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

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.

- 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

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)

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

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

DEPARTMENT OF HEALTH

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: M0UP12

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,

Kamala 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: 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
	245591	A. BUILDING _____ B. WING _____	C 01/13/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 1/12/21 through 1/13/21, 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: H5591021C, with a deficiency cited at F689. 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=G	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		2/19/21

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

Electronically 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.

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F 689	Continued From page 1 by: Based on observation, interview and document review, the facility failed to conduct adequate assessment, provide appropriate supervision, or an assistive device to prevent a fall for 1 of 3 residents (R1). R1 self-transferred without her walker or appropriate supervision resulting in a fall with hip fracture. Findings include: Facility incident report records indicated R1 fell on 1/5/21 at 6:58 p.m., and later complained of pain resulting in a trip to the Emergency Department (ED) for evaluation where R1 was diagnosed with a right femur (hip) fracture. R1's 1/5/21 at 6:58 p.m., Risk Management report identified R1 was found on the floor with her legs in front of her and a blanket folded under her left leg. The report further indicated R1's walker was tipped over and faced away from the resident. R1's wheelchair was near the wall on the opposite side of the room. When interviewed, R1 stated she got out of her recliner and was attempting to go to bed when she lost her balance and fell backwards. The resident said she took her blanket from the walker and tucked it under her leg while she waited for staff to come and soften things. The report indicated R1 had impaired memory, confusion, weakness and used a walker. In addition, the report identified R1 had a suspected fracture. R1's 11/13/20, quarterly Minimum Data Set (MDS) identified R1 had moderately impaired cognition, poor memory, poor decision-making ability, difficulty understanding others, and altered levels of consciousness. The MDS indicated R1	F 689	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 requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. F689-G Free of Accident Hazards/Supervision/Devices R1 care plan updated on 2/5/2021 to reflect current fall interventions. R1's current assistive device for mobility and transfers will be kept within reach. A silent pressure alarm will be used to alert staff should R1 attempt self-transfer. R1 is now on a 2 hour scheduled repositioning schedule. All residents who experienced a fall in the last 30 days or a have been assessed to have a high fall risk will have a care plan review to ensure current interventions are adequate to address their current needs. Staff huddles will be done and documented across all shifts to ensure all direct-care staff are educated on expectations and interventions. This will be completed by 2/19/21.	

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F 689	Continued From page 2 required extensive assistance of 1 staff for bed mobility, transfers, toileting, dressing, and walked with an assistive device in her room, in corridors, and on and off the unit. Further, the MDS indicated R1 was dependent on staff to pick objects off the floor, required a walker for transfers and walking, and used a wheelchair for mobility. R1's current diagnose report identified diagnoses of a right leg fracture, heart failure, type 2 diabetes, age-related osteoporosis, obesity, unsteadiness of gait, muscle weakness, macular degeneration, presence of a left artificial knee joint, dizziness and giddiness, anxiety, anemia, and delirium related to known physiological conditions, depression, and wandering. R1's 1/12/20, care plan identified R1 had moderate cognitive impairment, impaired decision making, memory and safety awareness. The care plan also indicated R1 had poor vision, had difficulty expressing herself, and had difficulty understanding others. R1 would attempt to ambulate, transfer and toilet herself without staff assistance. She was known to rummage and hoard items in her room and would enter other resident rooms as part of her behaviors. R1 was a fall risk due to a history of multiple falls, confusion, and self-transfer attempts. R1 was incontinent of urine. R1 required use of a gait belt, front wheeled walker, wheelchair, and assistance of one staff to transfer, walk, toilet. R1's interventions included to ensure use of proper footwear, use gripper socks while in bed, and for staff to ensure adequate lighting. Staff were to assist R1 to the toilet every two to three hours. When R1 wandered, staff were to redirect, use simple cues, remind her to ask for assistance, and use a grabber to retrieve items	F 689	To protect residents at risk for similar situations, staff identified 11 resident who have history of attempted self-transferring and inconsistent call light use. Care plan review shows 6 were found to have effective care plan interventions. The others were updated to address the resident's current condition and needs. DNS/designee will provide re-education to all nursing staff, on completing comprehensive assessment, reading care plans, and implementing interventions to prevent recurrence on 2/9/2021. The IDT/PT/OT was provided re-education on reviewing the incident investigation, falls huddle worksheet to conduct RCA, monitoring effectiveness and ensuring appropriate care plan interventions are added to prevent recurrence by the DNS on 2/3/2021. Completion Date 2/19/2021. DNS/designee will audit 5 random Residents weekly X 4 then monthly X 2 to ensure post fall per GSS policy and procedure was completed. Results presented at QAPI for review and recommendations.	

