

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 2, 2021

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

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

Dear Administrator:

On January 5, 2021, we informed you that we may impose enforcement remedies.

On January 29, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 18, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 18, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 18, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of Good Samaritan Society - Pipestone February 2, 2021 Page 2 payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

• Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 18, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Pipestone will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is Good Samaritan Society - Pipestone February 2, 2021 Page 4

mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services Departmental Appeals Board, MS 6132 Director, Civil Remedies Division 330 Independence Avenue, S.W. Cohen Building – Room G-644 Washington, D.C. 20201 (202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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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,

Kumala Piske 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 February 2, 2021

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

Re: Event ID: MOUP12

Dear Administrator:

The above facility survey was completed on January 29, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Kumala 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>

	-						APPROVED	
		& MEDICAID SERVICES					/B NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	COM	IPLETED	
		245591	B. WING				C 13/2021	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
COOD 8	AMARITAN SOCIETY	DIRECTONE		1:	311 NORTH HIAWATHA			
0000 5/	AMARITAN SUCIET	- FIFESTONE		Ρ	IPESTONE, MN 56164			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMENT	rs	FC	00				
	survey was comple complaint investiga NOT to be in comp	n 1/13/21, an abbreviated ted at your facility to conduct a tion. Your facility was found liance with 42 CFR Part 483, ong Term Care Facilities.						
		laint was found to be H5591021C, with a deficiency						
		f correction (POC) will serve f compliance upon the ptance.						
	signature is not req							
F 689 SS=G	on-site revisit of you validate that substa regulations has bee your verification. Free of Accident Ha	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with azards/Supervision/Devices 1)(2)	F 6	89			2/19/21	
	§483.25(d) Acciden The facility must en §483.25(d)(1) The r as free of accident	its. Isure that - resident environment remains hazards as is possible; and						
	supervision and ass accidents.	resident receives adequate sistance devices to prevent NT is not met as evidenced						
LABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE	
Electron	ically Signed						02/03/2021	

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.

DEDADTMENT OF LIEALTH AND LIUMANN CEDVICES

PRINTED: 02/08/2021

		& MEDICAID SERVICES			OMB NO.		
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY IPLETED	
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		245591	B. WING			13/2021	
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE	E, ZIP CODE	E	
GOOD S	AMARITAN SOCIETY	- PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164			
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F 689	Continued From pa	ge 1	F 6	89			
	by:	0					
	Based on observat	tion, interview and document		F689			
		ailed to conduct adequate		Preparation and execu			
		le appropriate supervision, or to prevent a fall for 1 of 3		response and plan of constitute an admission			
		self-transferred without her		the provider of the trut			
		te supervision resulting in a		alleged or conclusions			
	fall with hip fracture			statement of deficienc			
	•			correction is prepared			
	Findings include:			solely because the pro			
				and state law require i			
		ort records indicated R1 fell on					
		and later complained of pain the Emergency Department		substantial compliance requirements of partic			
		where R1 was diagnosed with		response and plan of			
	a right femur (hip) f			constitutes the centers compliance in accorda	s allegation of		
		p.m., Risk Management was found on the floor with		7305 of the State Ope			
		her and a blanket folded under		F689-G			
		port further indicated R1's		Free of Accident			
		over and faced away from the		Hazards/Supervision/I	Devices		
		elchair was near the wall on		R1 care plan updated			
		f the room. When interviewed,		reflect current fall inter			
		but of her recliner and was		current assistive devic	,		
		bed when she lost her ckwards. The resident said		transfers will be kept w pressure alarm will be			
		et from the walker and tucked		should R1 attempt sel			
		le she waited for staff to come		now on a 2 hour schee			
		The report indicated R1 had		schedule. All resident			
	impaired memory, o	confusion, weakness and used		a fall in the last 30 day			
		n, the report identified R1 had		assessed to have a hi			
	a suspected fractur	е.		a care plan review to e			
	R1's 11/13/20 quar	terly Minimum Data Set		interventions are adec their current needs. S			
		had moderately impaired		done and documented			
		nory, poor decision-making		ensure all direct-care			
	ability, difficulty und	lerstanding others, and altered		on expectations and ir			
		ness. The MDS indicated R1		will be completed by 2			

Facility ID: 00455

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CENTE	RS FOR MEDICARE	AND HUMAN SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	СОМ	E SURVEY PLETED
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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD S	AMARITAN SOCIETY	- PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164		
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F 689	mobility, transfers, i with an assistive de and on and off the fu- indicated R1 was d objects off the floor transfers and walkin mobility. R1's curre diagnoses of a righ type 2 diabetes, ag obesity, unsteadine macular degenerati knee joint, dizzines anemia, and deliriu physiological condit wandering. R1's 1/12/20, care f moderate cognitive making, memory ar plan also indicated difficulty expressing understanding othe ambulate, transfer assistance. She wa hoard items in her f resident rooms as f a fall risk due to a h confusion, and self- incontinent of urine belt, front wheeled assistance of one s R1's interventions i proper footwear, us and for staff to ensu- were to assist R1 to hours. When R1 wa use simple cues, re-	assistance of 1 staff for bed toileting, dressing, and walked wice in her room, in corridors, unit. Further, the MDS ependent on staff to pick , required a walker for ng, and used a wheelchair for nt diagnose report identified t leg fracture, heart failure, e-related osteoporosis, ss of gait, muscle weakness, ion, presence of a left artificial s and giddiness, anxiety, m related to known tions, depression, and plan identified R1 had impairment, impaired decision nd safety awareness. The care R1 had poor vision, had g herself, and had difficulty rs. R1 would attempt to and toilet herself without staff is known to rummage and room and would enter other part of her behaviors. R1 was history of multiple falls, transfer attempts. R1 was . R1 required use of a gait walker, wheelchair, and taff to transfer, walk, toilet. ncluded to ensure use of the gripper socks while in bed, ure adequate lighting. Staff to the toilet every two to three andered, staff were to redirect,	F 6	 89 To protect residents at risk situations, staff identified 1 have history of attempted s and inconsistent call light u review shows 6 were found effective care plan interver others were updated to ad resident's current condition DNS/designee will provide all nursing staff, on complet comprehensive assessme plans, and implementing in prevent recurrence on 2/9/IDT/PT/OT was provided r reviewing the incident invehuddle worksheet to condumonitoring effectiveness a appropriate care plan inter added to prevent recurrence on 2/3/2021. Completion I DNS/designee will audit 5 Residents weekly X 4 them ensure post fall per GSS p procedure was completed. presented at QAPI for revier recommendations. 	1 resident who self-transferring use. Care plan d to have ntions. The dress the n and needs. re-education to eting nt, reading care nterventions to 2021. The e-education on stigation, falls uct RCA, nd ensuring ventions are ce by the DNS Date 2/19/2021. random monthly X 2 to olicy and Results	

