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	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Pipestone	1311 North Hiawatha Pipestone, MN 56164

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and document review, the facility failed revise the care plan when new physician orders were received for 1 of 3 sampled residents (R55) receiving oxygen therapy upon return from the hospital. Findings include: R55's 3/24/25, admission Minimum Data Set (MDS) assessment identified R55 cognition was intact, R55 had no behaviors. On 5/5/25, the MDS noted she and was receiving oxygen therapy. Observations on 5/19/25 identified at: 1) 8:25 a.m., R55 was noted to be awake lying in her bed. Her oxygen tubing was not applied to her person but was observed lying on the bed next to her. The oxygen concentrator was noted to be on and set to deliver oxygen at 3 liters/minute (L/min). 2) 8:35 a.m., nursing assistant (NA)-B was assisting R55 with morning cares. NA-B ensured R55 had her oxygen on via nasal cannula (NC). NA-B then transferred R55. Following R55's transfer, NA-B switched R55 from her oxygen concentrator set at 3 L/min over to her portable oxygen tank and turned it on. The flow rate was pre-set at 2.5 L/min. 3) 11:06 a.m., of R55 while registered nurse (RN)-B performed a dressing change, identified R55's oxygen flow rate was set at 3 L/min. R55's 3/31/25, hospital discharge summary identified an order for oxygen at 2 L/min. per NC for 1 month. R55's current care plan identified a focus area of oxygen therapy initiated revised on 3/31/25 related to acute respiratory failure with hypoxia (lack of oxygen). R55 was to have no signs or symptoms of poor oxygen absorption through the review date. Staff were to monitor for signs and symptoms of respiratory distress and report to the provider. R55's head of her bed was to be elevated as she tolerated. R55 was to have oxygen at 2 L/min. per NC at rest and overnight to maintain her oxygen saturation above 92%. R55's 4/29/25, hospital discharge summary identified a new physician order was placed for R55 to receive oxygen at 1-2 L/min. per NC during the day, with titrating up to 2 L/min. per NC overnight. (continued on next page)

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the above-mentioned care plan identified no changes were made when a new order was received to change the oxygen flow rate on 4/29/25. R55's 5/21/25, Order Summary Report (OSR) identified R55 had an order for oxygen to be administered at 2 liters (L) per nasal cannula (NC) at rest and overnight to maintain an oxygen saturation over 92 %, The order summary report identified diagnoses of a history of acute respiratory failure with hypoxia. There was no indication the OSR had been updated to the newer 4/29/25 physician order from the original order placed on 3/31/25, to show the change in flow rate to 1-2 L per min. during the day and 2 L/min at night. R55's May 2025, medication administration record (MAR) identified an order was documented for oxygen to be administered at 2 L/min. via NC at rest and overnight to maintain oxygen saturation above 92%. Staff were to check twice a day at 8:00 a.m. and again at 8:00 p.m Staff documented R55's oxygen saturations levels were identified to be 91% to 96%, however, there was no indication staff were checking the actual flow rate, nor had they verified the MAR with the correct physician order which was changed to 1-2 L during the day and 2 L/min. at night. Further observations on 5/20/25 identified at: 4) 5/20/25 at 8:43 a.m., R55 was noted to be seated at the breakfast table. Her portable oxygen tank was set at flow rate of 3 L/min. 5) 5/20/25 at 9:04 a.m., R55 noted to be in her room. Her oxygen was connected to the oxygen concentrator with the flow rate set at 3 L/min. Observation and interview on 5/20/25 at 10:11 a.m., of R55's oxygen flow rate with RN-C identified R55's oxygen was set at 3 L/min RN-C reviewed the MAR and noted R55's oxygen flow rate was supposed to be at 2 L/min. per NC at rest and during the night. Direct care staff were not allowed to change the flow rate and only switch the oxygen tubing from the concentrator to the portable oxygen tank as needed for transfers. RN-C thought R55's family member messed with the oxygen at times. RN-C made no mention if in knowing R55's family member was known to adjust R55's physician ordered oxygen rate, the family member had been educated by staff not to adjust it, or to alert staff if they noticed R55 had any breathing difficulty requiring oxygen adjustment. RN-C also failed to verify the accuracy of the MAR with the updated physician order for 1-2 L per min during the day and 2 L/min at night that was changed on 4/29/25. Interview and document review on 5/21/25 at 10:31 a.m., with administrator identified her expectation was a resident's oxygen administration orders were to be followed, be consistent in the medical record, and appropriately documented and administered. The administrator reviewed the OSR. She confirmed that OSR (entered by staff) noted R55 was to receive oxygen at 2 L/min. There was no indication the administrator was aware R55's oxygen administration order had been changed on 4/29/25 for 1-2 L/min. via NC during the day and 2 L/min. at night. Review of the 7/8/24, Oxygen Administration policy identified oxygen was to be administered with a physician order. A licensed nurse was to be on duty and responsible for the proper administration of the oxygen for the resident. There was no mention of how staff were to appropriately document the amount of oxygen that was being administered. