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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

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: kamala.fiske-downing@state.mn.us

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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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

Nicole 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,

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: kamala.fiske-downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00455	A. BUILDING: _____ B. WING _____	C 09/18/2020

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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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: On 9/16/20 through 9/18/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5591017C, with a licensing order issued at S830. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision and care plans followed for 2 of 2 residents (R1 and R2) to prevent potential future falls. Findings include: R2's 9/10/20, State Agency (SA) report identified R2 fell on 9/8/20 at 6:30 p.m. R2 was found on the floor. Prior to the incident R2 was agitated	2 830	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	10/20/20

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2 830	Continued From page 2 because R4 was in her room. R2 called staff for help, and staff assisted R4 out of R2's room. After staff assisted R4 out of the room, R2 was found on the floor. R2 had no pain immediately after the fall, and initially declined evaluation at the emergency department (ED). Throughout the night, R2 developed increased hip pain and was transferred to the ED. R2 was found to have a non-displaced left femur fracture. R2 declined further medical intervention and returned to the facility. R2's 7/2/20, annual Minimum Data Set (MDS) identified her cognition was intact. R2's diagnoses included history of stroke with left-sided hemiparesis and hemiplegia (left-sided leg and arm impairment), difficulty speaking, weakness, anxiety, severe depression, expressive language disorder, epilepsy, history of left hip fracture, left hip pain, and muscle weakness. R2 required extensive assistance of one staff to transfer between surfaces, and to use the toilet. R2 was frequently incontinent of urine, and had occasional bowel incontinence. R2 was not on a toileting program. R2 had constant pain rated 8 of 10 that affected her daily activities. R2's 9/16/20, care plan identified R2 had chronic pain in her left arm and leg. R2 had impaired verbal ommunication. R2 had limited physical mobility and used a wheelchair with locking brakes for transportation. R2 required assistance of one staff for transfers between surfaces, person cares and toileting. Staff were to implement 15-minute checks when needed. R2 was not aware of her limitations and was impulsive. R2 was a fall risk. Staff were to remind R2 to activate her call light for assistance and lock her wheelchair brakes. Staff were to ensure R2's wheelchair was next to her bed. The care	2 830	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. F689 1. According to the deficiency statement, the facility failed to ensure proper supervision and care plans for 2 of 2 residents. Surveyor observed no call light within reach of R (1). Call light was immediately given to R (1). R (1) did not have a toileting program in place. On 9/28/20 an every three hour schedule to prompt to void was added to plan of care. R (1)□s care plan did not identify need for increased supervision to prevent falls. Care plan modified on 10/12/20 to include need for increased supervision to prevent falls. Surveyor observed wheelchair on opposite side of room when R (2) was in bed. Wheelchair was placed next to bed immediately upon notification of observation. R (2) did not have a toileting program in place, however on 8/3/20 care plan was updated with an every 3 hour prompt to void schedule. R (2)□s care plan did not identify need for increased supervision to prevent falls. Careplan modified on 10/12/20 to include need for increased supervision to prevent falls.	

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2 830	Continued From page 3 plan failed to identify the need for increased supervision required to prevent potential falls. Observation on 9/16/2020 at 9:52 a.m., of R2 identified R2 was lying in bed, eyes closed, with the head of the bed elevated. R2's wheelchair was located on the wall opposite and not kept next to her bed as care planned in case she attempted self-transfer. Interview on 9/16/20 9:56 a.m., NA-A identified R2 used a full body lift and assistance of 2 staff. Prior to her last fall, R2 pivot transferred with assistance of 1 staff. R2 had a stroke and had since been angry. She was impulsive, and had difficulty communicating. She fell frequently. R2 was easily frustrated and frequently refused care. R2's fall preventions included placement of grip strips by her bed, call lights were placed all over her room. Falls were difficult to prevent because she refused to call for help and refused care. R2 had a history of transferring without assistance and had self-transferred less after her fall, but today she was found sitting on the edge of her bed. Staff try to position her as far from edge of bed as possible. R2 was unaccepting of her limitations. Observation and interview on 9/16/20 at 10:10 a.m., of R2's door with NA-A identified staff were to observe her every hour. R2 attempts to self-transfer had decreased down since her fall and fracture, however, she continued to scoot to the edge of the bed. This am she was found at the edge of her bed and was assisted back into bed. R2 did not have her wheelchair by her bed because of her fracture and reduced attempts to self-transfer. R2 was alert, and did not want to be in a nursing home. She wanted to be with her family. R2's had difficulty expressing her needs	2 830	2. This has the potential to affect all residents with increased risk for falls. Interdisciplinary review of residents with high fall risk and/or major injury will be completed and care plans will be reviewed and modified by Case Manager, or designee by 10/26/20. 3. All Nursing Staff are educated during orientation on where to find, read, and follow care plan/Kardex upon hire per Clinical Educator. All Nursing Staff will be re-educated per the Director of Nursing, or designee on importance to follow care plans, communicate changes to care plans and the vital role the care plan plays in ensuring residents are safe by 10/26/20. 4. Re-education was provided to three CNAs who were observed not following care plans on 9/17/20, education included importance of following care plan/Kardex with each resident interaction to allow residents to be in the safest position/safe environment to minimize fall risk. Re-education will be provided to all nursing staff regarding fall prevention policies and care plan being followed. This will be completed by the Director of Nursing, or designee with mandatory education. Professional Nursing Staff were educated on 9/28/20 and 9/30/20 by the Director of Nursing. Nursing Assistant Staff to be educated by 10/26/20 or prior to their next scheduled shift. 5. To monitor performance and ensure compliance the DON, or designee, will audit resident care plans with history of falls. Four residents□ care plans will be	

