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM	R/CLIA /IBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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2 830	Continued From pa	age 10		2 830			
2 830	-	age 10 R CORRECTION: Two	enty-one	2 830			
Vinnesota D	epartment of Health						
	-			0000			

		I AND HUMAN SERVICES E & MEDICAID SERVICES		FORM	D: 10/27/2020 MAPPROVED D: 0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		TE SURVEY MPLETED
	PROVIDER OR SUPPLIER	245591		OS STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA	C /18/20 <u>20</u>
GOOD S	AMARITAN SOCIETY	- PIPESTONE		PIPESTONE, MN 56164	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 COMMEN	тѕ	F 000		
	survey was comple complaint investiga NOT to be in comp	h 9/18/20, an abbreviated eted at your facility to conduct a ation. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.			
		blaint was found to be H5591017C, with a deficiency			
		f correction (POC) will serve of compliance upon the ptance.			
	signature is not rec page of the CMS-2	nrolled in ePOC, your juired at the bottom of the first 567 form. Your electronic POC will be used as bliance.			
F 689 SS=D	on-site revisit of yo validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with azards/Supervision/Devices 1)(2)	F 689		10/26/20
	as free of accident	nsure that - resident environment remains hazards as is possible; and			
	supervision and as accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced			
		DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE
Electron	ically Signed				10/20/2020

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

	RS FOR MEDICAR	RE & MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI	TIPLE CONSTRUCTION		E SURVEY PLETED
	ENNI	245591	B. WING	MEDCE		C 18/202 <u>0</u>
NAME OF F	ROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOOD SA	AMARITAN SOCIET	TY - PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164		-
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIOI DATE
F 689	Continued From	page 1	F 6	89		
	review, the facility	vation, interview, and document y failed to ensure appropriate care plans followed for 2 of 2		Statement of Compliance: Preparation and execution of	of this	
		d R2) to prevent potential future		response and plan of correct constitute an admission or a the provider of the truth of th	ction does not agreement by ne facts	
		te Agency (SA) report identified		alleged or conclusions set for statement of deficiencies. T correction is prepared and/o	he plan of or executed	
	the floor. Prior to because R4 was help, and staff as	at 6:30 p.m. R2 was found on the incident R2 was agitated in her room. R2 called staff for sisted R4 out of R2's room.		solely because it is required provisions of state and fede the purposes of any allegati center is not in substantial of with federal requirements of	ral law. For on that the compliance	
	found on the floo after the fall, and the emergency d night, R2 develop	ed R4 out of the room, R2 was r. R2 had no pain immediately initially declined evaluation at epartment (ED). Throughout the bed increased hip pain and was		with federal requirements of this response and plan of co constitutes the center's alle compliance in accordance v 7305 of the State Operation	prrection gation of vith section is Manual.	
	non-displaced lef	ED. R2 was found to have a term fracture. R2 declined attributed to the tervention and returned to the		This plan of correction cons written allegation of substar compliance with Federal Me Medicaid requirements.	ntial	
	identified her cog included history of hemiparesis and	ual Minimum Data Set (MDS) nition was intact. R2's diagnoses of stroke with left-sided hemiplegia (left-sided leg and		F689 1. According to the deficie the facility failed to ensure p supervision and care plans	proper for 2 of 2	
	anxiety, severe d disorder, epilepsy hip pain, and mus	difficulty speaking, weakness, epression, expressive language y, history of left hip fracture, left scle weakness. R2 required unce of one staff to transfer		residents. Surveyor observ within reach of R (1). Call li immediately given to R (1). have a toileting program in 9/28/20 an every three hour	ght was R (1) did not place. On	
	between surfaces frequently inconti occasional bowe	s, and to use the toilet. R2 was nent of urine, and had incontinence. R2 was not on a . R2 had constant pain rated 8 of		prompt to void was added to R (1)'s care plan did not ide increased supervision to pre Care plan modified on 10/12 need for increased supervision	o plan of care. ntify need for event falls. 2/20 to include	