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:		NG	CO	MPLETED
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		245591	B. WING _			/13/2021
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
GOOD S	AMARITAN SOCIETY	- PIPESTONE		1311 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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	-	F 68	89		
	others in the day ro in her room. R1's w	s encouraged to visit with oom to prevent self-transferring valker was to be removed from				
	potential unassisted	in use for walking to prevent d transfers. R1's wheelchair ext to her bed when not in use.				
	Staff were to monit consult physical the	or R1 for changes in gait and erapy (PT) and occupational changes were identified. On				
	1/11/20, after she for care plan was upda	ell and fractured her hip, R1's ated to keep excess blankets hental hazards in her closet				
	and out-of-sight. St wheelchair was in a	a safe position while she re to remind her to refrain from				
		n her walker. The care plan dicated R1 was no longer safe tric recliner.				
	registered nurse (R	n 1/12/21 at 2:57 p.m., RN)-A stated she had worked day R1 fell. RN-A stated R1				
	was her normal sel anxiety in the afterr	f during the day and had noon, which was normal for ated that evening, R1 was tired				
	wanted to lie down times to get up and	but had attempted several walk. Staff provided one to her and kept her in the area				
	shift report at the til	on. RN-A stated she was in me R1 fell and had not seen r and the time of the fall.				
	Around 7:00 p.m. F and assisted with F	RN-A was called to R1's room R1's initial fall assessment. on the floor facing the head of				
	her bed with her leg had a blanket unde	gs straight in front of her. She er her left leg by her knee. as unsure how R1 would have				
	gotten a blanket. R	N-A said she thought R1 must Inket before she fell. RN-A said				

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DA	D. 0938-039
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F 689	blanket and said R complained of pain and identified it was too long. RN-A add knew she should ha was assessed, and transferred from the complaints of pain of pain while lying in b RN-A identified dur discussion of the ev (NA)-A had observe her fall and had bee evening meal. RN-// assisted R1 to the r entered R1's room appeared R1 had g attempted to walk to recliner footrest wa (slightly opened). R used the recliner co to self-transferring. facing the opposite "way behind her," p room against the w was on the farthest by her dresser in fro stated it appeared t had been moved. I a history of falls and she was confused a her call light reliably items such as blant rummage in her clo people were "stealin tried to hide things	age 4 ecall how she'd gotten the 1 was not a good historian. R1 in an area above her sacrum is because she sat on the floor ed that R1 had stated she ave waited for help. After R1 no injury found, R1 was e floor to the bed with no during the transfer and denied bed. Further interview with ing R1's post-fall huddle, vent identified nurse aide ed R1 in her recliner prior to en there since after the A stated she was unsure who recliner, but when she [RN-A] to assess her after her fall, it jotten up from the recliner and owards her bed. RN-A said the s observed up 10 degrees N-A was not sure if R1 had ontrol to adjust the chair prior R1's walker was tipped over of R1. R1's wheelchair was warked on the other side of all next to her TV. R1's bed wall and R1 was on the floor ont of her bed. RN-A also the blankets from R1's bed RN- A further clarified R1 had d now fell frequently because and forgetful and did not use y. RN-A said R1 liked to stack kets on her walker and liked to uset. She sometimes thought ng" items in her room, and she so they would not be stolen, here she placed them. RN-A				

