

Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Good Samaritan So	ciety Pipestone		Report Number: H5591011	Date of Visit: June 21, 2017		
Facility Address: 1311 North Hiawatha			Time of Visit: 3:00 a.m. to 11:00 a.m.	Date Concluded: March 12, 2018		
Facility City: Pipestone			Investigator's Name and Pam Hovdet, RN, Special			
State:	ZIP:	County:				
Minnesota	56164	Pipestone —				
Nursing Home						

Allegation(s):

It is alleged that a resident was neglected when staff/alleged perpetrator (AP) failed to follow the resident's care plan. The resident had a fall and sustained multiple fractures.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) failed to follow the resident's care plan and the resident fell. The resident sustained four fractures to his/her right hand because of the fall.

The resident was severely cognitively impaired and required assistance with all activities of daily living. The resident was at risk for falls due to a history of cerebrovascular accidents, weakness, and poor safety awareness. The resident was identified to be at risk for falls and the resident's care plan had fall interventions in place, including the alarm monitor to alert staff to the resident's movement, and to assist staff in monitoring movement.

The resident was sitting in his/her wheelchair with an alarm monitor attached when the resident requested to use the bathroom. The AP pushed the resident into the bathroom and unhooked the alarm monitor prior to transferring the resident to the toilet. The AP then left the resident in the bathroom alone on the toilet with no alarm on the resident, and went down the hallway to assist another resident. Shortly after the AP left the resident's room, a nurse in the hallway heard the resident scream and found the resident lying on his/her right side with his/her right arm tucked behind the resident. The resident had attempted to self

Facility Name: Good Samaritan Society Report Number: H5591011 Pinestone transfer from the toilet to the wheelchair and fell onto the bathroom floor. The nurse assessed the resident for injuries and notified the physician and family. Staff continued to monitor the resident and administered pain medication and ice as ordered by the physician. The following morning, the resident had an increase in pain and swelling in the right hand. The family was notified and the resident was taken to the clinic. X-rays indicated the resident had fractures of the second to fifth metacarpals (bones in the hand). An orthoplast splint (a device used to immobilize, protect, and support injuries such as fractures, sprains and strains) was applied to the resident's right hand. When interviewed, the resident did not remember where the fall occurred, and stated staff tell him/her to ask for help instead of trying to do things on his/her own. When interviewed, the AP stated s/he forgot and was not thinking when s/he stepped out of the resident's room to assist another resident. The AP was immediately re-educated on following the resident's care plan after the incident. A corrective action notice indicated the staff was issued a written warning for failure to follow policy and procedure and failure to follow the care plan. Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557) Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557): ☐ Abuse Neglect
 Financial Exploitation ☐ Inconclusive based on the following information: Substantiated
 ■ ☐ Not Substantiated **Mitigating Factors:** The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the \(\) Individual(s) and/or \(\) Facility is responsible for the Neglect ☐ Financial Exploitation. This determination was based on the following: ☐ Abuse The facility is responsible as they did not have policies and procedures sufficient to ensure safeguards and clear direction on how to implement fall interventions. In addition, the individual was responsible for failing to follow the care plan and corresponding facility policies and procedures. The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) - Compliance Met

Compliance:

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued. Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met. Deficiencies are issued on form 2567: X Yes ☐ No (The 2567 will be available on the MDH website.) State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) - Compliance Not Met The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met. State licensing orders were issued: x Yes □ No (State licensing orders will be available on the MDH website.) State Statutes Chapters 144 & 144A - Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met. State licensing orders were issued: X Yes □ No (State licensing orders will be available on the MDH website.) **Compliance Notes: Definitions:**

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Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

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Pinestone

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
 - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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"Su	nnesota Statutes, section 626.5572, subdivision 19 - Substan Ibstantiated" means a preponderance of the evidence shows t Itreatment occurred.	
45000000000	e Investigation included the following: cument Review: The following records were reviewed duri	ng the investigation:
X	Medical Records	
X	Care Guide	
X	Medication Administration Records	
X	Weight Records	
X	Nurses Notes	
X	Assessments	
X	Physician Orders	
X	Treatment Sheets	
X	Physician Progress Notes	
X	Care Plan Records	
X	Facility Incident Reports	
X	Laboratory and X-ray Reports	
X	Therapy and/or Ancillary Services Records	
Otl	her pertinent medical records:	
Ad ×	ditional facility records: Staff Time Sheets, Schedules, etc.	
X	Facility Internal Investigation Reports	
X	Personnel Records/Background Check, etc.	
x	Facility In-service Records	
X	Facility Policies and Procedures	
Nu	mber of additional resident(s) reviewed: Four	
We	ere residents selected based on the allegation(s)? Yes	○ No ○ N/A

Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation? Yes \bigcirc No \bigcirc N/A Specify: Interviews: The following interviews were conducted during the investigation: \bigcirc N/A Yes \bigcirc No Interview with reporter(s) Specify: If unable to contact reporter, attempts were made on: Date: Time: Time: Time: Date: Date: Interview with family:

Yes

No

N/A Specify: Did you interview the resident(s) identified in allegation: Yes ○ N/A Specify: \bigcirc No \bigcirc No Did you interview additional residents? • Yes Total number of resident interviews: Nine Interview with staff:

Yes ○ No ○ N/A Specify: Tennessen Warnings \bigcirc No Tennessen Warning given as required:

Yes Total number of staff interviews: Ten Physician Interviewed: Yes No Nurse Practitioner Interviewed: Yes No No Physician Assistant Interviewed: Yes ○ N/A Specify: Interview with Alleged Perpetrator(s):

Yes ○ No Attempts to contact: Time: Date: Time: Time: Date: Date: If unable to contact was subpoena issued: Yes, date subpoena was issued Were contacts made with any of the following: ☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify

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Observations were conducted related to:
Personal Care
Nursing Services
X Call Light
▼ Infection Control
▼ Use of Equipment
X Cleanliness
▼ Dignity/Privacy Issues
▼ Safety Issues
▼ Transfers
X Facility Tour
▼ Injury
Was any involved equipment inspected: ○ Yes ○ No ● N/A
Was equipment being operated in safe manner: Yes No N/A
Were photographs taken: O Yes O No Specify:
cc:
Health Regulation Division - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
The Office of Ombudsman for Long-Term Care
Pipestone Police Department
Pipestone City Attorney
Pipestone County Attorney

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Facility Name: Good Samaritan Society Pinestone

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

PRINTED: 04/05/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		B. WING			R-C 08/02/2017		
NAME OF F	PROVIDER OR SUPPLIER	243391	D. William		TREET ADDRESS, CITY, STATE, ZIP CODE	U0/I	02/201/
	AMARITAN SOCIETY	- PIPESTONE		13	311 NORTH HIAWATHA IPESTONE, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENT	revisit was conducted on	{F 00	00}			
	to complaint H5591 Pipestone is in com	on deficiencies issued related 011. Good Samaritan Society ipliance with 42 CFR Part 483, nents for Long Term Care		:			
	signature is not req page of the CMS-2 correction is require	ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, it is required that the facility of of the electronic documents.					
					TITLE		/YEN DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

10/09/2017

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.

PRINTED: 04/05/2018 FORM APPROVED

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: ___ R-C B. WING _ 08/02/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1311 NORTH HIAWATHA GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {2 000} Initial Comments {2 000} *****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:** A licensing order follow-up was completed to follow up on correction orders issued related to complaint H5591011, Good Samaritan Society Pipestone was found in compliance with state regulations. The facility is enrolled in ePOC and therefore a

Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 10/09/17

STATE FORM

HPQ412

PRINTED: 04/05/2018 FORM APPROVED

Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: ___ R-C B. WING 08/02/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) {2 000} {2 000} Continued From page 1 signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.

Minnesota Department of Health STATE FORM

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

PRINTED: 03/12/2018 FORM APPROVED OMB NO. 0938-0391

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appropriate alternatives prior to installing a side or	
bed rail. If a bed or side rail is used, the facility	
must ensure correct installation, use, and	
maintenance of bed rails, including but not limited	
to the following elements.	
(1) Access the recident for risk of seturns and	
(1) Assess the resident for risk of entrapment	
from bed rails prior to installation.	
(2) Review the risks and benefits of bed rails with	
the resident or resident representative and obtain	
informed consent prior to installation.	
(3) Ensure that the bed's dimensions are	
appropriate for the resident's size and weight.	
This REQUIREMENT is not met as evidenced	
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	I