Facility ID: 00455

If continuation sheet Page 2 of 10

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
D PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COMPLETED
	ENDI	245591	B. WING	VIEDCE	C 09/18/2020
AME OF I	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C	
	AMARITAN SOCIET			1311 NORTH HIAWATHA	
1000 5	AMARITAN SUCIET	F - PIPESTONE		PIPESTONE, MN 56164	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLET
F 689	Continued From p	bage 2	F 689	9	
	R2's 9/16/20, card pain in her left arr verbal ommunica mobility and used brakes for transpo of one staff for tra person cares and implement 15-mir was not aware of impulsive. R2 was R2 to activate her lock her wheelcha R2's wheelchair w plan failed to iden supervision requin Observation on 9/ identified R2 was the head of the be was located on th next to her bed as attempted self-tra Interview on 9/16/ R2 used a full boo Prior to her last fa	e plan identified R2 had chronic n and leg. R2 had impaired tion. R2 had limited physical a wheelchair with locking portation. R2 required assistance unsfers between surfaces, toileting. Staff were to nute checks when needed. R2 her limitations and was s a fall risk. Staff were to remind call light for assistance and air brakes. Staff were to ensure vas next to her bed. The care tify the need for increased red to prevent potential falls. (16/2020 at 9:52 a.m., of R2 lying in bed, eyes closed, with ed elevated. R2's wheelchair e wall opposite and not kept s care planned in case she		 Surveyor observed wheelch opposite side of room when bed. Wheelchair was place immediately upon notification observation. R (2) did not h program in place, however plan was updated with an e prompt to void schedule. R plan did not identify need for supervision to prevent falls. modified on 10/12/20 to inc increased supervision to prevent falls. 2. This has the potential to residents with increased ris Interdisciplinary review of rehigh fall risk and/or major in completed and care plans w and modified by Case Mana designee by 10/26/20. 3. All Nursing Staff are ed orientation on where to find follow care plan/Kardex upo Clinical Educator. All Nursi re-educated per the Director or designee on importance 	A R (2) was in ad next to bed on of nave a toileting on 8/3/20 care very 3 hour (2)'s care r increased Careplan lude need for event falls. o affect all k for falls. esidents with jury will be vill be reviewed ager, or ucated during , read, and on hire per ng Staff will be r of Nursing,
	since been angry difficulty commun was easily frustra R2's fall preventio strips by her bed, her room. Falls w she refused to ca had a history of tr and had self-trans	She was impulsive, and had icating. She fell frequently. R2 ted and frequently refused care. ons included placement of grip call lights were placed all over vere difficult to prevent because Il for help and refused care. R2 ansferring without assistance sferred less after her fall, but und sitting on the edge of her		 plans, communicate change plans and the vital role the of in ensuring residents are sa 10/26/20. 4. Re-education was prov CNAs who were observed r care plans on 9/17/20, educ importance of following care with each resident interaction 	es to care care plan plays ife by ided to three not following cation included e plan/Kardex