Facility ID: 00455

If continuation sheet Page 5 of 12

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY	
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PROVIDER OR SUPPLIER						
AMARITAN SOCIETY	- PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164			
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO DATE	
because R1 had a recliner without call if R1 was able to us due to her cognition whether the wheeld within R1's reach w After her last fall or to use the wheelch R1's recent fall, R1 assistance of 1 stat When interviewed of stated she'd worker fell. R1 was still in t After supper she as she took her emploi unsure who assisted said when R1 fell, s she returned from the saying, "help me" a NA-B said she offer and when she atter the bed R1 "screan called the nurse to pain in her knee arc hospital. NA-B said falls were to keep the awake. R1 went to sit in her recliner from supposed to have and walk, but R1 w	history of getting up from the ling for help. RN-A was unsure se the controls on the recliner h. She was also unsure chair was supposed to be while she was in the recliner. In 12/21/20, R1 was supposed air most of the time. Prior to was supposed to have ff to transfer and walk. On 1/12/21 at 4:12 p.m., NA-B d the evening shift the day R1 the dining room at 6:00 p.m. asisted other residents before by esupper break. NA-B was ed R1 back to her room, and she [NA-B] was on break. After break, R1 was in her bed and she wanted to get up. red R1 assistance to the toilet, mpted to move R1's legs out of ned in pain". NA-B said she R1's room because R1 had ea, and R1 was sent to the I R1's interventions to prevent her door open while she was bed early and was known to equently after supper. R1 was 1 staff assist her to transfer as "busy and hard to keep an	F 68	39			
	Continued From pa because R1 had a recliner without call if R1 was able to us due to her cognition whether the wheelch R1's recent fall, R1 assistance of 1 star When interviewed of stated she'd worke fell. R1 was still in the After supper she as she took her emploi unsure who assisted said when R1 fell, si she returned from the saying, "help me" and NA-B said she offe and when she atter the bed R1 "scream called the nurse to pain in her knee are hospital. NA-B said falls were to keep from and walk, but R1 were and walk were and were and were and were a	PF CORRECTION IDENTIFICATION NUMBER:	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULT A. BUILDIN 245591 B. WING	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ABUILDING 245591 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE AMARITAN SOCIETY - PIPESTONE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SINCHARTON) Continued From page 5 ID because R1 had a history of getting up from the recliner without calling for help. RN-A was unsure whether the wheelchair was supposed to be within R1's reach while she was in the recliner. After her last fall on 12/21/20, R1 was supposed to use the wheelchair most of the time. Prior to R1's recent fall, R1 was supposed to have assistance of 1 staff to transfer and walk. When interviewed on 1/12/21 at 4:12 p.m., NA-B stated she'd worked the evening shift the day R1 fell. R1 was still in the dining room at 6:00 p.m. After supper she assisted other residents before she took her employee supper break. NA-B was unsure who assisted R1 back to her room, and said when R1 fell, she [NA-B] was on break. After she returned from break, R1 was sin the bed saying, "help me" and she wanted to get up. NA-B said she offered R1 assistance to the toilet, and when She attempted to move R1's legs out of the bed R1 "screamed in pain". NA-B said she called the nurse to R1's room because R1 had pain in her knee area, and R1 was shen to the hospital. NA-B said R1's interventions to prevent falls were to keep her door open while she was supposed to have 1 staff assisther to transfer	OF DEFICIENCIES (X1) PROVIDERSUPPLIERCIAL (X2) MULTIPLE CONSTRUCTION (X3) DA OF CORRECTION 245591 INVING 01 2ROVIDER OR SUPPLIER 245591 INVING 01 AMARITAN SOCIETY - PIPESTONE STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164 SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLANO OF CORRECTION PROVIDERS PLANO OF CORRECTION CANONECRS PLANO OF CORRECTION RECULATORY OR LSC IDENTIFYING INFORMATION) PARTY PARTY AND OF CORRECTION CORRECTIVE ACTION SHOLD BE Continued From page 5 F 689 PROVIDERS PLANO OF CORRECTION CANONECRS PLANO OF CORRECTION Continued From page 5 F 689 F 689 F 689 Declause R1 had a history of getting up from the recliner Providers PLANO OF CORRECTION OF 118 (2000) DEFICIENCY WAS SUPPOSED to THE APPROPRIATE DEFICIENCY Substated and 12/12/0, R1 was supposed to be F 689 F 689 When interviewed on 1/12/21 at 4:12 p.m., NA-B Stated she'd worked the evening shift the day R1 F 689 After supper she assisted other residents before S for the set was also unsure S for the set was also unsure After supper she assisted other residento because R1 had S for the s	

If continuation sheet Page 6 of 12

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	D: 02/08/2021 M APPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
		245591	B. WING	i		01	C / 13/2021
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD	-	
GOOD S	AMARITAN SOCIETY	- PIPESTONE			1311 NORTH HIAWATHA PIPESTONE, MN 56164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 689	would walk in her m In addition, NA-B s call light for assistant During interview or identified she gene the weekends. NA- confused and forge required assistance to assist her to the had frequent urges never called for hel attempting to self-tr require assistance gait belt to safely tr her recliner, staff n "frequently because When R1 was with not remain seated bring her to the are closer observation. activities that she w R1 mostly wandere usually only sat in t "about an hour" and feet up in the recline remember to put he unsure if R1 had an never had her feet aware of. Staff wer her bed, away from R1's walker was to room away from he potentially self-tran	dependently without help and oom without staff assistance. aid R 1 would rarely use the ince. 1/12/21 at 1:50 p.m., NA-C rally provided cares for R1 on C stated R1 was known to be etful, and before the fall R1 e of 1 staff to walk. Staff were toilet every 2 to 3 hours. R1 to use the bathroom and p. She had a history of ransfer. R1 continued to of 1 staff, a walker, and her ansfer. If R1 wanted to sit in eeded to check on her e she didn't sit there very long". essed to be restless and would in her recliner, staff would vould have to do on her own. ed when she was restless. R1 he recliner in her room for d staff were to never put her er feet down. NA-C was n electric recliner and said R1 up on her recliner that she was e to have R1's wheelchair by n her chair. She was unsure if be beside her or across the er to prevent her from	F	286			
		confused but easily redirected. In thought people were stealing					

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STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY	
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:		NG	`´co	MPLETED	
		245591	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER	243331	D: 11110 _	STREET ADDRESS, CITY, STATE, ZIP CO	01/13/2021		
	AMARITAN SOCIETY	- PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164	_		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE	
F 689	often and would do her wheelchair to b was requesting to li staff would catch he Staff provided verb She was supposed gait belt, and her fra able to get up and a Sometimes she trie stated she knew R ² table to attempt to g walker was unavail had Sundowner's a the call light. When interviewed of stated R1 was foun facing towards her NA-A said R1 had r tried to get to her w observed positione NA-A said prior to t go the bathroom, c transferred her to h reclined the recline R1"usually sat in he tired that day when surprised she got u was independent a needed to have sta fall, R1's wheelchai her room, and the v end of her bed. Bot NA-A stated R1's w bed at the time of th given R1 her blue s	nge 7 d things. R1 self-transferred so at any time of the day from ed, or bed to wheelchair. R1 ie down more frequently and er attempting to self-transfer. al cues for R1 to call for help. to be assisted with 1 staff, a ont wheeled walker. She was around her room by herself. ed to get to her walker. NA-D 1 would use her over the bed get around her room if her able. Further, NA-D said R1 and would not consistently use on 1/12/21 at 4:51 p.m., NA-A id lying by the foot of the bed, recliner across the room. no pain initially and stated she valker. The walker was d toward the end of the bed. he fall, she had assisted R1 to hange into pajamas, and ter recliner. NA-A said she'd r all the way back adding, er recliner. She seemed really 1 put her in the recliner. I was p". She was a person who few months ago but now ff to help. At the time of the ir was parked in the corner of walker was still at the end of the he fall. NA-A also stated she'd anowflake blanket when she She was noted to have	F 6	89			