07/12/2017 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/12/2018 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245591			B. WING			C 07/2017	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - PIPESTONE				STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA PIPESTONE, MN 56164	<u> Ui/</u>	J1/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 323	by: Based on interview facility failed to provate of 5 residents (Ray was left alone on the transfer, fell to the fractures in the right fractures. The calculation of the bed when in be attached to the whore resident's moveme monitoring moveme Rahad an activities performance deficit intolerance and cor interventions included of one staff for trant Rahad and required and required and required and required and required and for staff indicated Rahadam and for staff all scene huddle 1:30 p.m. indicated toilet alone in the base of the provided resident in the provided resident in the base of the provided resident in the provident in the provi	w and document review, the vide adequate supervision for R1) reviewed for falls, when R1 he toilet. R1 attempted to self floor, and sustained four ht hand. ed 5/24/17, indicated R1 was at a to weakness, history of ecident, and poor safety are plan interventions for falls etector down on the floor beside ed and TABS (an alarm that is eelchair and clips on the chair used to alert staff to ent and to assist staff in ent. The care plan indicated s of daily living (ADL) self care t related to weakness, activity infusion. The care plan ded R1 required the assistance ensiers. Inimum Data Set (MDS) dated R1 was severely cognitively red the assistance of one staff	F3	F323 Statement of Compliance: Preparation and execution of this response and plan of correction of constitute an admission or agree the provider of the truth of the fact alleged or conclusions set forth in statement of deficiencies. The placorrection is prepared and/or executed by the provisions of state and federal late the purposes of any allegation the center is not in substantial compliant with federal requirements of partition this response and plan of correct constitutes the center is allegatic compliance in accordance with second finance in accordance with second finance with Federal Medicar Medicaid requirements. 1. Resident (R1) careplan state a tabs alarm on resident while in wheelchair. Care plan was updat 5/29/17 by the charge nurse to in staff supervision while on the toile 2. All residents that are a fall risuse a tabs alarm. 3. Initial certified nursing assistatinterviewed and received a correction. Re-education in regards to following standard of care, policy procedures and prevention of fall given to the CNA s/NA by DON mandatory meeting on July 13th those who could not attend will here.	ment by ts the an of cuted e v. For at the ance cipation, on n of ection hual. a e and d to have the ed on clude tt. k and at was stive o and s was at the and		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245591	B. WING			07/0) 07/2017
	PROVIDER OR SUPPLIER			13	TREET ADDRESS, CITY, STATE, ZIP CODE 311 NORTH HIAWATHA IPESTONE, MN 56164	1 31/3	.,
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	floor injuring R1's A nursing progres p.m. indicated R1 milligrams (mg) for A nursing progres p.m. indicated the fall and the secon and hard to bend A nursing progres p.m. indicated R1 mg for pain. A nursing progres p.m. indicated R1 warm to the touch freely with minimal discomfort. A nursing progres a.m. indicated R1 had increased. F scheduled for a man and increased. F scheduled for a man and indicated R1 mg for pain. A physicians progres a.m. indicated R1 mg for pain. A physicians progres a.m. indicated R1 mg for pain. A physicians progres a.m. indicated R1 mg for pain. A physicians progres a.m. indicated R1 mg for pain.	he wheelchair and fell to the	F3	323	watched video by July 25th or prior next scheduled shift. All new hire assistants will be educated on the Kardex and a checklist of clinical performance will be conducted by development coordinator before the CNA/NA can work independently. 4. To monitor performance and e that solutions are sustained, audits conducted by the Director of Nursing/designee of certified nursi assistants providing care to reside tab alarms, 1 x per week for 4 weethen 1 x per month for 3 months. results will be brought to the QAPI committee for review and or recommendations. 5. Date: 7/25/17	nursing use of the staff e nsure s will be ng nts with eks and The	

PRINTED: 03/12/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WING 07/07/2017 245591 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 3 A nursing progress note dated 5/30/17, at 5:04 p.m. indicated Acetaminophen 650 mg was given to R1 for pain and at 7:00 p.m. Tramadol 50 mg was given to R1 for severe pain. A nursing progress note dated 5/31/17, at 7:19 a.m. indicated an ice pack was given to R1 and arm elevated on pillow. R1 stated her right arm was not too painful. A nursing progress note dated 5/31/17, at 9:24 a.m. indicated Tramadol 50 mg was given to R1 for severe pain in right hand at 9:24 a.m., 1:42p.m., 7:07p.m. and at 8:50 p.m. indicated Acetaminophen 650 mg was given to R1 for breakthrough pain in right hand. A nursing progress note dated 6/1/17, indicated Tramadol 50 mg was given to R1 for severe wrist pain and a headache at 12:53 p.m. and again at 6:34 p.m. for severe right hand pain, and Acetaminophen 650 mg was given to R1 for right hand pain. Nursing progress notes dated 6/2/17, indicated R1 received Tramadol 50 mg for severe right hand pain at 6:32 p.m. and it was effective.