Facility ID: 00455

If continuation sheet Page 3 of 10

DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE	SURVEY
וחאב	245591	B. WING			C 18/2020
		18	311 NORTH HIAWATHA		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	(X5) COMPLETIO DATE
mitations. bbservation and i .m., of R2's door o observe her ev- elf-transfer had o nd fracture, how he edge of the be- ded. R2 did not her ecause of her fra- elf-transfer. R2 a nursing home amily. R2's had nd became easile lentify her needs bbservation on 9/ 12's wheelchair of pposite R2's become bbservation, inter- n 9/16/20 at 12:4 urse (LPN)-A ide gainst the wall o 12's care plan inco- ext to the bed for nti-back brakes ack. R2 was no t this time, and we elf-transfer. The rall because she elf-transfer since R2's current car	nterview on 9/16/20 at 10:10 with NA-A identified staff were ery hour. R2 attempts to decreased down since her fall ever, she continued to scoot to ed. This am she was found at ed and was assisted back into ave her wheelchair by her bed acture and reduced attempts to was alert, and did not want to be acture and reduced attempts to was alert, and did not want to be acture and reduced attempts to was alert, and did not want to be acture and reduced attempts to was alert, and did not want to be acture and reduced attempts to was alert, and did not want to be acture and reduced attempts to was alert, and docuer attempts to acture and reduced attempted to a her last fall. LPN-A was unsure e plan was to place the	F 689	 nursing staff regarding fall prevent policies and care plan being for This will be completed by the E Nursing, or designee with mane ducation. Professional Nursing were educated on 9/28/20 and the Director of Nursing. Nursing Staff to be educated by 10/26/2 to their next scheduled shift. 5. To monitor performance and compliance the DON, or design audit resident care plans with h falls. Four residents' care plans reviewed; that have a risk for falls followed weekly for 4 we 1x per month for 3 months unt are sustained. Results will be monthly at Quality Assurance/Performance Improvisional care plans with the falls of the care plans with the provided weekly for the plane plane weekly for the plane plane plane. 	vention llowed. Director of datory ng Staff 9/30/20 by ng Assistant 20 or prior nd ensure nee, will nistory of s will be alls and e plan is eks, then il results reviewed	
	FOR MEDICAR FOR MEDICAR DEFICIENCIES CORRECTION DVIDER OR SUPPLIEN IARITAN SOCIET SUMMARY S (EACH DEFICIEN REGULATORY OR Continued From p mitations. Dbservation and i .m., of R2's door o observe her ev elf-transfer had c nd fracture, how he edge of the be ed. R2 did not h ecause of her fra elf-transfer. R2 f n a nursing home amily. R2's had c nd became easil dentify her needs Dbservation on 9/ 2's wheelchair c pposite R2's bec Dbservation, inter n 9/16/20 at 12:4 urse (LPN)-A ide gainst the wall of 12's care plan inc ext to the bed fo nti-back brakes f ack. R2 was not t this time, and w elf-transfer. The vall because she elf-transfer since R2's current car heelchair away f	CORRECTION IDENTIFICATION NUMBER: 245591 DVIDER OR SUPPLIER ARRITAN SOCIETY - PIPESTONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 mitations. Observation and interview on 9/16/20 at 10:10 .m., of R2's door with NA-A identified staff were o observe her every hour. R2 attempts to elf-transfer had decreased down since her fall nd fracture, however, she continued to scoot to be edge of the bed. This am she was found at the edge of her bed and was assisted back into ed. R2 did not have her wheelchair by her bed ecause of her fracture and reduced attempts to	FOR MEDICARE & MEDICAID SERVICES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591 CORRECTION 245591 DUILER 245591 DUIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCIES IDENTIFY AND AND INCH AND AND INCH AND AND INCHTON	FOR MEDICARE & MEDICAID SERVICES Deficiencies ORDECTION INPERIENCE DEVIDER OR SUPPLIER LARITAN SOCIETY - PIPESTONE SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Stream Somitations. PREDICE from the provider of the provider the provider of the provider of the provider of the t	FOR MEDICARE & MEDICAID SERVICES OMB NO. DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE CORRECTION (X1) PROVIDER/SUPPLIERCLA (X2) MULTIPLE CONSTRUCTION (X3) DATE CORRECTION 245591 (X2) MULTIPLE CONSTRUCTION (X3) DATE DVIDER OR SUPPLIER 245591 (X2) MULTIPLE CONSTRUCTION (X3) DATE TARITAN SOCIETY - PIPESTONE IN ORTH HAWATHA (2007) SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION SHOULD BE (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION Intraction SUMMARY STATEMENT OF DEFICIENCIES (Y2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION Intraction SUMPLIER SUMMARY STATEMENT OF DEFICIENCIES (Y2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION SUMMARY STATEMENT OF DEFICIENCIES (Y2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION Solution Construction MULTIPLE CONSTRUCTION (Y2) MULTIPLE CONSTRUCTION