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F 689	Continued From page 3	F 689		

off the floor. R1 was encouraged to visit with others in the day room to prevent self-transferring in her room. R1's walker was to be removed from her room when not in use for walking to prevent potential unassisted transfers. R1's wheelchair was to be placed next to her bed when not in use. Staff were to monitor R1 for changes in gait and consult physical therapy (PT) and occupational therapy (OT) when changes were identified. On 1/11/20, after she fell and fractured her hip, R1's care plan was updated to keep excess blankets and other environmental hazards in her closet and out-of-sight. Staff were to ensure R1's wheelchair was in a safe position while she rummaged and were to remind her to refrain from hanging blankets on her walker. The care plan revised 1/11/20, indicated R1 was no longer safe to operate her electric recliner.

During interview on 1/12/21 at 2:57 p.m., registered nurse (RN)-A stated she had worked the day shift on the day R1 fell. RN-A stated R1 was her normal self during the day and had anxiety in the afternoon, which was normal for her. She further stated that evening, R1 was tired wanted to lie down but had attempted several times to get up and walk. Staff provided one to one interaction with her and kept her in the area by the nurses' station. RN-A stated she was in shift report at the time R1 fell and had not seen R1 between supper and the time of the fall. Around 7:00 p.m. RN-A was called to R1's room and assisted with R1's initial fall assessment. RN-A said R1 was on the floor facing the head of her bed with her legs straight in front of her. She had a blanket under her left leg by her knee. RN-A stated she was unsure how R1 would have gotten a blanket. RN-A said she thought R1 must have gotten the blanket before she fell. RN-A said

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F 689	Continued From page 4 R1 was unable to recall how she'd gotten the blanket and said R1 was not a good historian. R1 complained of pain in an area above her sacrum and identified it was because she sat on the floor too long. RN-A added that R1 had stated she knew she should have waited for help. After R1 was assessed, and no injury found, R1 was transferred from the floor to the bed with no complaints of pain during the transfer and denied pain while lying in bed. Further interview with RN-A identified during R1's post-fall huddle, discussion of the event identified nurse aide (NA)-A had observed R1 in her recliner prior to her fall and had been there since after the evening meal. RN-A stated she was unsure who assisted R1 to the recliner, but when she [RN-A] entered R1's room to assess her after her fall, it appeared R1 had gotten up from the recliner and attempted to walk towards her bed. RN-A said the recliner footrest was observed up 10 degrees (slightly opened). RN-A was not sure if R1 had used the recliner control to adjust the chair prior to self-transferring. R1's walker was tipped over facing the opposite of R1. R1's wheelchair was "way behind her," parked on the other side of room against the wall next to her TV. R1's bed was on the farthest wall and R1 was on the floor by her dresser in front of her bed. RN-A also stated it appeared the blankets from R1's bed had been moved. RN- A further clarified R1 had a history of falls and now fell frequently because she was confused and forgetful and did not use her call light reliably. RN-A said R1 liked to stack items such as blankets on her walker and liked to rummage in her closet. She sometimes thought people were "stealing" items in her room, and she tried to hide things so they would not be stolen, and would forget where she placed them. RN-A said the recliner footrest was not used for R1	F 689		