Nursing progress notes dated 6/3/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m., Tramadol 50 mg at 2:00 p.m. and 6: 41 p.m. and Acetaminophen 650 mg at 9:17 p.m. for right

Nursing progress notes dated 6/4/17, indicated R1 received Acetaminophen 650 mg at 6:40 a.m. and Tramadol 50 mg at 1:28 p.m. and 6:19 p.m. for right hand pain and all were effective.

hand pain and all were effective.

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STATEMENT OF BELLOCITION AND AND AND AND AND AND AND AND AND AN		1 ` ′		E CONSTRUCTION	COMPLETED		
		245591	B. WING	i			7/2017
,,,,,,,	PROVIDER OR SUPPLIEI AMARITAN SOCIET			1	TREET ADDRESS, CITY, STATE, ZIP CODE 311 NORTH HIAWATHA PIPESTONE, MN 56164		
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F 323	Continued From p		F	323			
	R1 received Tram	notes dated 6/5/17, indicated nadol 50 mg at 6:14 p.m. and 550 mg at 9:26 p.m. for right th were effective.					;
	a.m. indicated R1 surgeon and an o to immobilize, pro	ss note dated 6/6/17, at 11:51 was seen by the orthopedic orthoplast splint (a device used otect and support injuries such tins and strains) was applied and ir weeks.					
	R1 received Tran	notes dated 6/6/17, indicated nadol 50 mg at 6:31 p.m. for and pain and it was effective.					
		notes dated 6/7/17, indicated on was given to R1.					
	R1 received Acet for pain and it wa physician was fax Acetaminophen t day and as needed due to R1's reluc- medication. At 6	notes dated 6/8/17, indicated aminophen 650 mg at 8:49 a.m. s effective. At 10:43 a.m. the ked a request for the o be scheduled three times a ed to help with pain management tance to request pain :13 p.m. R1 received Tramadol pain and it was effective.					
	R1 received Transevere pain and the physician fax	s notes dated 6/9/17, indicated nadol 50 mg at 10:01 a.m. for it was effective. At 11:56 a.m. ed an order for Tylenol 650 mg y related to pain for right hand					
		s notes dated 6/11/17, indicated madol 50 mg at 4:30 p.m. for					

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		245591	B. WING			07/0	7/2017	
NAME OF PROVIDE				1311	EET ADDRESS, CITY, STATE, ZIP CODE I NORTH HIAWATHA ESTONE, MN 56164	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
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A con the d warn to fol R1's An ir at 6: when for s own. An ir 6/21 R1 c anot the the the the the to R bath (LPI	rective action irector of nursing to nursing low policy and care plan for aterview with 145 a.m. R1 see the fall occupant to help and the toilet National from R1's TABS alarm of oilet, and did once R1 was obtained on the policy and wasn't ing on the policy and wasn't ing on the policy and wasn't ing on the policy on the policy of the po	was effective. notice dated 6/9/17, indicated sing (DON) issued a written assistant (NA)-E, due to failure d procedure and failure to follow		323				
R1 a RN- follo An i 6/2:	alone on the t B stated she w the care pl nterview with 1/17, at 11:00	ow R1's care plan when NA-E lef oilet without the TABS alarm. would have expected NA-E to an. LPN-D was conducted on a.m. LPN-D stated she was in heard R1 scream and found R1						

PRINTED: 03/12/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING С **B WING** 07/07/2017 245591 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 323 F 323 Continued From page 6 responsive and lying on the floor in the bathroom on R1's right side. R1 told LPN-D she was trying to get up off the toilet and fell. LPN-D stated R1 had pain in the right hand but was moving the fingers and rotating the wrist. LPN-D notified the physician and family and was instructed to monitor the hand and notify the physician if R1's condition worsened. LPN-D stated NA-E admitted to leaving R1 unattended on the toilet, and R1 should not have been left alone without the TABS alarm. An interview with the DON was conducted on 7/5/17, at 11:40 a.m. The DON stated staff are trained to stay with a resident that is assessed as a fall risk when on the toilet, or if the TABS monitor is not connected to the resident. The DON stated it is the standard of care, and NA-E told the DON she should not have left R1 alone and did not follow the care plan. The DON stated she would have expected NA-E to follow the interventions on the care plan. The facilty policy titled Fall Prevention and Management revised 5/16, indicated an avoidable accident means that an accident occurred

because the location failed to implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to

reduce the risk of an accident.