If continuation sheet Page 8 of 12

STATEMENT	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
	JI CONNECTION	245591	A. BUILDII B. WING	NG		С
	PROVIDER OR SUPPLIER	245591	D. WING _	STREET ADDRESS, CITY, STATE, ZIP COD	01/13/2021	
	AMARITAN SOCIETY	- PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164	/ C	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 689	was unsure how lon fall. NA-A was in an dietary staff found f staff would have ch fell about a half hou was supposed to be bathroom. NA-A wa checked on more fi be supervised at tir of staff to ensure ho When interviewed of occupational therapy physical therapy (P a general decline, a OT-A said R1 also was not able to do assistance and PT assistance of 1 staft transfers and mobil continue to transfer advised staff check assistance. She wa transfers and walki rummage and pick OT were involved in OT-A said nursing f her bed as an inter- from self-transferrin her walker within re case she attempted her walker for a lon walker if it was out	er knee after she fell. NA-A ng R1 laid on the floor after the nother resident room when R1. NA-A was unsure what necked on her. NA-A said R1 ur after she cared for R1. R1 e checked every 2-3 hours for as unsure if R1 was to be requently or if she needed to mes she wasn't in direct sight er safety. on 1/12/21 at 5:12 p.m., bist (OT)-A identified R1 had T) ordered on 10/16/20, due to and R1 had a history of falls. had increased knee pain and things safely without had deemed R1 required ff, a gait belt, and walker for lity. OT-A was aware R1 would r without assistance but a her more often and provide er possible. She stated R1 mentia, falls and transferring Prior to this last fall, R1 was	F 6	89		

If continuation sheet Page 9 of 12

DEPAR	IMENT OF HEALTH			FORM	APPROVED				
		& MEDICAID SERVICES				01	OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		COM	E SURVEY PLETED	
		245591	B. WING					C 1 3/2021	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, Z	IP CODE			
GOOD S	AMARITAN SOCIETY	- PIPESTONE			311 NORTH HIAWATHA				
	· ···· · · · · · · · · · · · · · · · ·			P	PIPESTONE, MN 56164				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD	BE	(X5) COMPLETION DATE	
F 689	had a bag on the w personal items such personal items such personal items. PT-A stated during a.m., R1 was walkin R1 attempted to ca times. She was not previous education ability to get out of H independently. Due required staff assisis safety. R1 made por remembered to use always put R1's wa never formally direct within her reach wh in her room. RN-C stated during p.m., R1's intervent place her walker aw would call for help. RN-B said during in p.m., she was the ca able to rise from sit assistance prior to to RN-B said R1 was sit to stand safely. F was for R1 to use a belt and assistance mention R1 was to prior to her fall in ca self-transfer. There when she fractured have her walker wit consensus among s	ge 9 alker that contained her h as her toothbrush and other interview on 1/13/21 at 9:29 ng on her own prior to her fall. rry items with her walker at able to remember cues or for walker safety. R1 had the her recliner, bed or wheelchair to her history of falls, she tance with a gait belt for bor choices and had not always e her walker. PT-A would lker within reach however, had cted staff to keep R1's walker en she was left unsupervised interview on 1/13/21 at 1:57 tions for fall safety included to way from her to see if R1 terview on 1/13/21 at 2:29 ease manager for R1. R1 was ting to standing without staff her fall on 1/5/21. However, inconsistent with performing R1's care plan prior to her fall walker to ambulate with a gait of 1 staff. There was no have her walker within reach ase she attempted to was discussion after her fall her hip whether she should hin reach. There was no staff as to whether it would and OT were to have		89		SY)			

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PRINTED: 02/08/2021

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •				E SURVEY IPLETED
_			A. BUILDI	ING	à		С
		245591	B. WING				0 13/2021
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE			1311 NORTH HIAWATHA		
400000				F	PIPESTONE, MN 56164		
(X4) ID			ID	.,			(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		DATE
					DEFICIENCY)		
	1						
F 689	Continued From pa	-	F 6	89	1		
		afe walker use after her return					
		Staff later decided to keep R1's					
		ner to prevent her attempts to was no mention how staff					
		see if the measure was					
		lace R1 at higher risk for falls.					
		ought it would be safer to keep					
		er in her recliner to maintain					
		oted to self-transfer. There was					
		aff were to supervise R1 after in her room at night prior to					
	bed in an effort to p						
		rsing (DON) stated during					
		1 at 2:15 p.m., she could not 's walker was to be within R1's					
		ecliner. The DON stated staff					
		implement interventions to					
		ty following her falls. She					
	declined comment	regarding whether it would be					
	safer for R1 to use						
		eep the walker out of R1's					
	sight.						
	The medical directo	or was interviewed on 1/14/21					
	at 9:06 a.m., and st	tated if PT and OT determined					
		a walker to maintain safety					
	0	d walking, the device should					
		hin reach. He further clarified oesn't call or wait for staff					
	-	ed assistive devices for					
		nsferring, should have their					
		each to provide the safest					
		The medical director stated					
		ssessed whether or not R1					
		he in her room without direct					
		ng she had a history of ransfer and walk without staff					
	knowledge or assis						