If continuation sheet Page 4 of 10

TATEMENT	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			B NO. 0938-039 (3) DATE SURVEY COMPLETED	
		245591	A. BUILDING	I EDCEME	C	
	PROVIDER OR SUPPLIE			REET ADDRESS, CITY, STATE, ZIP CODE	09/18/20 <u>20</u>	
			131	1 NORTH HIAWATHA PESTONE, MN 56164		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 689	Continued From	page 4	F 689			
	plan and notify th managers and di care plan were u team (IDT) would interventions wer notify the director placing the whee identified she was R2's second fall. shift prior to the s frequently checke increased agitation R2's fall incident falls during the pa 1) On 8/1/20 at 7 floor following an wheelchair to the 2) On 8/14/20 at floor on her butto herself in the whee brakes were add 3) On 8/27/20 at floor on her stom side. R2 attempt locking the whee the call light. R2 v a.m., and had no 4) On 8/30/20 at floor after an atter without assistance	30 p.m., R2 was found on the attempt to self-transfer from the bed. R2 was not injured. 12:40 p.m., R2 was found on the cks after attempting to reposition eelchair. R2 forgot to lock the s. No injury occurred. Anti-back ed to R2's wheelchair. 12:45 p.m., R2 was found on the ach with her right arm out to the ed to self-transfer without chair brakes, and had not used was offered the toilet at 11:50				
	staff remained in care plan. 5) On 9/1/20 at 7 floor after an atte	the bathroom according to R2's 10 a.m., R2 was found on the mpt to self-transfer from the bed R2 was uninjured.				

If continuation sheet Page 5 of 10

CENTER	RS FOR MEDICAL	TH AND HUMAN SERVICE	S		PRINTED: 10/27/202 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245591	B. WING		C 09/18/2020
NAME OF F	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP	
GOOD S	AMARITAN SOCIE	TY - PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULI R LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE COMPLÉTION E APPROPRIATE DATE
F 689	Continued From	page 5	F 689		
	fell at 6:30 p.m. had fallen twice o	report on 9/8/20, identified The report made no mention on 9/8/20. Additional fall vas requested. No vas provided.			
	R2's 9/8/20, SA r two falls on 9/8/2	report made no mention R2 20.	had		
	occupational their interviewed R2 of was alert but had OT-A's interview had increased im patient enough to which caused R2 frustrated nothing resident. OT-A is move the resider had an extensive opinion of R2's fa self-transferring Changes to reside communicated th that was provided nurses and the D		R2 ession. and not needs, s also e loud as to R2 d her eet e		
	R1 was sitting in her room. Her he were closed. He R1's bed was un within R1's reach person was in the	0/16/20 at 12:56 p.m., ident her wheelchair in the midd ead was down, and her eye r feet were resting on the f made. No call light was obs n. An unidentified maintena e room fixing the air condition	le of es loor. served nce oner.		
		rterly MDS assessment ide ognitive impairment. R1's		acility ID: 00455	If continuation sheet Page 6 of

If continuation sheet Page 6 of 10

	OF DEFICIENCIES	<u>RE & MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	MB NO. 0938-03 (X3) DATE SURVEY	
ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED		
	ENDI	245591	B. WING	ILENCEMI	C 09/18/2020	
AME OF F	PROVIDER OR SUPPLIE		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
OOD SA	AMARITAN SOCIET	Y - PIPESTONE		I1 NORTH HIAWATHA PESTONE, MN 56164		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETI	
F 689	Continued From	page 6	F 689			
		ed, Dementia, macular	1 000			
	degeneration, her	art disease, constipation,				
		disorder, history of urinary tract osteoporosis, muscle				
		red balance and gait, and a				
		falls with fractures. R1				
		e assistance of one staff for gand personal cares. R1 was				
		Ider and occasional bowel				
	incontinence. R1	was not on a toileting program.				
	R1 had one fall w assessment.	ith an injury since her prior				
	B1's 9/16/20, car	e plan fall interventions included				
		ulatory due to a lower extremity				
		ht was to be placed on R1's left				
		her recliner, and on the bed d. Staff were to ensure R1's				
		in reach and on her left side at				
		ere to assist and cue R1 for				
		There was no mention R1 d supervision to prevent				
	potential falls.					
		reports identified the following				
	falls: 1) On 1/30/20 at	7:00 a.m., R1 was found sitting				
	on the floor near	her roommate's bed. R1 was				
	uninjured.					
		:05 p.m., R1 was found on the ecliner. R1 attempted to walk				
		alker or staff assistance. Her				
		eside the resident. No injuries				
	occurred. 3) On $5/5/20$ at 7	:45 p.m., R1 found R1 on the				
		right side covered in a blanket				
	with her head res	ting on the metal foot of the side				
	table. R1 attemp recliner. R1 had	ted to walk from her chair to her				