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: С 07/07/2017 B. WING 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA GOOD SAMARITAN SOCIETY - PIPESTONE PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 000 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:** ***REVISED*** A complaint investigation was conducted to investigate complaint #H5591011. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE 07/12/17

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C 07/07/2017 B. WING 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 2 000 2 000 Continued From page 1 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 electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. 7/13/17 2 830 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 interview and document review, the corrected facility failed to provide adequate supervision for 1 of 5 residents (R1) reviewed for falls, when R1

was left alone on the toilet. R1 attempted to self

	ta Department of He	alth	T	(VO) MILITIDI E	(X3) DATE SURVEY		
STATEMENT OF DEFICIENCIES (X1)				CONSTRUCTION	COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A.		A. BUILDING		С			
				B. WING		07/07/2017	į
		00455				0.70-7-0-1	
NAME OF F	PROVIDER OR SUPPLIER			RESS, CITY, ST			ļ
00000	AMARITAN SOCIETY	DIDESTONE		H HIAWATH			
GOOD S				E, MN 56164		ON (VE)	
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2 830	Continued From pa	age 2		2 830			
	transfer, fell to the fractures in the righ		d four				
	Findings include:						
	resident) to wheeled resident's movement monitoring movement. The second monitoring movement had an activities performance deficing intolerance and content interventions included of one staff for transport of the second monitoring movement monitoring monitor	I to weakness, hist coident, and poor stare plan interventice tector down on the ed and TABS (an a reelchair and clips contain used to alert stand to assist stanent. The care planes of daily living (Alest related to weakn onfusion. The care ded R1 required the nsfers. Inimum Data Set (Inc.)	cory of safety ons for falls of floor beside larm that is on the staff to aff in indicated DL) self care ess, activity of plan he assistance MDS) dated cognitively				
	for activities of da R1's nursing assisting indicated R1 requ	stant care guide da ired the motions ar	ated 6/21/17, nd TABS				
	A fall scene huddles 1:30 p.m. indicate toilet alone in the attached to R1.	if to watch for self the worksheet dated at the staff left R1 sitting bathroom without the self attempted to se	ransferring. I 5/29/17, at ng on the the TAB alarm If transfer				
	from the toilet to the floor injuring R1's A nursing progress p.m. indicated R1	the wheelchair and	fell to the /17, at 2:03 ninophen 650				

HPQ411

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: 07/07/2017 B. WING 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 (X5) COMPLETE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 2830 Continued From page 3 2 830 A nursing progress note dated 5/29/17, at 2:41 p.m. indicated the physician was notified of the fall and the second and third fingers were swollen and hard to bend but the swelling had gone down. A nursing progress note dated 5/29/17, at 6:33 p.m. indicated R1 was given Acetaminophen 650 mg for pain. A nursing progress note dated 5/29/17, at 11:08 p.m. indicated R1's right hand was swollen and warm to the touch. R1 was able to move fingers freely with minimal pain and denied any other discomfort. A nursing progress note dated 5/30/17, at 8:41 a.m. indicated R1's right hand pain and swelling had increased. Family was notified and R1 was scheduled for a medical appointment. A nursing progress note dated 5/30/17, at 9:20 a.m. indicated R1 was given Acetaminophen 650 mg for pain. A physicians progress note dated 5/30/17, at 2:10 p.m. indicated R1 had fractures of the 2nd through 5th metacarpals (bones in the hand). A splint was applied and R1 was referred to an orthopedic surgeon for further evaluation. The physician ordered Tramadol 50 mg four times a day as needed for break through pain along with the Acetaminophen, ice, and elevation. A nursing progress note dated 5/30/17, at 5:04 p.m. indicated Acetaminophen 650 mg was given to R1 for pain and at 7:00 p.m. Tramadol 50 mg was given to R1 for severe pain. A nursing progress note dated 5/31/17, at 7:19