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F 689	Continued From page 5	F 689		

because R1 had a history of getting up from the recliner without calling for help. RN-A was unsure if R1 was able to use the controls on the recliner due to her cognition. She was also 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 in her 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 sent to the hospital. NA-B said R1's interventions to prevent falls were to keep her door open while she was awake. R1 went to bed early and was known to sit in her recliner frequently after supper. R1 was supposed to have 1 staff assist her to transfer and walk, but R1 was "busy and hard to keep an eye on", and R1 was to have the wheelchair by her bed for safety. NA-B stated cares during the evenings were busy and staff were in and out of rooms a lot providing care to all residents. Staff tried to check on residents as they pass by the rooms. NA-B said R1 frequently wanted to walk, and use to walk all day and verbalize she wanted to go home. NA-B stated R1 was able to get up

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F 689	Continued From page 6	F 689		

from her recliner independently without help and would walk in her room without staff assistance. In addition, NA-B said R 1 would rarely use the call light for assistance.

During interview on 1/12/21 at 1:50 p.m., NA-C identified she generally provided cares for R1 on the weekends. NA-C stated R1 was known to be confused and forgetful, and before the fall R1 required assistance of 1 staff to walk. Staff were to assist her to the toilet every 2 to 3 hours. R1 had frequent urges to use the bathroom and never called for help. She had a history of attempting to self-transfer. R1 continued to require assistance of 1 staff, a walker, and her gait belt to safely transfer. If R1 wanted to sit in her recliner, staff needed to check on her "frequently because she didn't sit there very long". When R1 was witnessed to be restless and would not remain seated in her recliner, staff would bring her to the area by the nurse's desk for closer observation. R1 was not receptive to activities that she would have to do on her own. R1 mostly wandered when she was restless. R1 usually only sat in the recliner in her room for "about an hour" and staff were to never put her feet up in the recliner because she would not remember to put her feet down. NA-C was unsure if R1 had an electric recliner and said R1 never had her feet up on her recliner that she was aware of. Staff were to have R1's wheelchair by her bed, away from her chair. She was unsure if R1's walker was to be beside her or across the room away from her to prevent her from potentially self-transferring.

NA-D stated during interview on 1/12/21 at 3:47 p.m., that R1 was confused but easily redirected. NA-D said R1 often thought people were stealing

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

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from her, so she hid things. R1 self-transferred often and would do so at any time of the day from her wheelchair to bed, or bed to wheelchair. R1 was requesting to lie down more frequently and staff would catch her attempting to self-transfer. Staff provided verbal cues for R1 to call for help. She was supposed to be assisted with 1 staff, a gait belt, and her front wheeled walker. She was able to get up and around her room by herself. Sometimes she tried to get to her walker. NA-D stated she knew R1 would use her over the bed table to attempt to get around her room if her walker was unavailable. Further, NA-D said R1 had Sundowner's and would not consistently use the call light.

When interviewed on 1/12/21 at 4:51 p.m., NA-A stated R1 was found lying by the foot of the bed, facing towards her recliner across the room. NA-A said R1 had no pain initially and stated she tried to get to her walker. The walker was observed positioned toward the end of the bed. NA-A said prior to the fall, she had assisted R1 to go the bathroom, change into pajamas, and transferred her to her recliner. NA-A said she'd reclined the recliner all the way back adding, R1"usually sat in her recliner. She seemed really tired that day when I put her in the recliner. I was surprised she got up". She was a person who was independent a few months ago but now needed to have staff to help. At the time of the fall, R1's wheelchair was parked in the corner of her room, and the walker was placed towards the end of her bed. Both items were away from R1. NA-A stated R1's walker was still at the end of the bed at the time of the fall. NA-A also stated she'd given R1 her blue snowflake blanket when she was in the recliner. She was noted to have grabbed the blanket from the end of her bed. It

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was found under her knee after she fell. NA-A was unsure how long R1 laid on the floor after the fall. NA-A was in another resident room when dietary staff found R1. NA-A was unsure what staff would have checked on her. NA-A said R1 fell about a half hour after she cared for R1. R1 was supposed to be checked every 2-3 hours for bathroom. NA-A was unsure if R1 was to be checked on more frequently or if she needed to be supervised at times she wasn't in direct sight of staff to ensure her safety.