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2 830	Continued From page 4 and became easily agitated if staff were unable to identify her needs. Observation on 9/16/20 at 12:40 p.m., identified R2's wheelchair continued to be against the wall opposite R2's bed. Observation, interview, and docuement review, on 9/16/20 at 12:47 p.m., with licensed practical nurse (LPN)-A identified R2's wheelchair was against the wall opposite her bed. Before her fall, R2's care plan included to keep the wheelchair next to the bed for safety. The wheelchair had anti-back brakes to prevent the chair from rolling back. R2 was not able to transfer independently at this time, and was not currently at risk to self-transfer. The NAs put the wheelchair by the wall because she had not attempted to self-transfer since her last fall. LPN-A was unsure if R2's current care plan was to place the wheelchair away from R2's bedside. Review of R2's current care plan with LPN-A identified R2's wheelchair was to be placed at the bedside. LPN-A identified staff were to continue to follow the care plan until the care plans were reviewed. Any charge nurse was able to modify the care plan and notify the registered nursed, case managers and director of nursing (DON) when care plan were updated. The interdisciplinary team (IDT) would review care plans to determine interventions were appropriate. LPN-A planned to notify the director of nursing (DON) to review placing the wheelchair at the bedside. LPN-A identified she was the nurse on duty at the time R2's second fall. R2 had also fallen earlier in the shift prior to the start of LPN-A's shift. Staff frequently checked on R2 because of her increased agitation. R2 was difficult to redirect. R2's fall incident reports identified the following	2 830	reviewed; that have a risk for falls and observation will occur that care plan is being followed weekly for 4 weeks, then 1x per month for 3 months until results are sustained. Results will be reviewed monthly at Quality Assurance/Performance Improvement meetings by the Interdisciplinary Team.	

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2 830	Continued From page 5 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 requested. No 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. OT-A's interview identified R2 was agitated and had increased impulsivity. R2 felt staff were not	2 830		

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2 830	Continued From page 6 patient enough to allow her to express her needs, which caused R2 a lot of frustration. R2 was also frustrated nothing was being done about the loud resident. OT-A identified the best option was to move the residents away from each other. R2 had an extensive fall history. OT-A identified her opinion of R2's falls and history of self-transferring were "cries for attention". Changes to resident care plans were communicated though a communication sheet that was provided to case managers, charge nurses and the DON. Observation on 9/16/20 at 12:56 p.m., identified R1 was sitting in her wheelchair in the middle of her room. Her head was down, and her eyes were closed. Her feet were resting on the floor. R1's bed was unmade. No call light was observed within R1's reach. An unidentified maintenance person was in the room fixing the air conditioner. R1's 9/8/20, quarterly MDS assessment identified R1 had severe cognitive impairment. R1's diagnoses included, Dementia, macular degeneration, heart disease, constipation, diarrhea, bladder disorder, history of urinary tract infections (UTIs), osteoporosis, muscle weakness, impaired balance and gait, and a history of multiple falls with fractures. R1 required extensive assistance of one staff for transfers, toileting and personal cares. R1 was had frequent bladder and occasional bowel incontinence. R1 was not on a toileting program. R1 had one fall with an injury since her prior assessment. R1's 9/16/20, care plan fall interventions included R1 was non-ambulatory due to a lower extremity fracture. A call light was to be placed on R1's left arm rest when in her recliner, and on the bed	2 830		