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: C 07/07/2017 B. WING _ 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 Continued From page 4 2 830 a.m. indicated an ice pack was given to R1 and arm elevated on pillow. R1 stated her right arm was not too painful. A nursing progress note dated 5/31/17, at 9:24 a.m. indicated Tramadol 50 mg was given to R1 for severe pain in right hand at 9:24 a.m., 1:42p.m., 7:07p.m. and at 8:50 p.m. indicated Acetaminophen 650 mg was given to R1 for breakthrough pain in right hand. A nursing progress note dated 6/1/17, indicated Tramadol 50 mg was given to R1 for severe wrist pain and a headache at 12:53 p.m. and again at 6:34 p.m. for severe right hand pain, and Acetaminophen 650 mg was given to R1 for right hand pain. Nursing progress notes dated 6/2/17, indicated R1 received Tramadol 50 mg for severe right hand pain at 6:32 p.m. and it was effective. Nursing progress notes dated 6/3/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m., Tramadol 50 mg at 2:00 p.m. and 6: 41 p.m. and Acetaminophen 650 mg at 9:17 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/4/17, indicated R1 received Acetaminophen 650 mg at 6:40 a.m. and Tramadol 50 mg at 1:28 p.m. and 6:19 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/5/17, indicated R1 received Tramadol 50 mg at 6:14 p.m. and Acetaminophen 650 mg at 9:26 p.m. for right hand pain and both were effective. A nursing progress note dated 6/6/17, at 11:51

Minnesota Department of Health STATE FORM

a.m. indicated R1 was seen by the orthopedic

HPQ411

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 5 surgeon and an orthoplast splint (a device used to immobilize, protect and support injuries such as fractures, sprains and strains) was applied and to follow up in four weeks. Nursing progress notes dated 6/6/17, indicated R1 received Tramadol 50 mg at 6:31 p.m. for throbbing right hand pain and it was effective. Nursing progress notes dated 6/7/17, indicated no pain medication was given to R1. Nursing progress notes dated 6/8/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m. for pain and it was effective. At 10:43 a.m. the physician was faxed a request for the Acetaminophen to be scheduled three times a day and as needed to help with pain management due to R1's reluctance to request pain medication. At 6:13 p.m. R1 received Tramadol 50 mg for severe pain and it was effective. Nursing progress notes dated 6/9/17, indicated R1 received Tramadol 50 mg at 10:01 a.m. for severe pain and it was effective. At 11:56 a.m. the physician faxed an order for Tylenol 650 mg three times a day related to pain for right hand fractures. Nursing progress notes dated 6/11/17, indicated R1 received Tramadol 50 mg at 4:30 p.m. for severe pain and it was effective. A corrective action notice dated 6/9/17, indicated the director of nursing (DON) issued a written warning to nursing assistant (NA)-E, due to failure to follow policy and procedure and failure to follow R1's care plan for TABS use.

An interview with R1 was conducted on 6/21/17,

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C 07/07/2017 B. WING 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 2830 2 830 Continued From page 6 at 6:45 a.m. R1 stated she did not remember where the fall occurred, but staff told R1 to wait for staff to help and not try to do things on her own. An interview with NA-E was conducted on 6/21/17, at 8:35 a.m. NA-E stated after putting R1 on the toilet NA-E left R1's room and went to another resident's room a couple of doors down the hall from R1's room. NA-E stated she took the TABS alarm off R1 before transferring R1 to the toilet, and did not put the TABS alarm back on R1 once R1 was on the toilet. NA-E stated she forgot and wasn't thinking and had received training on the policy and knew R1 was not to be left alone when the TABS alarm was not attached to R1. NA-E stated after leaving R1 alone in the bathroom, R1 fell and the licensed practical nurse (LPN)-D found R1 on the floor. An interview with registered nurse (RN)-B was conducted on 6/21/17, at 9:15 a.m. RN-B stated NA-E did not follow R1's care plan when NA-E left R1 alone on the toilet without the TABS alarm. RN-B stated she would have expected NA-E to follow the care plan. An interview with LPN-D was conducted on 6/21/17, at 11:00 a.m. LPN-D stated she was in the hallway and heard R1 scream and found R1 responsive and lying on the floor in the bathroom on R1's right side. R1 told LPN-D she was trying to get up off the toilet and fell. LPN-D stated R1 had pain in the right hand but was moving the fingers and rotating the wrist. LPN-D notified the physician and family and was instructed to monitor the hand and notify the physician if R1's condition worsened. LPN-D stated NA-E admitted to leaving R1 unattended on the toilet, and R1 should not have been left alone without

Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA GOOD SAMARITAN SOCIETY - PIPESTONE PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 2 830 2 830 Continued From page 7 the TABS alarm. An interview with the DON was conducted on 7/5/17, at 11:40 a.m. The DON stated staff are trained to stay with a resident that is assessed as a fall risk when on the toilet, or if the TABS monitor is not connected to the resident. The DON stated it is the standard of care, and NA-E told the DON she should not have left R1 alone and did not follow the care plan. The DON stated she would have expected NA-E to follow the interventions on the care plan. The facilty policy titled Fall Prevention and Management revised 5/16, indicated an avoidable accident means that an accident occurred because the location failed to implement interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 21850 21850 MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment.