When interviewed on 1/12/21 at 5:12 p.m., occupational therapist (OT)-A identified R1 had physical therapy (PT) ordered on 10/16/20, due to a general decline, and R1 had a history of falls. OT-A said R1 also had increased knee pain and was not able to do things safely without assistance and PT had deemed R1 required assistance of 1 staff, a gait belt, and walker for transfers and mobility. OT-A was aware R1 would continue to transfer without assistance but advised staff check her more often and provide assistance whenever possible. She stated R1 had a history of dementia, falls and transferring without assistance. Prior to this last fall, R1 was able to get up on her own without staff assistance. She was able to use her walker for transfers and walking. She was even also able to rummage and pick things up off the floor. PT and OT were involved in exercises for strengthening. OT-A said nursing had placed R1's wheelchair by her bed as an intervention to potentially deter her from self-transferring and R1 should have had her walker within reach while in her recliner, in case she attempted to self-transfer. R1 had used her walker for a long time and would look for her walker if it was out of reach or out of sight. She was supposed to use it to pivot transfer. She also

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had a bag on the walker that contained her personal items such as her toothbrush and other personal items.

PT-A stated during interview on 1/13/21 at 9:29 a.m., R1 was walking on her own prior to her fall. R1 attempted to carry items with her walker at times. She was not able to remember cues or previous education for walker safety. R1 had the ability to get out of her recliner, bed or wheelchair independently. Due to her history of falls, she required staff assistance with a gait belt for safety. R1 made poor choices and had not always remembered to use her walker. PT-A would always put R1's walker within reach however, had never formally directed staff to keep R1's walker within her reach when she was left unsupervised in her room.

RN-C stated during interview on 1/13/21 at 1:57 p.m., R1's interventions for fall safety included to place her walker away from her to see if R1 would call for help.

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, RN-B said R1 was inconsistent with performing sit to stand safely. R1's care plan prior to her fall was for R1 to use a walker to ambulate with a gait belt and assistance of 1 staff. There was no mention R1 was to have her walker within reach prior to her fall in case she attempted to self-transfer. There was discussion after her fall when she fractured her hip whether she should have her walker within reach. There was no consensus among staff as to whether it would make her safer. PT and OT were to have

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evaluated R1 for safe walker use after her return from the hospital. Staff later decided to keep R1's walker away from her to prevent her attempts to self-transfer. There was no mention how staff were to monitor to see if the measure was effective or could place R1 at higher risk for falls. RN-B stated she thought it would be safer to keep R1's walker near her in her recliner to maintain safety if she attempted to self-transfer. There was no mention how staff were to supervise R1 after she was left alone in her room at night prior to bed in an effort to prevent falls.

The Director of Nursing (DON) stated during interview on 1/13/21 at 2:15 p.m., she could not answer whether R1's walker was to be within R1's reach while in her recliner. The DON stated staff were attempting to implement interventions to maintain R1's safety following her falls. She declined comment regarding whether it would be safer for R1 to use her walker without supervision, or to keep the walker out of R1's sight.

The medical director was interviewed on 1/14/21 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.