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2 830	Continued From page 7 railing when in bed. Staff were to ensure R1's call light was within reach and on her left side at all times. Staff were to assist and cue R1 for decision making. There was no mention R1 required increased supervision to prevent potential falls. R1's fall incident 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. 2) On 3/3/20 at 2:05 p.m., R1 was found on the floor next to her recliner. R1 attempted to walk without using a walker or staff assistance. Her walker was not beside the resident. No injuries occurred. 3) On 5/5/20 at 7:45 p.m., R1 found R1 on the floor lying on her right side covered in a blanket with her head resting on the metal foot of the side table. R1 attempted to walk from her chair to her recliner. R1 had no injuries. 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	2 830		

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	00455	A. BUILDING: _____ B. WING _____	C 09/18/2020

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2 830	Continued From page 8 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 staff were monitored to ensure care plans were followed or ensure appropriate supervision was maintained. 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 to be visible and accessible to residents. R1 had just gotten up, and the maintenance man was in the room. NA-B pulled back R1's blankets and placed her call light within reach. She was unsure if R1 used her call light to call for assistance. NA-B felt R1 was not unsupervised at the time the light was out of reach because the maintenance man was present in the room. NA-B agreed maintenence was not responsible for the care of residents and would be unfamiliar with thier needs. Interview on 9/16/20, at 4:04 p.m., with the DON and administrator identified charge nurses completed initial fall investigations and were able to update care plans. The charge nurse updated the IDT of interventions on the fall incident report for IDT to review. Staff were to continue to follow care plans until they were updated and staff	2 830		

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2 830	Continued From page 9 educated of changes to care plans. Changes to resident care plans was communicated during daily stand-up, at shift change report, and as needed. The staff development nurse was not in the facility at this time. She was unsure what documentation was available to ensure staff followed care plans after they were revised. The May, 2016, Fall Prevention and Management policy and procedure identified the purpose of the policy was to develop a fall prevention and management program; implement a proactive approach to fall prevention and management; identify risk factors and implement interventions before falls occur, give prompt treatment after falls; to prevent further injury, and provide guidance for documentation. The policy identified staff were to document falls in the Risk Management Module. Staff were to complete a post fall huddle and use the Falls Tool UDA to identify risk factors and assist in planning resident safety. Updates to care plans to prevent falls were to be communicated in the 24 hour shift report. Fall investigations were to be systematic and investigated using Root Cause Analysis. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented and the provider is promptly notified of a change in condition. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review.	2 830		

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2 830	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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F 000	INITIAL COMMENTS On 9/16/20 through 9/18/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5591017C, with a deficiency cited at 689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		10/26/20

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

Electronically 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.

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F 689	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to ensure appropriate supervision and care plans followed for 2 of 2 residents (R1 and R2) to prevent potential future falls. Findings include: R2's 9/10/20, State Agency (SA) report identified R2 fell on 9/8/20 at 6:30 p.m. R2 was found on the floor. Prior to the incident R2 was agitated because R4 was in her room. R2 called staff for help, and staff assisted R4 out of R2's room. After staff assisted R4 out of the room, R2 was found on the floor. R2 had no pain immediately after the fall, and initially declined evaluation at the emergency department (ED). Throughout the night, R2 developed increased hip pain and was transferred to the ED. R2 was found to have a non-displaced left femur fracture. R2 declined further medical intervention and returned to the facility. R2's 7/2/20, annual Minimum Data Set (MDS) identified her cognition was intact. R2's diagnoses included history of stroke with left-sided hemiparesis and hemiplegia (left-sided leg and arm impairment), difficulty speaking, weakness, anxiety, severe depression, expressive language disorder, epilepsy, history of left hip fracture, left hip pain, and muscle weakness. R2 required extensive assistance of one staff to transfer between surfaces, and to use the toilet. R2 was frequently incontinent of urine, and had occasional bowel incontinence. R2 was not on a toileting program. R2 had constant pain rated 8 of 10 that affected her daily activities.	F 689	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. F689 1. According to the deficiency statement, the facility failed to ensure proper supervision and care plans for 2 of 2 residents. Surveyor observed no call light within reach of R (1). Call light was immediately given to R (1). R (1) did not have a toileting program in place. On 9/28/20 an every three hour schedule to prompt to void was added to plan of care. R (1)'s care plan did not identify need for increased supervision to prevent falls. Care plan modified on 10/12/20 to include need for increased supervision to prevent falls.	