Facility ID: 00455

If continuation sheet Page 11 of 12

PRINTED: 02/08/2021

	-	AND HUMAN SERVICES			FORM	02/08/2021 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		245591	B. WING		C 01/13/2021	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- PIPESTONE		1311 NORTH HIAWATHA PIPESTONE, MN 56164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 11	F 689			
	and Management F before falls occur re for any fall risk. Inter planned and person all staff to prevent a the 24-hour Report any daily stand-up r meetings. Any iden referral needs were the appropriate dep After falls occurred implemented, staff	were to continue to monitor f interventions and adjust				

If continuation sheet Page 12 of 12

Minnesc	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00455	B. WING		01/1) 3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE 1311 NO	RTH HIAWAT ONE, MN 561	HA		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	survey was conduct with State Licensurvey NOT in compliance Please indicate in y correction that you and identify the date	TS: 1/13/21, an abbreviated ted to determine compliance e. Your facility was found to be with the MN State Licensure. Your electronic plan of have reviewed these orders, e when they will be completed				
LABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE		(X6) DATE 02/03/21

Electronically Signed

STATE FORM

If continuation sheet 1 of 14

		A. BUILDING: _	·····		PLETED
	00455	B. WING			C 13/2021
PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AMARITAN SOCIETY	- PIPESTONE				
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	ge 1	2 000			
The following complaint was found to be SUBSTANTIATED: H5591021C with a licensing order issued at S830.					
the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested	Correction Orders using ag numbers have been ota state statutes/rules for e assigned tag number eft column entitled "ID Prefix tute/rule out of compliance is ary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met illowing the surveyors findings Method of Correction and				
receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm. The State delineated on the a Department of Hea you electronically. is necessary for Sta enter the word "CO available for text. Ye electronic State lice heading completion be corrected prior to the Minnesota Depa	nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are ttached Minnesota lth orders being submitted to Although no plan of correction ate Statutes/Rules, please RRECTED" in the box bu must then indicate in the ensure process, under the date, the date your orders will b electronically submitting to				
	AMARITAN SOCIETY SUMMARY STA (EACH DEFICIENCY REGULATORY OR LS Continued From pa The following comp SUBSTANTIATED: order issued at S83 Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far la Tag." The state sta listed in the "Summ column and replace the correction order the findings which a statute after the sta as evidence by." Fo are the Suggested I Time period for Cor You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm. The State delineated on the a you electronically. A is necessary for State heading completion be corrected prior to	AMARITAN SOCIETY - PIPESTONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5591021C with a licensing order issued at S830. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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 http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	Image: Construction of the state statute after the statement, "This Rule is not met as evidence by." Following the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion 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 state statute fruite is not met as evidence by." Following the state statute/rule out of compliance is listed in the "Summary Statement of Health is not met as evidence by." Following the state statute/rule out of compliance is listed in the "Summary Statement of Health is not met as evidence by." Following the state statute in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm. The State licensing orders are delineated on the attached Minnesota are 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	Interview Interview <thinterview< th=""> <thinterview< th=""> <thi< td=""><td>00455 B. WING 01/ ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILS THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE SUBSTANTIATED: H5591021C with a licensing order issued at S830. Minnesota Department of Health is documenting the State Licensing Correction and Tag." The state statute/rule out of compliance is listed in the far left column atlift de TIDP Profix Tag." The state statute/rule action colleges is the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure process, under the hemeding co</td></thi<></thinterview<></thinterview<>	00455 B. WING 01/ ROVIDER OR SUPPLER STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WILS THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREPX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE SUBSTANTIATED: H5591021C with a licensing order issued at S830. Minnesota Department of Health is documenting the State Licensing Correction and Tag." The state statute/rule out of compliance is listed in the far left column atlift de TIDP Profix Tag." The state statute/rule action colleges is the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure process, under the hemeding co

Minnesota Department of Health STATE FORM

GXOP11

If continuation sheet 2 of 14

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		COM	E SURVEY PLETED C
		00455	B. WING		13/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- PIPESTONE	RTH HIAWAT NE, MN 561		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLET DATE
2 000	Continued From pa	lge 2	2 000		
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.			
2 830	MN Rule 4658.052 Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830		2/19/21
	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	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the ain in bed or the resident hed.			
	by: Based on observative review, the facility for assessment, provide an assistive deviceve residents (R1). R1 walker or appropriation fall with hip fractures Findings include: Facility incident rep	ent is not met as evidenced ion, interview and document ailed to conduct adequate de appropriate supervision, or to prevent a fall for 1 of 3 self-transferred without her the supervision resulting in a bort records indicated R1 fell on , and later complained of pain		F689 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 the provisions of federal and state law require it. For the purposes of any allegation that the center is not in substantial compliance with federal	