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F 689	Continued From page 11 Review of the facility's 6/24/20, Fall Prevention and Management Rehab/Skilled policy, identified before falls occur residents were to be assessed for any fall risk. Interventions were to be care planned and personalized and communicated to all staff to prevent a fall before it occurred, using the 24-hour Report, care plan, Kardex, and during any daily stand-up meetings and fall committee meetings. Any identified environmental or device referral needs were also to be communicated to the appropriate departments such as PT or OT. After falls occurred and interventions implemented, staff were to continue to monitor the effectiveness of interventions and adjust interventions as needed.	F 689		

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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 1/12/21 through 1/13/21, 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: 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/infobul.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 heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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		

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2 000	Continued From page 2 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.	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 conduct adequate assessment, provide appropriate supervision, or an assistive device to prevent a fall for 1 of 3 residents (R1). R1 self-transferred without her walker or appropriate supervision resulting in a fall with hip fracture. Findings include: Facility incident report records indicated R1 fell on 1/5/21 at 6:58 p.m., and later complained of pain	2 830	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	2/19/21

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2 830	Continued From page 3 resulting in a trip to the Emergency Department (ED) for evaluation where R1 was diagnosed with a right femur (hip) fracture. R1's 1/5/21 at 6:58 p.m., Risk Management report identified R1 was found on the floor with her legs in front of her and a blanket folded under her left leg. The report further indicated R1's walker was tipped over and faced away from the resident. R1's wheelchair was near the wall on the opposite side of the room. When interviewed, R1 stated she got out of her recliner and was attempting to go to bed when she lost her balance and fell backwards. The resident said she took her blanket from the walker and tucked it under her leg while she waited for staff to come and soften things. The report indicated R1 had impaired memory, confusion, weakness and used a walker. In addition, the report identified R1 had a suspected fracture. R1's 11/13/20, quarterly Minimum Data Set (MDS) identified R1 had moderately impaired cognition, poor memory, poor decision-making ability, difficulty understanding others, and altered levels of consciousness. The MDS indicated R1 required extensive assistance of 1 staff for bed mobility, transfers, toileting, dressing, and walked with an assistive device in her room, in corridors, and on and off the unit. Further, the MDS indicated R1 was dependent on staff to pick objects off the floor, required a walker for transfers and walking, and used a wheelchair for mobility. R1's current diagnose report identified diagnoses of a right leg fracture, heart failure, type 2 diabetes, age-related osteoporosis, obesity, unsteadiness of gait, muscle weakness, macular degeneration, presence of a left artificial knee joint, dizziness and giddiness, anxiety, anemia, and delirium related to known	2 830	requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. F689-G Free of Accident Hazards/Supervision/Devices R1 care plan updated on 2/2/2021 to reflect current fall interventions. All Residents who experienced a fall in the last 30 days will have a comprehensive assessment to determine RCA and develop interventions to provide adequate supervision and safety. DNS/designee will provide re-education to all nursing staff, on completing comprehensive assessment, reading care plans, and implementing interventions to prevent recurrence on 2/9/2021. The IDT/PT/OT was provided re-education on reviewing the incident investigation, falls huddle worksheet to conduct RCA, monitoring effectiveness and ensuring appropriate care plan interventions are added to prevent recurrence by the DNS on 2/3/2021. Completion Date 2/19/2021. DNS/designee will audit 5 random Residents weekly X 4 then monthly X 2 to ensure post fall per GSS policy and procedure was completed. Results presented at QAPI for review and recommendations.	

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2 830	Continued From page 4 physiological conditions, depression, and wandering. R1's 1/12/20, care plan identified R1 had moderate cognitive impairment, impaired decision making, memory and safety awareness. The care plan also indicated R1 had poor vision, had difficulty expressing herself, and had difficulty understanding others. R1 would attempt to ambulate, transfer and toilet herself without staff assistance. She was known to rummage and hoard items in her room and would enter other resident rooms as part of her behaviors. R1 was a fall risk due to a history of multiple falls, confusion, and self-transfer attempts. R1 was incontinent of urine. R1 required use of a gait belt, front wheeled walker, wheelchair, and assistance of one staff to transfer, walk, toilet. R1's interventions included to ensure use of proper footwear, use gripper socks while in bed, and for staff to ensure adequate lighting. Staff were to assist R1 to the toilet every two to three hours. When R1 wandered, staff were to redirect, use simple cues, remind her to ask for assistance, and use a grabber to retrieve items off the floor. R1 was encouraged to visit with others in the day room to prevent self-transferring in her room. R1's walker was to be removed from her room when not in use for walking to prevent potential unassisted transfers. R1's wheelchair was to be placed next to her bed when not in use. Staff were to monitor R1 for changes in gait and consult physical therapy (PT) and occupational therapy (OT) when changes were identified. On 1/11/20, after she fell and fractured her hip, R1's care plan was updated to keep excess blankets and other environmental hazards in her closet and out-of-sight. Staff were to ensure R1's wheelchair was in a safe position while she rummaged and were to remind her to refrain from	2 830		