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F 689	Continued From page 2 R2's 9/16/20, care plan identified R2 had chronic pain in her left arm and leg. R2 had impaired verbal ommunication. R2 had limited physical mobility and used a wheelchair with locking brakes for transportation. R2 required assistance of one staff for transfers between surfaces, person cares and toileting. Staff were to implement 15-minute checks when needed. R2 was not aware of her limitations and was impulsive. R2 was a fall risk. Staff were to remind R2 to activate her call light for assistance and lock her wheelchair brakes. Staff were to ensure R2's wheelchair was next to her bed. The care plan failed to identify the need for increased supervision required to prevent potential falls. Observation on 9/16/2020 at 9:52 a.m., of R2 identified R2 was lying in bed, eyes closed, with the head of the bed elevated. R2's wheelchair was located on the wall opposite and not kept next to her bed as care planned in case she attempted self-transfer. Interview on 9/16/20 9:56 a.m., NA-A identified R2 used a full body lift and assistance of 2 staff. Prior to her last fall, R2 pivot transferred with assistance of 1 staff. R2 had a stroke and had since been angry. She was impulsive, and had difficulty communicating. She fell frequently. R2 was easily frustrated and frequently refused care. R2's fall preventions included placement of grip strips by her bed, call lights were placed all over her room. Falls were difficult to prevent because she refused to call for help and refused care. R2 had a history of transferring without assistance and had self-transferred less after her fall, but today she was found sitting on the edge of her bed. Staff try to position her as far from edge of bed as possible. R2 was unaccepting of her	F 689	Surveyor observed wheelchair on opposite side of room when R (2) was in bed. Wheelchair was placed next to bed immediately upon notification of observation. R (2) did not have a toileting program in place, however on 8/3/20 care plan was updated with an every 3 hour prompt to void schedule. R (2)'s care plan did not identify need for increased supervision to prevent falls. Careplan modified on 10/12/20 to include need for increased supervision to prevent falls. 2. This has the potential to affect all residents with increased risk for falls. Interdisciplinary review of residents with high fall risk and/or major injury will be completed and care plans will be reviewed and modified by Case Manager, or designee by 10/26/20. 3. All Nursing Staff are educated during orientation on where to find, read, and follow care plan/Kardex upon hire per Clinical Educator. All Nursing Staff will be re-educated per the Director of Nursing, or designee on importance to follow care plans, communicate changes to care plans and the vital role the care plan plays in ensuring residents are safe by 10/26/20. 4. Re-education was provided to three CNAs who were observed not following care plans on 9/17/20, education included importance of following care plan/Kardex with each resident interaction to allow residents to be in the safest position/safe environment to minimize fall risk.	

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F 689	Continued From page 3 limitations. Observation and interview on 9/16/20 at 10:10 a.m., of R2's door with NA-A identified staff were to observe her every hour. R2 attempts to self-transfer had decreased down since her fall and fracture, however, she continued to scoot to the edge of the bed. This am she was found at the edge of her bed and was assisted back into bed. R2 did not have her wheelchair by her bed because of her fracture and reduced attempts to self-transfer. R2 was alert, and did not want to be in a nursing home. She wanted to be with her family. R2's had difficulty expressing her needs and became easily agitated if staff were unable to identify her needs. Observation on 9/16/20 at 12:40 p.m., identified R2's wheelchair continued to be against the wall opposite R2's bed. Observation, interview, and docuement review, on 9/16/20 at 12:47 p.m., with licensed practical nurse (LPN)-A identified R2's wheelchair was against the wall opposite her bed. Before her fall, R2's care plan included to keep the wheelchair next to the bed for safety. The wheelchair had anti-back brakes to prevent the chair from rolling back. R2 was not able to transfer independently at this time, and was not currently at risk to self-transfer. The NAs put the wheelchair by the wall because she had not attempted to self-transfer since her last fall. LPN-A was unsure if R2's current care plan was to place the wheelchair away from R2's bedside. Review of R2's current care plan with LPN-A identified R2's wheelchair was to be placed at the bedside. LPN-A identified staff were to continue to follow the care plan until the care plans were reviewed.	F 689	Re-education will be provided to all nursing staff regarding fall prevention policies and care plan being followed. This will be completed by the Director of Nursing, or designee with mandatory education. Professional Nursing Staff were educated on 9/28/20 and 9/30/20 by the Director of Nursing. Nursing Assistant Staff to be educated by 10/26/20 or prior to their next scheduled shift. 5. To monitor performance and ensure compliance the DON, or designee, will audit resident care plans with history of falls. Four residents' care plans will be reviewed; that have a risk for falls and observation will occur that care plan is being followed weekly for 4 weeks, then 1x per month for 3 months until results are sustained. Results will be reviewed monthly at Quality Assurance/Performance Improvement meetings by the Interdisciplinary Team.	