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no policy related to care plans provided by the end of survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and document review, the facility failed to ensure the correct physician order was followed and appropriately monitored for 1 of 3 sampled residents (R55) recieving oxygen therapy. Findings include: R55's 3/24/25, admission Minimum Data Set (MDS) assessment identified R55 cognition was intact, R55 had no behaviors. On 5/5/25, the MDS noted she and was receiving oxygen therapy. Observations on 5/19/25 identified at: 1) 8:25 a.m., R55 was noted to be awake lying in her bed. Her oxygen tubing was not applied to her person but was observed lying on the bed next to her. The oxygen concentrator was noted to be on and set to deliver oxygen at 3 liters/minute (L/min). 2) 8:35 a.m., nursing assistant (NA)-B was assisting R55 with morning cares. NA-B ensured R55 had her oxygen on via nasal cannula (NC). NA-B then transferred R55. Following R55's transfer, NA-B switched R55 from her oxygen concentrator set at 3 L/min over to her portable oxygen tank and turned it on. The flow rate was pre-set at 2.5 L/min. 3) 11:06 a.m., of R55 while registered nurse (RN)-B performed a dressing change, identified R55's oxygen flow rate was set at 3 L/min. R55's 3/31/25, hospital discharge summary identified an order for oxygen at 2 L/min. per NC for 1 month. R55's current care plan identified a focus area of oxygen therapy initiated revised on 3/31/25 related to acute respiratory failure with hypoxia (lack of oxygen). R55 was to have no signs or symptoms of poor oxygen absorption through the review date. Staff were to monitor for signs and symptoms of respiratory distress and report to the provider. R55's head of her bed was to be elevated as she tolerated. R55 was to have oxygen at 2 L/min. per NC at rest and overnight to maintain her oxygen saturation above 92%. R55's 4/29/25, hospital discharge summary identified a new physician order was placed for R55 to receive oxygen at 1-2 L/min. per NC during the day, with titrating up to 2 L/min. per NC overnight. Further review of the above-mentioned care plan identified no changes were made when a new order was received to change the oxygen flow rate on 4/29/25. R55's 5/21/25, Order Summary Report (OSR) identified R55 had an order for oxygen to be administered at 2 liters (L) per nasal cannula (NC) at rest and overnight to maintain an oxygen saturation over 92 %. , The order summary report identified diagnoses of a history of acute respiratory failure with hypoxia. There was no indication the OSR had been updated to the newer 4/29/25 physician order from the original order placed on 3/31/25, to show the change in flow rate to 1-2 L per min. during the day and 2 L/min at night. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's May 2025, medication administration record (MAR) identified an order was documented for oxygen to be administered at 2 L/min. via NC at rest and overnight to maintain oxygen saturation above 92%. Staff were to check twice a day at 8:00 a.m. and again at 8:00 p.m Staff documented R55's oxygen saturations levels were identified to be 91% to 96%, however, there was no indication staff were checking the actual flow rate, nor had they verified the MAR with the correct physician order which was changed to 1-2 L during the day and 2 L/min. at night. Further observations on 5/20/25 identified at: 4) 5/20/25 at 8:43 a.m., R55 was noted to be seated at the breakfast table. Her portable oxygen tank was set at flow rate of 3 L/min. 5) 5/20/25 at 9:04 a.m., R55 noted to be in her room. Her oxygen was connected to the oxygen concentrator with the flow rate set at 3 L/min. Observation and interview on 5/20/25 at 10:11 a.m., of R55's oxygen flow rate with RN-C identified R55's oxygen was set at 3 L/min RN-C reviewed the MAR and noted R55's oxygen flow rate was supposed to be at 2 L/min. per NC at rest and during the night. Direct care staff were not allowed to change the flow rate and only switch the oxygen tubing from the concentrator to the portable oxygen tank as needed for transfers. RN-C thought R55's family member messed with the oxygen at times. RN-C made no mention if in knowing R55's family member was known to adjust R55's physician ordered oxygen rate, the family member had been