If continuation sheet 3 of 14

	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		00455	B. WING 01/1			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE	TH HIAWAT NE, MN 561			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
2 830	Continued From pa	ge 3	2 830			
	resulting in a trip to (ED) for evaluation a right femur (hip) f R1's 1/5/21 at 6:58 report identified R1 her legs in front of H her left leg. The rep walker was tipped of resident. R1's when the opposite side of R1 stated she got of balance and fell bar she took her blanke it under her leg whi and soften things. T impaired memory, of a walker. In addition a suspected fractur R1's 11/13/20, quar (MDS) identified R1 cognition, poor mer ability, difficulty und levels of conscious required extensive mobility, transfers, f with an assistive de and on and off the f indicated R1 was d objects off the floor transfers and walkin mobility. R1's curre diagnoses of a righ type 2 diabetes, ag obesity, unsteadine macular degenerati	the Emergency Department where R1 was diagnosed with racture. p.m., Risk Management was found on the floor with her and a blanket folded under oort further indicated R1's over and faced away from the elchair was near the wall on f the room. When interviewed, out of her recliner and was bed when she lost her ckwards. The resident said et from the walker and tucked le she waited for staff to come The report indicated R1 had confusion, weakness and used h, the report identified R1 had		requirements of participation, this response and plan of correction constitutes the centers allegation compliance in accordance with se 7305 of the State Operations Mar F689-G Free of Accident Hazards/Supervision/Devices R1 care plan updated on 2/2/2027 reflect current fall interventions. A Residents who experienced a fall last 30 days will have a comprehe assessment to determine RCA and develop interventions to provide a supervision and safety. DNS/des provide re-education to all nursing completing comprehensive assess reading care plans, and implement interventions to prevent recurrence 2/9/2021. The IDT/PT/OT was pro- re-education on reviewing the inci- investigation, falls huddle workshe conduct RCA, monitoring effective and ensuring appropriate care pla interventions are added to prevent recurrence by the DNS on 2/3/202 Completion Date 2/19/2021. DNS/designee will audit 5 random Residents weekly X 4 then month ensure post fall per GSS policy ar procedure was completed. Result presented at QAPI for review and recommendations.	to lin the in the dequate ignee will staff, on sment, nting e on ovided dent eet to eness n t 21.	

If continuation sheet 4 of 14

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE	RTH HIAWATH NE, MN 5616			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF C		(X5) COMPLET
PRÉFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	HE APPROPRIATE	DATE
2 830	Continued From pa	ge 4	2 830			
	physiological conditions, depression, and wandering.					
	moderate cognitive making, memory ar plan also indicated difficulty expressing understanding othe ambulate, transfer assistance. She wa hoard items in her r resident rooms as p a fall risk due to a h confusion, and self- incontinent of urine belt, front wheeled assistance of one s R1's interventions in proper footwear, us and for staff to ensu- were to assist R1 to hours. When R1 wa use simple cues, re assistance, and use off the floor. R1 wa others in the day ro in her room. R1's w her room when not potential unassisted was to be placed no Staff were to monite consult physical the therapy (OT) when 1/11/20, after she fe care plan was upda and other environm and out-of-sight. St wheelchair was in a	plan identified R1 had impairment, impaired decision nd safety awareness. The care R1 had poor vision, had g herself, and had difficulty rs. R1 would attempt to and toilet herself without staff is known to rummage and room and would enter other part of her behaviors. R1 was istory of multiple falls, -transfer attempts. R1 was . R1 required use of a gait walker, wheelchair, and .taff to transfer, walk, toilet. Included to ensure use of the gripper socks while in bed, ure adequate lighting. Staff to the toilet every two to three andered, staff were to redirect, e a grabber to retrieve items s encouraged to visit with om to prevent self-transferring valker was to be removed from in use for walking to prevent d transfers. R1's wheelchair ext to her bed when not in use or R1 for changes in gait and erapy (PT) and occupational changes were identified. On ell and fractured her hip, R1's ted to keep excess blankets isental hazards in her closet aff were to ensure R1's a safe position while she re to remind her to refrain from				

STATEME	ota Department of He INT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00455	B. WING		01/	13/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	SAMARITAN SOCIETY	- PIPESTONE	RTH HIAWATH NE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 5	2 830			
	revised 1/11/20, inc	hanging blankets on her walker. The care plan revised 1/11/20, indicated R1 was no longer safe to operate her electric recliner.				
	registered nurse (R the day shift on the was her normal sel anxiety in the aftern her. She further sta wanted to lie down times to get up and one interaction with by the nurses' static shift report at the tin R1 between supper Around 7:00 p.m. F and assisted with F RN-A said R1 was her bed with her leg had a blanket unde RN-A stated she wa gotten a blanket. R have gotten the bla R1 was unable to re blanket and said R1 complained of pain and identified it was too long. RN-A add knew she should hav was assessed, and transferred from the complaints of pain of pain while lying in b RN-A identified dur discussion of the ev	1/12/21 at 2:57 p.m., N)-A stated she had worked day R1 fell. RN-A stated R1 f during the day and had noon, which was normal for ited that evening, R1 was tired but had attempted several walk. Staff provided one to her and kept her in the area on. RN-A stated she was in me R1 fell and had not seen r and the time of the fall. RN-A was called to R1's room R1's initial fall assessment. on the floor facing the head of gs straight in front of her. She r her left leg by her knee. as unsure how R1 would have N-A said she thought R1 must nket before she fell. RN-A said ecall how she'd gotten the 1 was not a good historian. R1 in an area above her sacrum s because she sat on the floor ed that R1 had stated she ave waited for help. After R1 no injury found, R1 was e floor to the bed with no during the transfer and denied wed. Further interview with ing R1's post-fall huddle, vent identified nurse aide				
innesota E	knew she should ha was assessed, and transferred from the complaints of pain of pain while lying in b RN-A identified dur discussion of the ev (NA)-A had observe her fall and had bee evening meal. RN-A	ave waited for help. After R1 no injury found, R1 was e floor to the bed with no during the transfer and denied bed. Further interview with ing R1's post-fall huddle,			-	