If continuation sheet Page 7 of 10

STATE PLANOF CORRECTION (X) PROVIDERSUPPLER (X) MUTIPLE CONSTRUCTION (X) DATE EURPYCY AND PLANOF CORRECTION 245591 (X) MUTIPLE CONSTRUCTION (X) DATE EURPYCY MARE OF PROVIDER OR SUPPLER 245591 (X) WING C (O) 78/2020 GOOD SAMARITAN SOCIETY - PIPESTONE STREET ADDRESS, CITY, STATE, ZIP CODE (A) MUTIPLE CONSTRUCTION NUMBER: COUPTRESTONE COUPTRESTONE COUPTRESTONE PREFX SUMMARY STATEMENT OF DEFICIENCIES IN OPTIME/CONSTRUCTION CONTROL OF DEFICIENCIES (EACH CORRECTION GUERA COTION SHOULD BE COUPTRESS PREFX SUMMARY STATEMENT OF DEFICIENCIES IN OPTIME/CONSTRUCTION SHOULD BE COUPTRESS COUPTRESS PREFX SUMMARY STATEMENT OF DEFICIENCIES IN OPTIME/CONSTRUCTION SHOULD BE COUPTRESS COUPTRESS PREFX Continued From page 7 IN ON SHOULD BE IN OPTIME/CONSTRUCTION SHOULD BE COUPTRESS F 689 Continued From page 7 IN ON SHOULD SHOUL			AND HUMAN SERVICES			FORM	10/27/2020 APPROVED 0938-0391
Provide PROVIDER OR SUPPLIER 245591 B. WING STREET ADDRESS, CITY, STATE, ZP CODE GOOD SAMARTIAN SOCIETY - PIPESTONE 1311 NORTH HIAWATIA PIPESTONE, INN 56164 1311 NORTH HIAWATIA PIPESTONE, INN 56164 (MI ID PHEFK TKG SUMMARY STATEMENT OF DEPICIENCIES IEACH DEPICIENCY MUST BE PRECEEDED BY FULL REGULATIONY OR LSC DEVTRYING INFORMATION ID PREFIX REGULATIONY OR LSC DEVTRYING INFORMATION ID PREFIX TKG PROVIDERS PLAN OF CORRECTION CROSS REFERENCIAN SHOULD BE CROSS REFERENCIAN SHOULD BE DEFICIENCY COMMETTING INFORMATION F 689 Continued From page 7 4) On 8/6/20 at 8:40 p.m., R1 was found on the floor. R1 believed it was time for dinner, and a hematoma and skin tear on her left leg. R1 had a recent UTI. A follow-up urinalysis was ordered and R1 was found to have a non-displaced left lower tibia and fibula fractures. F 689 Interview on 9/16/20 at 10:19 a.m., with NA-A identified changes in residents' plans of care were communicated during shift report and during stand-up meetings. Staff could look at lectronic care plans. Additional communication was also in a binder at the nurse station. Staff could also ask the charge nurses if they had questions about resident care. Interview on 9/16/20 at 10:21 a.m., with LPN-A identified R1 had a history of falls. She had recently fractured her leg. R1 had weakness and issues with transferring. N&s were responsible for following the care plan. Changes in residents' plans of care were communicated the communication book at the nurse station. She was unsure who ensured staff were monitored to ensure care plans were followed or ensure	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	E SURVEY
GOOD SAMARITAN SOCIETY - PIPESTONE 1311 NORTH HIAWATHA PIPESTONE, MN 56164 CODE JAMARITAN SOCIETY - PIPESTONE D PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY UNIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDERS PLAN OF CORRECTION (EACH OPRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Ord DATE F 689 Continued From page 7 4) On 8/6/20 at 8:40 p.m., R1 was found on the floor. R1 believed it was time for dinner, and attempted to walk to dinner. R1 was conclused. R1 had multiple bruised on her left arm, and a hematoma and skin tear on her left leg. R1 had a recent UTI. A follow-up uninalysis was ordered and R1 was found to have a UTI. F 689 R1's 8/7/20, SA report identified R1 reported left leg pain at 3:00 a.m. R1 was transferred to the ED and was found to have a non-displaced left lower tibia and fibula fractures. F 689 Interview on 9/16/20 at 10:19 a.m., with NA-A identified changes in residents' plans of care were communicated during shift report and during stand-up meetings. Staff could also ask the charge nurses fithey had questions about resident care. Interview on 9/16/20 at 10:21 a.m., with LPN-A identified R1 had a history of falls. She had recently fractured her leg. R1 had weakness and issues with transferring. NAs were responsible for following the care plan. Changes in residents' plans of care were communicated to was unsure who ensured staff were monitored to ensure care plans were followed or ensure		ENDI	245591		/ EDCEM		
Production Provide stratement of DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S REPERANOF CORRECTION (EACH ODERICTIVE ACTION SHOLD BE CROSS REFERENCE TO THE APPROPRIATE DEFICIENCY) O D DATE F 689 Continued From page 7 4) On 8/6/20 at 8:40 p.m., R1 was found on the floor. R1 believed it was time for dinner, and attempted to walk to dinner. R1 was confused. R1 had multiple bruised on her left tarm, and a hematoma and skin tear on her left leg. R1 had a recent UTI. A follow-up urinalysis was ordered and R1 was found to have a UTI. F 689 R1's 8/7/20, SA report identified R1 reported left leg pain at 3:00 a.m. R1 was transferred to the ED and was found to have a non-displaced left lower tibia and fibula fractures. Interview on 9/16/20 at 10:19 a.m., with NA-A identified changes in residents' plans of care were communicated during shift report and during stand-up meetings. Staff could look at electronic care plans. Additional communication was also in a binder at the nurse station. Staff could also ask the charge nurses if they had questions about resident care. Interview on 9/16/20 at 10:21 a.m., with LPN-A identified R1 had a history of falls. She had recently fractured her leg. R1 had weakness and issues with transferring. NAs were responsible for following the care plan. Changes in residents' plans of care were communicated the communication book at the nurse station. She was unsure who ensured statif were monitored to ensure care plans were followed or ensure					W Rear Description () and Rear 1 W R		