educated by staff not to adjust it, or to alert staff if they noticed R55 had any breathing difficulty requiring oxygen adjustment. RN-C also failed to verify the accuracy of the MAR with the updated physician order for 1-2 L per min during the day and 2 L/min at night that was changed on 4/29/25. Interview and document review on 5/21/25 at 10:31 a.m., with administrator identified her expectation was a resident's oxygen administration orders were to be followed, be consistent in the medical record, and appropriately documented and administered. The administrator reviewed the OSR. She confirmed that OSR (entered by staff) noted R55 was to receive oxygen at 2 L/min. There was no indication the administrator was aware R55's oxygen administration order had been changed on 4/29/25 for 1-2 L/min. via NC during the day and 2 L/min. at night. Review of the 7/8/24, Oxygen Administration policy identified oxygen was to be administered with a physician order. A licensed nurse was to be on duty and responsible for the proper administration of the oxygen for the resident. There was no mention of how staff were to appropriately document the amount of oxygen that was being administered.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and document review, the facility failed accurately reconcile physician orders upon return from the hospital and update the electronic medical record for 1 of 3 sampled residents (R55) receiving oxygen therapy. Findings include: R55's 3/24/25, admission Minimum Data Set (MDS) assessment identified R55 cognition was intact, R55 had no behaviors. On 5/5/25, the MDS noted she and was receiving oxygen therapy. Observations on 5/19/25 identified at: 1) 8:25 a.m., R55 was noted to be awake lying in her bed. Her oxygen tubing was not applied to her person but was observed lying on the bed next to her. The oxygen concentrator was noted to be on and set to deliver oxygen at 3 liters/minute (L/min). 2) 8:35 a.m., nursing assistant (NA)-B was assisting R55 with morning cares. NA-B ensured R55 had her oxygen on via nasal cannula (NC). NA-B then transferred R55. Following R55's transfer, NA-B switched R55 from her oxygen concentrator set at 3 L/min over to her portable oxygen tank and turned it on. The flow rate was pre-set at 2.5 L/min. 3) 11:06 a.m., of R55 while registered nurse (RN)-B performed a dressing change, identified R55's oxygen flow rate was set at 3 L/min. R55's 3/31/25, hospital discharge summary identified an order for oxygen at 2 L/min. per NC for 1 month. R55's current care plan identified a focus area of oxygen therapy initiated revised on 3/31/25 related to acute respiratory failure with hypoxia (lack of oxygen). R55 was to have no signs or symptoms of poor oxygen absorption through the review date. Staff were to monitor for signs and symptoms of respiratory distress and report to the provider. R55's head of her bed was to be elevated as she tolerated. R55 was to have oxygen at 2 L/min. per NC at rest and overnight to maintain her oxygen saturation above 92%. R55's 4/29/25, hospital discharge summary identified a new physician order was placed for R55 to receive oxygen at 1-2 L/min. per NC during the day, with titrating up to 2 L/min. per NC overnight. Further review of the above-mentioned care plan identified no changes were made when a new order was received to change the oxygen flow rate on 4/29/25. R55's 5/21/25, Order Summary Report (OSR) identified R55 had an order for oxygen to be administered at 2 liters (L) per nasal cannula (NC) at rest and overnight to maintain an oxygen saturation over 92 %, The order summary report identified diagnoses of a history of acute respiratory failure with hypoxia. There was no indication the OSR had been updated to the newer 4/29/25 physician order from the original order placed on 3/31/25, to show the change in flow rate to 1-2 L per min. during the day and 2 L/min at night. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R55's May 2025, medication administration record (MAR) identified an order was documented for oxygen to be administered at 2 L/min. via NC at rest and overnight to maintain oxygen saturation above 92%. Staff were to check twice a day at 8:00 a.m. and again at 8:00 p.m Staff documented R55's oxygen saturations levels were identified to be 91% to 96%, however, there was no indication staff were checking the actual flow rate, nor had they verified the MAR with the correct physician order which was changed to 1-2 L during the day and 2 L/min. at night. Further observations on 5/20/25 identified at: 4) 5/20/25 at 8:43 a.m., R55 was noted to be seated at the breakfast table. Her portable oxygen tank was set at flow rate of 3 L/min. 5) 5/20/25 at 9:04 a.m., R55 noted to be in her room. Her oxygen was connected to the oxygen concentrator with the flow rate set at 3 L/min. Observation and interview on 5/20/25 at 10:11 a.m., of R55's oxygen flow rate with RN-C identified R55's oxygen was set at 3 L/min RN-C reviewed the