Minnesota Department of Health STATE FORM

GXOP11

If continuation sheet 6 of 14

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		00455	B. WING 01/			13/2021
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE	RTH HIAWATH NE, MN 5616			
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 6	2 830			
	appeared R1 had g attempted to walk t recliner footrest wa (slightly opened). F used the recliner co to self-transferring. facing the opposite "way behind her," p room against the w was on the farthest by her dresser in fr stated it appeared t had been moved. I a history of falls and she was confused a her call light reliably items such as blan rummage in her clo people were "steali tried to hide things and would forget w said the recliner foo because R1 had a recliner without call if R1 was able to us due to her cognition whether the wheelch within R1's reach w After her last fall or to use the wheelch R1's recent fall, R1 assistance of 1 stat	to assess her after her fall, it jotten up from the recliner and owards her bed. RN-A said the is observed up 10 degrees RN-A was not sure if R1 had ontrol to adjust the chair prior R1's walker was tipped over of R1. R1's wheelchair was parked on the other side of rall next to her TV. R1's bed wall and R1 was on the floor ont of her bed. RN-A also the blankets from R1's bed RN- A further clarified R1 had d now fell frequently because and forgetful and did not use y. RN-A said R1 liked to stack kets on her walker and liked to oset. She sometimes thought ng" items in her room, and she so they would not be stolen, here she placed them. RN-A otrest was not used for R1 history of getting up from the ling for help. RN-A was unsure se the controls on the recliner n. She was also unsure chair was supposed to be while she was in the recliner. n 12/21/20, R1 was supposed air most of the time. Prior to was supposed to have ff to transfer and walk.				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	СОМ	E SURVEY PLETED
		00455	B. WING	B. WING		C 13/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE	RTH HIAWATH NE, MN 56164			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 7	2 830			
	she returned from to saying, "help me" a NA-B said she offer and when she atter the bed R1 "scream called the nurse to pain in her knee are hospital. NA-B said falls were to keep to awake. R1 went to sit in her recliner fre supposed to have 1 and walk, but R1 w eye on", and R1 wa her bed for safety. I evenings were busy rooms a lot providin tried to check on re rooms. NA-B said F and use to walk all to go home. NA-B said from her recliner in would walk in her ro In addition, NA-B sa call light for assista During interview on identified she gener the weekends. NA- confused and forge required assistance to assist her to the had frequent urges never called for hel attempting to self-tr require assistance gait belt to safely tra- her recliner, staff ne	she [NA-B] was on break. After break, R1 was in her bed and she wanted to get up. red R1 assistance to the toilet, npted to move R1's legs out of hed in pain". NA-B said she R1's room because R1 had ea, and R1 was sent to the R1's interventions to prevent her door open while she was bed early and was known to equently after supper. R1 was I staff assist her to transfer as "busy and hard to keep an as to have the wheelchair by NA-B stated cares during the y and staff were in and out of ng care to all residents. Staff sidents as they pass by the R1 frequently wanted to walk, day and verbalize she wanted stated R1 was able to get up dependently without help and bom without staff assistance. aid R 1 would rarely use the nce. 1/12/21 at 1:50 p.m., NA-C rally provided cares for R1 on C stated R1 was known to be tful, and before the fall R1 e of 1 staff to walk. Staff were toilet every 2 to 3 hours. R1 to use the bathroom and p. She had a history of ansfer. R1 continued to of 1 staff, a walker, and her ansfer. If R1 wanted to sit in eeded to check on her e she didn't sit there very long"				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _			
		00455	B. WING	B. WING		C 13/2021
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
	AMARITAN SOCIETY	- PIPESTONE	RTH HIAWATH			
		PIPESTO	ONE, MN 5616			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 8	2 830			
	When R1 was with not remain seated is bring her to the are closer observation. activities that she w R1 mostly wandered usually only sat in t "about an hour" and feet up in the reclin remember to put he unsure if R1 had ar never had her feet aware of. Staff were her bed, away from R1's walker was to room away from he potentially self-tran NA-D stated during p.m., that R1 was of NA-D said R1 ofter from her, so she his often and would do her wheelchair to b was requesting to li staff provided verb She was supposed gait belt, and her fro able to get up and a Sometimes she trie stated she knew R table to attempt to get	essed to be restless and would in her recliner, staff would a by the nurse's desk for R1 was not receptive to yould have to do on her own. ed when she was restless. R1 he recliner in her room for d staff were to never put her er because she would not er feet down. NA-C was n electric recliner and said R1 up on her recliner that she was e to have R1's wheelchair by n her chair. She was unsure if be beside her or across the er to prevent her from	5			
	the call light. When interviewed of stated R1 was four	on 1/12/21 at 4:51 p.m., NA-A d lying by the foot of the bed, recliner across the room.				

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	COM	E SURVEY PLETED
		00455	B. WING	B. WING		13/2021
IAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PIPESTONE	RTH HIAWATH DNE, MN 56164			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 830	NA-A said R1 had r tried to get to her w observed positione NA-A said prior to t go the bathroom, c transferred her to h reclined the recline R1"usually sat in he tired that day when surprised she got u was independent a needed to have sta fall, R1's wheelchai her room, and the end of her bed. Bot NA-A stated R1's w bed at the time of tl given R1 her blue s was in the recliner. grabbed the blanke was found under he was unsure how low fall. NA-A was in ar dietary staff found F staff would have ch fell about a half hou was supposed to be bathroom. NA-A was checked on more fi be supervised at tir of staff to ensure how	no pain initially and stated she valker. The walker was d toward the end of the bed. he fall, she had assisted R1 to hange into pajamas, and er recliner. NA-A said she'd r all the way back adding, er recliner. She seemed really I put her in the recliner. I was p". She was a person who few months ago but now ff to help. At the time of the r was parked in the corner of walker was placed towards the h items were away from R1. ralker was still at the end of the from the end of her bed. It er knee after she fell. NA-A ng R1 laid on the floor after the nother resident room when R1. NA-A was unsure what tecked on her. NA-A said R1 ur after she cared for R1. R1 e checked every 2-3 hours for as unsure if R1 was to be requently or if she needed to nes she wasn't in direct sight er safety.		DEFICIENCY		