Minnesota Department of Health STATE FORM

Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: С B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 8 Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced Based on interview and document review, facility staff failed to ensure 1 of 5 residents reviewed, (R1), was free from maltreatment when R1 was neglected when staff left R1 alone on the toilet. and R1 attempted to self transfer and fell to the floor. This resulted in actual harm when R1 sustained four fractures in the right hand. Findings include: R1's care plan dated 5/24/17, indicated R1 was at risk for falls related to weakness, history of cerebrovascular accident, and poor safety awareness. The care plan interventions for falls included motion detector down on the floor beside the bed when in bed and TABS (an alarm that is attached to the wheelchair and clips on the resident) to wheelchair used to alert staff to resident's movement and to assist staff in monitoring movement. The care plan indicated R1 had an activities of daily living (ADL) self care

performance deficit related to weakness, activity

Minnesot	ta Department of He	ealth				LVO DATE C	LIDVEV
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X		•	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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555	·						
	intolerance and col interventions include of one staff for tran	nfusion. The care plan ded R1 required the ass nsfers.	istance				,
	5/30/17, indicated	nimum Data Set (MDS) R1 was severely cogniti ired the assistance of or ly living.	vely				
	indicated R1 requi	tant care guide dated 6/ red the motions and TAI to watch for self transfe	BS				
	1:30 p.m. indicated toilet alone in the battached to R1. R	e worksheet dated 5/29/d staff left R1 sitting on to bathroom without the TA attempted to self transhe wheelchair and fell to right fingers.	the \B alarm sfer				
	p.m. indicated R1	s note dated 5/29/17, at was given Acetaminoph or pain to the right hand.	nen 650				
	p.m. indicated the	s note dated 5/29/17, at physician was notified of d and third fingers were but the swelling had gor	of the swollen				
	A nursing progres p.m. indicated R1 mg for pain.	s note dated 5/29/17, at was given Acetaminoph	t 6:33 hen 650				
	p.m. indicated R1 warm to the touch	es note dated 5/29/17, at 's right hand was swolle n. R1 was able to move al pain and denied any c	en and fingers				
	A nursing progres	ss note dated 5/30/17, a	t 8:41				

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Minnesota Department of Health (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: _ C B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21850 21850 Continued From page 10 a.m. indicated R1's right hand pain and swelling had increased. Family was notified and R1 was scheduled for a medical appointment. A nursing progress note dated 5/30/17, at 9:20 a.m. indicated R1 was given Acetaminophen 650 mg for pain. A physicians progress note dated 5/30/17, at 2:10 p.m. indicated R1 had fractures of the 2nd through 5th metacarpals (bones in the hand). A splint was applied and R1 was referred to an orthopedic surgeon for further evaluation. The physician ordered Tramadol 50 mg four times a day as needed for break through pain along with the Acetaminophen, ice, and elevation. A nursing progress note dated 5/30/17, at 5:04 p.m. indicated Acetaminophen 650 mg was given to R1 for pain and at 7:00 p.m. Tramadol 50 mg was given to R1 for severe pain. A nursing progress note dated 5/31/17, at 7:19 a.m. indicated an ice pack was given to R1 and arm elevated on pillow. R1 stated her right arm was not too painful. A nursing progress note dated 5/31/17, at 9:24 a.m. indicated Tramadol 50 mg was given to R1 for severe pain in right hand at 9:24 a.m., 1:42 p.m., 7:07 p.m. and at 8:50 p.m. indicated Acetaminophen 650 mg was given to R1 for breakthrough pain in right hand. A nursing progress note dated 6/1/17, indicated Tramadol 50 mg was given to R1 for severe wrist pain and a headache at 12:53 p.m. and again at 6:34 p.m. for severe right hand pain, and Acetaminophen 650 mg was given to R1 for right

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hand pain.