Přičív TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) PŘĚTX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLÉTIC DIVENCE TO THE APPROPRIATE COMPLÉTIC DIVENCE TO THE APPROPRIATE DEFICIENCY) F 689 Continued From page 7 F 689 F 689 F 689 4) On 8/6/20 at 8:40 p.m., R1 was found on the floor. R1 believedi ti was time for dinner, and a thematoma and skin tear on her left ag. R1 had a recent UTI. A follow-up urinalysis was ordered and R1 was found to have a UTI. F 689 R1's 8/7/20, SA report identified R1 reported left leg pain at 3:00 a.m. R1 was transferred to the ED and was found to have a non-displaced left lower tibia and fibula fractures. Interview on 9/16/20 at 10:19 a.m., with NA-A identified changes in residents' plans of care were communicated during shift report and during stand-up meetings. Staff could loka a lelectronic care plans. Additional communication was also in a binder at the nurse station. Staff could also ask the charge nurses if they had questions about resident care. Interview on 9/16/20 at 10:21 a.m., with LPN-A identified R1 had a history of falls. She had recently fractured her leg. R1 had wakness and issues with transferring. NAs were responsible for following the care plan. Changes in residents' plans of care were communicated the Ent	GOOD 5	AMARITAN SOCIETY	- PIPESTONE	Р	IPESTONE, MN 56164		
 4) On 8/6/20 at 8:40 p.m., R1 was found on the floor. R1 believed it was time for dinner, and attempted to walk to dinner. R1 was confused. R1 had multiple bruised on her left arm, and a hematoma and skin tear on her left leg. R1 had a recent UTI. A follow-up urinalysis was ordered and R1 was found to have a UTI. R1's 8/7/20, SA report identified R1 reported left leg pain at 3:00 a.m. R1 was transferred to the ED and was found to have a non-displaced left lower tibia and fibula fractures. Interview on 9/16/20 at 10:19 a.m., with NA-A identified changes in residents' plans of care were communicated during shift report and during stand-up meetings. Staff could look at electronic care plans. Additional communication was also in a binder at the nurse station. Staff could also ask the charge nurses if they had questions about resident care. Interview on 9/16/20 at 10:21 a.m., with LPN-A identified R1 had a history of falls. She had recently fractured her leg. R1 had weakness and issues with transferring. NAs were responsible for following the care plan. Changes in residents' plans of care were communicated the communicated the communicated the station. She was unsure who ensured staff were monitored to ensure care plans were followed to resure care plans. 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
Interview on 9/26/20 at 12:57 p.m., with NA-B was in the hallway and identified R1 had confusion daily. NA-B was unsure how R1 was as she was not usually scheduled on R1's unit. She was unsure if R1 used her call light to call for assistance. Staff were to ensure call lights were	F 689	 4) On 8/6/20 at 8:4 floor. R1 believed it attempted to walk the had multiple bruise hematoma and skin recent UTI. A follow and R1 was found R1's 8/7/20, SA repleg pain at 3:00 a.m. ED and was found lower tibia and fibu Interview on 9/16/2 identified changes were communicates stand-up meetings care plans. Addition a binder at the nurse the charge nurses resident care. Interview on 9/16/2 identified R1 had a recently fractured hissues with transfer for following the ca plans of care were communication body was unsure who er ensure care plans of appropriate superv Interview on 9/26/2 was in the hallway confusion daily. NA she was not usually was unsure if R1 us 	0 p.m., R1 was found on the a was time for dinner, and o dinner. R1 was confused. R1 d on her left arm, and a n tear on her left leg. R1 had a y-up urinalysis was ordered to have a UTI. oort identified R1 reported left n. R1 was transferred to the to have a non-displaced left la fractures. 0 at 10:19 a.m., with NA-A in residents' plans of care d during shift report and during . Staff could look at electronic nal communication was also in se station. Staff could also ask if they had questions about 0 at 10:21 a.m., with LPN-A history of falls. She had her leg. R1 had weakness and rring. NAs were responsible re plan. Changes in residents' communicated the ok at the nurse station. She nsured staff were monitored to were followed or ensure ision was maintained. 0 at 12:57 p.m., with NA-B and identified R1 had -B was unsure how R1 was as y scheduled on R1's unit. She sed her call light to call for	F 689			