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2 830	Continued From page 5 hanging blankets on her walker. The care plan revised 1/11/20, indicated R1 was no longer safe to operate her electric recliner. During interview on 1/12/21 at 2:57 p.m., registered nurse (RN)-A stated she had worked the day shift on the day R1 fell. RN-A stated R1 was her normal self during the day and had anxiety in the afternoon, which was normal for her. She further stated that evening, R1 was tired wanted to lie down but had attempted several times to get up and walk. Staff provided one to one interaction with her and kept her in the area by the nurses' station. RN-A stated she was in shift report at the time R1 fell and had not seen R1 between supper and the time of the fall. Around 7:00 p.m. RN-A was called to R1's room and assisted with R1's initial fall assessment. RN-A said R1 was on the floor facing the head of her bed with her legs straight in front of her. She had a blanket under her left leg by her knee. RN-A stated she was unsure how R1 would have gotten a blanket. RN-A said she thought R1 must have gotten the blanket before she fell. RN-A said R1 was unable to recall how she'd gotten the blanket and said R1 was not a good historian. R1 complained of pain in an area above her sacrum and identified it was because she sat on the floor too long. RN-A added that R1 had stated she knew she should have waited for help. After R1 was assessed, and no injury found, R1 was transferred from the floor to the bed with no complaints of pain during the transfer and denied pain while lying in bed. Further interview with RN-A identified during R1's post-fall huddle, discussion of the event identified nurse aide (NA)-A had observed R1 in her recliner prior to her fall and had been there since after the evening meal. RN-A stated she was unsure who assisted R1 to the recliner, but when she [RN-A]	2 830		

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entered R1's room to assess her after her fall, it appeared R1 had gotten up from the recliner and attempted to walk towards her bed. RN-A said the recliner footrest was observed up 10 degrees (slightly opened). RN-A was not sure if R1 had used the recliner control to adjust the chair prior to self-transferring. R1's walker was tipped over facing the opposite of R1. R1's wheelchair was "way behind her," parked on the other side of room against the wall next to her TV. R1's bed was on the farthest wall and R1 was on the floor by her dresser in front of her bed. RN-A also stated it appeared the blankets from R1's bed had been moved. RN- A further clarified R1 had a history of falls and now fell frequently because she was confused and forgetful and did not use her call light reliably. RN-A said R1 liked to stack items such as blankets on her walker and liked to rummage in her closet. She sometimes thought people were "stealing" items in her room, and she tried to hide things so they would not be stolen, and would forget where she placed them. RN-A said the recliner footrest was not used for R1 because R1 had a history of getting up from the recliner without calling for help. RN-A was unsure if R1 was able to use the controls on the recliner due to her cognition. She was also 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

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	00455	A. BUILDING: _____ B. WING _____	C 01/13/2021

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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2 830	Continued From page 7	2 830		

said when R1 fell, she [NA-B] was on break. After she returned from break, R1 was in her 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 sent to the hospital. NA-B said R1's interventions to prevent falls were to keep her door open while she was awake. R1 went to bed early and was known to sit in her recliner frequently after supper. R1 was supposed to have 1 staff assist her to transfer and walk, but R1 was "busy and hard to keep an eye on", and R1 was to have the wheelchair by her bed for safety. NA-B stated cares during the evenings were busy and staff were in and out of rooms a lot providing care to all residents. Staff tried to check on residents as they pass by the rooms. NA-B said R1 frequently wanted to walk, and use to walk all day and verbalize she wanted to go home. NA-B stated R1 was able to get up from her recliner independently without help and would walk in her room without staff assistance. In addition, NA-B said R 1 would rarely use the call light for assistance.