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Minnesota Department of Health (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: __ C B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 11 Nursing progress notes dated 6/2/17, indicated R1 received Tramadol 50 mg for severe right hand pain at 6:32 p.m. and it was effective. Nursing progress notes dated 6/3/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m., Tramadol 50 mg at 2:00 p.m. and 6: 41 p.m. and Acetaminophen 650 mg at 9:17 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/4/17, indicated R1 received Acetaminophen 650 mg at 6:40 a.m. and Tramadol 50 mg at 1:28 p.m. and 6:19 p.m. for right hand pain and all were effective. Nursing progress notes dated 6/5/17, indicated R1 received Tramadol 50 mg at 6:14 p.m. and Acetaminophen 650 mg at 9:26 p.m. for right hand pain and both were effective. A nursing progress note dated 6/6/17, at 11:51 a.m. indicated R1 was seen by the orthopedic surgeon and an orthoplast splint (a device used to immobilize, protect and support injuries such as fractures, sprains and strains) was applied and to follow up in four weeks. Nursing progress notes dated 6/6/17, indicated R1 received Tramadol 50 mg at 6:31 p.m. for throbbing right hand pain and it was effective. Nursing progress notes dated 6/7/17, indicated no pain medication was given to R1. Nursing progress notes dated 6/8/17, indicated R1 received Acetaminophen 650 mg at 8:49 a.m. for pain and it was effective. At 10:43 a.m. the physician was faxed a request for the

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Acetaminophen to be scheduled three times a

Minnesota Department of Health (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 21850 21850 Continued From page 12 day and as needed to help with pain management due to R1's reluctance to request pain medication. At 6:13 p.m. R1 received Tramadol 50 mg for severe pain and it was effective. Nursing progress notes dated 6/9/17, indicated R1 received Tramadol 50 mg at 10:01 a.m. for severe pain and it was effective. At 11:56 a.m. the physician faxed an order for Tylenol 650 mg three times a day related to pain for right hand fractures. Nursing progress notes dated 6/11/17, indicated R1 received Tramadol 50 mg at 4:30 p.m. for severe pain and it was effective. A corrective action notice dated 6/9/17, indicated the director of nursing (DON) issued a written warning to nursing assistant (NA)-E, due to failure to follow policy and procedure and failure to follow R1's care plan for TABS use. An interview with R1 was conducted on 6/21/17, at 6:45 a.m. R1 stated she did not remember where the fall occurred, but staff told R1 to wait for staff to help and not try to do things on her An interview with NA-E was conducted on 6/21/17, at 8:35 a.m. NA-E stated after putting R1 on the toilet NA-E left R1's room and went to another resident's room a couple of doors down the hall from R1's room. NA-E stated she took the TABS alarm off R1 before transferring R1 to the toilet, and did not put the TABS alarm back on R1 once R1 was on the toilet. NA-E stated she forgot and wasn't thinking and had received training on the policy and knew R1 was not to be

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left alone when the TABS alarm was not attached to R1. NA-E stated after leaving R1 alone in the

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Minnesota Department of Health (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 07/07/2017 00455 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) 21850 21850 Continued From page 13 bathroom, R1 fell and the licensed practical nurse (LPN)-D found R1 on the floor. An interview with registered nurse (RN)-B was conducted on 6/21/17, at 9:15 a.m. RN-B stated NA-E did not follow R1's care plan when NA-E left R1 alone on the toilet without the TABS alarm. RN-B stated she would have expected NA-E to follow the care plan. An interview with LPN-D was conducted on 6/21/17, at 11:00 a.m. LPN-D stated she was in the hallway and heard R1 scream and found R1 responsive and lying on the floor in the bathroom on R1's right side. R1 told LPN-D she was trying to get up off the toilet and fell. LPN-D stated R1 had pain in the right hand but was moving the fingers and rotating the wrist. LPN-D notified the physician and family and was instructed to monitor the hand and notify the physician if R1's condition worsened. LPN-D stated NA-E admitted to leaving R1 unattended on the toilet, and R1 should not have been left alone without the TABS alarm. An interview with the DON was conducted on 7/5/17, at 11:40 a.m. The DON stated staff are trained to stay with a resident that is assessed as a fall risk when on the toilet, or if the TABS monitor is not connected to the resident. The DON stated it is the standard of care, and NA-E told the DON she should not have left R1 alone and did not follow the care plan. The DON stated she would have expected NA-E to follow the interventions on the care plan. The facilty policy titled Fall Prevention and Management revised 5/16, indicated an avoidable accident means that an accident occurred because the location failed to implement

Minnesota Department of Health

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING _ 00455 07/07/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1311 NORTH HIAWATHA **GOOD SAMARITAN SOCIETY - PIPESTONE** PIPESTONE, MN 56164 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 21850 21850 Continued From page 14 interventions, including adequate supervision, consistent with a resident's needs, goals, plan of care and current standards of practice in order to reduce the risk of an accident. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

Minnesota Department of Health