If continuation sheet Page 8 of 10

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE SURVEY		
ND PLAN O	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED		
		245591	B. WING		C 09/18/2020		
	PROVIDER OR SUPPLI			REET ADDRESS, CITY, STATE, ZIP CODE	09/18/2020		
GOOD S	AMARITAN SOCIE			1 NORTH HIAWATHA			
			PIP	ESTONE, MN 56164			
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO		
F 689	Continued From	page 8	F 689				
		accessible to residents. R1 had					
		nd the maintenance man was in pulled back R1's blankets and					
		ght within reach. She was					
	unsure if R1 use	d her call light to call for					
		B felt R1 was not unsupervised a was out of reach because the	t				
		in was present in the room. NA-E	;				
	agreed maintene	ence was not responsible for the					
	care of residents thier needs.	and would be unfamiliar with					
	the needs.						
		5/20, at 4:04 p.m., with the DON					
		r identified charge nurses fall investigations and were able					
	to update care p	lans. The charge nurse updated					
		entions on the fall incident report					
		. Staff were to continue to follow hey were updated and staff					
		nges to care plans. Changes to					
		ins was communicated during					
		t shift change report, and as aff development nurse was not in					
		time. She was unsure what					
	documentation w	vas available to ensure staff					
	followed care pla	ans after they were revised.					
		Fall Prevention and Management					
		dure identified the purpose of the					
		velop a fall prevention and ogram; implement a proactive					
		prevention and management;					
	identify risk facto	ors and implement interventions					
		r, give prompt treatment after further injury, and provide					
		umentation. The policy identified	k				
	staff were to doc	ument falls in the Risk					
		odule. Staff were to complete a and use the Falls Tool UDA to					

Facility ID: 00455

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		AND HUMAN SERVICES			FORM	10/27/2020 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245591	B. WING	VIERCEM	09/1	C 18/2020
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	EN	•
GOOD S	AMARITAN SOCIETY	- PIPESTONE		I311 NORTH HIAWATHA PIPESTONE, MN 56164		-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 689	safety. Updates to were to be communi- report. Fall investig	age 9 and assist in planning resident care plans to prevent falls nicated in the 24 hour shift gations were to be systematic sing Root Cause Analysis.	F 689			

Facility ID: 00455