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F 689	Continued From page 4 Any charge nurse was able to modify the care plan and notify the registered nursed, case managers and director of nursing (DON) when care plan were updated. The interdisciplinary team (IDT) would review care plans to determine interventions were appropriate. LPN-A planned to notify the director of nursing (DON) to review placing the wheelchair at the bedside. LPN-A identified she was the nurse on duty at the time R2's second fall. R2 had also fallen earlier in the shift prior to the start of LPN-A's shift. Staff frequently checked on R2 because of her increased agitation. R2 was difficult to redirect. R2's fall incident reports identified the following 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.	F 689		

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F 689	Continued From page 5 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 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. OT-A's interview identified R2 was agitated and had increased impulsivity. R2 felt staff were not patient enough to allow her to express her needs, which caused R2 a lot of frustration. R2 was also frustrated nothing was being done about the loud resident. OT-A identified the best option was to move the residents away from each other. R2 had an extensive fall history. OT-A identified her opinion of R2's falls and history of self-transferring were "cries for attention". Changes to resident care plans were communicated though a communication sheet that was provided to case managers, charge nurses and the DON. Observation on 9/16/20 at 12:56 p.m., identified R1 was sitting in her wheelchair in the middle of her room. Her head was down, and her eyes were closed. Her feet were resting on the floor. R1's bed was unmade. No call light was observed within R1's reach. An unidentified maintenance person was in the room fixing the air conditioner. R1's 9/8/20, quarterly MDS assessment identified R1 had severe cognitive impairment. R1's	F 689		

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F 689	Continued From page 6 diagnoses included, Dementia, macular degeneration, heart disease, constipation, diarrhea, bladder disorder, history of urinary tract infections (UTIs), osteoporosis, muscle weakness, impaired balance and gait, and a history of multiple falls with fractures. R1 required extensive assistance of one staff for transfers, toileting and personal cares. R1 was had frequent bladder and occasional bowel incontinence. R1 was not on a toileting program. R1 had one fall with an injury since her prior assessment. R1's 9/16/20, care plan fall interventions included R1 was non-ambulatory due to a lower extremity fracture. A call light was to be placed on R1's left arm rest when in her recliner, and on the bed railing when in bed. Staff were to ensure R1's call light was within reach and on her left side at all times. Staff were to assist and cue R1 for decision making. There was no mention R1 required increased supervision to prevent potential falls. R1's fall incident 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. 2) On 3/3/20 at 2:05 p.m., R1 was found on the floor next to her recliner. R1 attempted to walk without using a walker or staff assistance. Her walker was not beside the resident. No injuries occurred. 3) On 5/5/20 at 7:45 p.m., R1 found R1 on the floor lying on her right side covered in a blanket with her head resting on the metal foot of the side table. R1 attempted to walk from her chair to her recliner. R1 had no injuries.	F 689		

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F 689	Continued From page 7	F 689		

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 communication book at the nurse station. She was unsure who ensured staff were monitored to ensure care plans were followed or ensure appropriate supervision was maintained.

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

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 09/18/2020

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 689	Continued From page 8 to be visible and accessible to residents. R1 had just gotten up, and the maintenance man was in the room. NA-B pulled back R1's blankets and placed her call light within reach. She was unsure if R1 used her call light to call for assistance. NA-B felt R1 was not unsupervised at the time the light was out of reach because the maintenance man was present in the room. NA-B agreed maintenence was not responsible for the care of residents and would be unfamiliar with thier needs. Interview on 9/16/20, at 4:04 p.m., with the DON and administrator identified charge nurses completed initial fall investigations and were able to update care plans. The charge nurse updated the IDT of interventions on the fall incident report for IDT to review. Staff were to continue to follow care plans until they were updated and staff educated of changes to care plans. Changes to resident care plans was communicated during daily stand-up, at shift change report, and as needed. The staff development nurse was not in the facility at this time. She was unsure what documentation was available to ensure staff followed care plans after they were revised. The May, 2016, Fall Prevention and Management policy and procedure identified the purpose of the policy was to develop a fall prevention and management program; implement a proactive approach to fall prevention and management; identify risk factors and implement interventions before falls occur, give prompt treatment after falls; to prevent further injury, and provide guidance for documentation. The policy identified staff were to document falls in the Risk Management Module. Staff were to complete a post fall huddle and use the Falls Tool UDA to	F 689		

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F 689	Continued From page 9 identify risk factors and assist in planning resident safety. Updates to care plans to prevent falls were to be communicated in the 24 hour shift report. Fall investigations were to be systematic and investigated using Root Cause Analysis.	F 689		