Minnesota Department of Health STATE FORM

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If continuation sheet 10 of 14

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	· · · · · · · · · · · · · · · · · · ·		
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AME OF F	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	TATE, ZIP CODE		
	AMARITAN SOCIETY	DIRECTONE 1311 NO	RTH HIAWATH	Α		
000 3/	AMANITAN SOCIETT	PIPESTONE	NE, MN 5616	4		-
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 10	2 830			
	continue to transfer advised staff check assistance whenev had a history of der without assistance. able to get up on he assistance. She wa transfers and walki rummage and pick OT were involved in OT-A said nursing her bed as an inter from self-transferrin her walker within re case she attempted her walker for a lon walker if it was out was supposed to u had a bag on the w	lity. OT-A was aware R1 would r without assistance but a her more often and provide er possible. She stated R1 mentia, falls and transferring Prior to this last fall, R1 was er own without staff as able to use her walker for ng. She was even also able to things up off the floor. PT and n exercises for strengthening. had placed R1's wheelchair by vention to potentially deter her ng and R1 should have had each while in her recliner, in d to self-transfer. R1 had used g time and would look for her of reach or out of sight. She se it to pivot transfer. She also valker that contained her h as her toothbrush and other				
	a.m., R1 was walki R1 attempted to ca times. She was not previous education ability to get out of independently. Due required staff assis safety. R1 made po remembered to use always put R1's wa never formally direct	interview on 1/13/21 at 9:29 ng on her own prior to her fall. rry items with her walker at able to remember cues or for walker safety. R1 had the her recliner, bed or wheelchair to her history of falls, she tance with a gait belt for bor choices and had not always her walker. PT-A would lker within reach however, had cted staff to keep R1's walker hen she was left unsupervised	5			
		interview on 1/13/21 at 1:57 tions for fall safety included to				

TATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	E SURVEY PLETED
		00455	B. WING		C 13/2021
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1000 5/	AMARITAN SOCIETY	- PIPESTONE PIPESTO	ONE, MN 5616	4	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	(X5)
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2 830	Continued From pa	200 11	2 830		
2 000	Continued From pa	ge n	2 000		
	place her walker away from her to see if R1 would call for help.				
		ter ieu er 1/12/01 et 0:00			
	RN-B said during interview on 1/13/21 at 2:29 p.m., she was the case manager for R1. R1 was				
	able to rise from sitting to standing without staff				
	assistance prior to her fall on 1/5/21. However,				
		inconsistent with performing			
	sit to stand safely.	R1's care plan prior to her fall			
		a walker to ambulate with a gai	t		
		of 1 staff. There was no			
		have her walker within reach			
		ase she attempted to was discussion after her fall			
		her hip whether she should			
		thin reach. There was no			
		staff as to whether it would			
		and OT were to have			
		afe walker use after her return			
		Staff later decided to keep R1's			
		her to prevent her attempts to			
		was no mention how staff			
		see if the measure was lace R1 at higher risk for falls.			
		lought it would be safer to keep			
		er in her recliner to maintain			
		oted to self-transfer. There was	5		
		aff were to supervise R1 after			
		in her room at night prior to			
	bed in an effort to p	prevent falls.			
		rsing (DON) stated during			
		1 at 2:15 p.m., she could not I's walker was to be within R1's			
		ecliner. The DON stated staff			
		implement interventions to			
		ty following her falls. She			
		regarding whether it would be			
	safer for R1 to use	regarding whether it would be her walker without			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) DENTIFICATION NUMBER: 00455		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					C 01/13/2021	
		00455	B. WING			
IAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		RTH HIAWATH ONE, MN 5616			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From page 12		2 830			
	sight.					
	at 9:06 a.m., and stated if PT and OT determined R1 required use of a walker to maintain safety during transfers and walking, the device should have been kept within reach. He further clarified any resident who doesn't call or wait for staff assistance, who used assistive devices for ambulating and transferring, should have their equipment within reach to provide the safest scenario possible. The medical director stated staff should have assessed whether or not R1 was able to be alone in her room without direct supervision, knowing she had a history of attempting to self-transfer and walk without staff knowledge or assistance.					
	and Management F before falls occur re for any fall risk. Inter planned and person all staff to prevent a the 24-hour Report any daily stand-up meetings. Any iden referral needs were the appropriate dep After falls occurred implemented, staff	were to continue to monitor f interventions and adjust	3			
	The director of nurs review/revise polici falls, accidents, and assure proper asse	THOD OF CORRECTION: sing or designee, could es and procedures related to d resident supervision to essment and interventions are . They could re-educate staff				

Minnesota Department of Health STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00455		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		B. WING			C 01/13/2021	
AME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		RTH HIAWATH DNE, MN 5616			
(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 APPROPRIA DEFICIENCY)		(X5) COMPLET DATE
2 830	Continued From page 13		2 830			
	evaluating and more implementation of the developed, with the brought to the facilit Committee for a sp determine the need complaince.	procedures. A system for nitoring consistent these policies could be e results of these audits being ity's Quality Assurance becific amount of time to d for continued monitoring or R CORRECTION: Twenty-one				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 7, 2021

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

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

Dear Administrator:

On February 2, 2021, we notified you a remedy was imposed. On February 3, 2021 and February 25, 2021 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of February 19, 2021.

As authorized by CMS the remedy of:

• Mandatory denial of payment for new Medicare and Medicaid admissions effective effective March 18, 2020, did not go into effect. (42 CFR 488.417 (b))

In our letter of on February 2, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 19, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kumala Piske Downing

Kamala Fiske-Downing Minnesota Department of Health

Good Samaritan Society - Pipestone March 7, 2021 Page 2 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

March 7, 2021

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

Re: Reinspection Results Event ID: GXOP12

Dear Administrator:

On February 25, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 18, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kumala 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>