During interview on 1/12/21 at 1:50 p.m., NA-C identified she generally provided cares for R1 on the weekends. NA-C stated R1 was known to be confused and forgetful, and before the fall R1 required assistance of 1 staff to walk. Staff were to assist her to the toilet every 2 to 3 hours. R1 had frequent urges to use the bathroom and never called for help. She had a history of attempting to self-transfer. R1 continued to require assistance of 1 staff, a walker, and her gait belt to safely transfer. If R1 wanted to sit in her recliner, staff needed to check on her "frequently because she didn't sit there very long".

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2 830	Continued From page 8 When R1 was witnessed to be restless and would not remain seated in her recliner, staff would bring her to the area by the nurse's desk for closer observation. R1 was not receptive to activities that she would have to do on her own. R1 mostly wandered when she was restless. R1 usually only sat in the recliner in her room for "about an hour" and staff were to never put her feet up in the recliner because she would not remember to put her feet down. NA-C was unsure if R1 had an electric recliner and said R1 never had her feet up on her recliner that she was aware of. Staff were to have R1's wheelchair by her bed, away from her chair. She was unsure if R1's walker was to be beside her or across the room away from her to prevent her from potentially self-transferring. NA-D stated during interview on 1/12/21 at 3:47 p.m., that R1 was confused but easily redirected. NA-D said R1 often thought people were stealing from her, so she hid things. R1 self-transferred often and would do so at any time of the day from her wheelchair to bed, or bed to wheelchair. R1 was requesting to lie down more frequently and staff would catch her attempting to self-transfer. Staff provided verbal cues for R1 to call for help. She was supposed to be assisted with 1 staff, a gait belt, and her front wheeled walker. She was able to get up and around her room by herself. Sometimes she tried to get to her walker. NA-D stated she knew R1 would use her over the bed table to attempt to get around her room if her walker was unavailable. Further, NA-D said R1 had Sundowner's and would not consistently use the call light. When interviewed on 1/12/21 at 4:51 p.m., NA-A stated R1 was found lying by the foot of the bed, facing towards her recliner across the room.	2 830		

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2 830	Continued From page 9 NA-A said R1 had no pain initially and stated she tried to get to her walker. The walker was observed positioned toward the end of the bed. NA-A said prior to the fall, she had assisted R1 to go the bathroom, change into pajamas, and transferred her to her recliner. NA-A said she'd reclined the recliner all the way back adding, R1"usually sat in her recliner. She seemed really tired that day when I put her in the recliner. I was surprised she got up". She was a person who was independent a few months ago but now needed to have staff to help. At the time of the fall, R1's wheelchair was parked in the corner of her room, and the walker was placed towards the end of her bed. Both items were away from R1. NA-A stated R1's walker was still at the end of the bed at the time of the fall. NA-A also stated she'd given R1 her blue snowflake blanket when she was in the recliner. She was noted to have grabbed the blanket from the end of her bed. It was found under her knee after she fell. NA-A was unsure how long R1 laid on the floor after the fall. NA-A was in another resident room when dietary staff found R1. NA-A was unsure what staff would have checked on her. NA-A said R1 fell about a half hour after she cared for R1. R1 was supposed to be checked every 2-3 hours for bathroom. NA-A was unsure if R1 was to be checked on more frequently or if she needed to be supervised at times she wasn't in direct sight of staff to ensure her safety. When interviewed on 1/12/21 at 5:12 p.m., occupational therapist (OT)-A identified R1 had physical therapy (PT) ordered on 10/16/20, due to a general decline, and R1 had a history of falls. OT-A said R1 also had increased knee pain and was not able to do things safely without assistance and PT had deemed R1 required assistance of 1 staff, a gait belt, and walker for	2 830		

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2 830	Continued From page 10	2 830		

transfers and mobility. OT-A was aware R1 would continue to transfer without assistance but advised staff check her more often and provide assistance whenever possible. She stated R1 had a history of dementia, falls and transferring without assistance. Prior to this last fall, R1 was able to get up on her own without staff assistance. She was able to use her walker for transfers and walking. She was even also able to rummage and pick things up off the floor. PT and OT were involved in exercises for strengthening. OT-A said nursing had placed R1's wheelchair by her bed as an intervention to potentially deter her from self-transferring and R1 should have had her walker within reach while in her recliner, in case she attempted to self-transfer. R1 had used her walker for a long time and would look for her walker if it was out of reach or out of sight. She was supposed to use it to pivot transfer. She also had a bag on the walker that contained her personal items such as her toothbrush and other personal items.

PT-A stated during interview on 1/13/21 at 9:29 a.m., R1 was walking on her own prior to her fall. R1 attempted to carry items with her walker at times. She was not able to remember cues or previous education for walker safety. R1 had the ability to get out of her recliner, bed or wheelchair independently. Due to her history of falls, she required staff assistance with a gait belt for safety. R1 made poor choices and had not always remembered to use her walker. PT-A would always put R1's walker within reach however, had never formally directed staff to keep R1's walker within her reach when she was left unsupervised in her room.

RN-C stated during interview on 1/13/21 at 1:57 p.m., R1's interventions for fall safety included to

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2 830	Continued From page 11 place her walker away from her to see if R1 would call for help. 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, RN-B said R1 was inconsistent with performing sit to stand safely. R1's care plan prior to her fall was for R1 to use a walker to ambulate with a gait belt and assistance of 1 staff. There was no mention R1 was to have her walker within reach prior to her fall in case she attempted to self-transfer. There was discussion after her fall when she fractured her hip whether she should have her walker within reach. There was no consensus among staff as to whether it would make her safer. PT and OT were to have evaluated R1 for safe walker use after her return from the hospital. Staff later decided to keep R1's walker away from her to prevent her attempts to self-transfer. There was no mention how staff were to monitor to see if the measure was effective or could place R1 at higher risk for falls. RN-B stated she thought it would be safer to keep R1's walker near her in her recliner to maintain safety if she attempted to self-transfer. There was no mention how staff were to supervise R1 after she was left alone in her room at night prior to bed in an effort to prevent falls. The Director of Nursing (DON) stated during interview on 1/13/21 at 2:15 p.m., she could not answer whether R1's walker was to be within R1's reach while in her recliner. The DON stated staff were attempting to implement interventions to maintain R1's safety following her falls. She declined comment regarding whether it would be safer for R1 to use her walker without supervision, or to keep the walker out of R1's	2 830		

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2 830	Continued From page 12 sight. The medical director was interviewed on 1/14/21 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. Review of the facility's 6/24/20, Fall Prevention and Management Rehab/Skilled policy, identified before falls occur residents were to be assessed for any fall risk. Interventions were to be care planned and personalized and communicated to all staff to prevent a fall before it occurred, using the 24-hour Report, care plan, Kardex, and during any daily stand-up meetings and fall committee meetings. Any identified environmental or device referral needs were also to be communicated to the appropriate departments such as PT or OT. After falls occurred and interventions implemented, staff were to continue to monitor the effectiveness of interventions and adjust interventions as needed. 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 interventions are being implemented. They could re-educate staff	2 830		

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2 830	Continued From page 13 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 a specific amount of time to determine the need for continued monitoring or complaince. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

DEPARTMENT OF HEALTH

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,

Kamala 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: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
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