MAR and noted R55's oxygen flow rate was supposed to be at 2 L/min. per NC at rest and during the night. Direct care staff were not allowed to change the flow rate and only switch the oxygen tubing from the concentrator to the portable oxygen tank as needed for transfers. RN-C thought R55's family member messed with the oxygen at times. RN-C made no mention if in knowing R55's family member was known to adjust R55's physician ordered oxygen rate, the family member had been educated by staff not to adjust it, or to alert staff if they noticed R55 had any breathing difficulty requiring oxygen adjustment. RN-C also failed to verify the accuracy of the MAR with the updated physician order for 1-2 L per min during the day and 2 L/min at night that was changed on 4/29/25. Interview and document review on 5/21/25 at 10:31 a.m., with administrator identified her expectation was a resident's oxygen administration orders were to be followed, be consistent in the medical record, and appropriately documented and administered. The administrator reviewed the OSR. She confirmed that OSR (entered by staff) noted R55 was to receive oxygen at 2 L/min. There was no indication the administrator was aware R55's oxygen administration order had been changed on 4/29/25 for 1-2 L/min. via NC during the day and 2 L/min. at night. Review of the 7/8/24, Oxygen Administration policy identified oxygen was to be administered with a physician order. A licensed nurse was to be on duty and responsible for the proper administration of the oxygen for the resident. There was no mention of how staff were to appropriately document the amount of oxygen that was being administered. There was no policy related to reconciling physician orders provided by the end of survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure employee illnesses were tracked to identify when employee would be able to return to work after an illness, dependent upon their symptoms for 3 of 5 sampled staff (trained medication aide (TMA)-A, nursing assistant (NA)-A, and dietary aide (DA)-B). In addition, the facility failed to ensure 1 of 5 sampled staff (dietary aide) had completed tuberculosis testing (TST) upon hire. This had the potential to affect all 62 residents in the facility. Findings include: Employee Surveillance Review of the December 2024 through April 2025 Monthly Report of Infections in Location- Employees, Children, Family and Visitors logs identified the following columns: 1) Name 2) ID Code 3) Assigned Unit 4) Date of onset 5) Type of Infection 6) Antibiotic Treatment 7) Cautionary Measures 8) Culture Results (if taken). The following randomly selected staff were identified to have absences from work: NA-A, TMA-A, and DA-B. Review of Absence/[NAME] Report sheets and matching timecards from February 2025 to April 2025 identified the following corresponding information: Name, date, time, called in, scheduled shift, reason for absence, illness and symptoms, and return to work date. On: 1) 2/21/25, nursing assistant (NA)-A was noted to have called in sick from work with symptoms of diarrhea (loose watery stool) and vomiting. NA-A returned to work on 2/23/25. There was no mention when or if NA-A symptoms resolved prior to returning to work. 2) 3/14/25, trained medication aide (TMA)-A was noted to have called in sick from work with symptoms of diarrhea and had left early from her shift. TMA-A timecard identified on 3/14/25, TMA-A had worked from 6:30 a.m. to 4:13 p.m. On 3/16/25, she had worked 1 hour and returned to work for a full day (8 hours) on 3/18/25. There was no mention when or if TMA-A symptoms resolved prior to returning to work. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3) 4/29/25, dietary aide (DA)-B was noted to have called in sick from work with symptoms of vomiting and fever. DA-B returned to work on 5/02/25. There was no mention when or if DA-B symptoms resolved prior to returning to work. Interview on 5/19/25 at 3:58 p.m., with director of nursing (DON) and registered nurse (RN)-A identified TMA-A had reported her illness on 3/14/25 had not felt well and left work early on 3/14/25 and again on 3/16/25. The DON identified the Absence/[NAME] report sheets was to track employee illnesses, by the infection preventionist (IP) to identify when employees was eligible to return to work and was not updated, accurately. RN-A identified processes to monitor staff illnesses was not consistent and would need to be evaluated for improvement. Review of May 2024 Employee Health Conditions Reporting and Managing-Infection Control policy identified employees was to communicate with department supervisors, such as the IP, nurse, or DON before returning to work. TB Review of employee health file of DA-A identified DA-A was hired on 3/17/25. DA-A had a baseline TB symptom screening on 3/24/25 and received the first step TST series on 3/14/25. The form lacked evidence of a second TST. Interview on 5/19/25 at 4:11 p.m. with director of nursing (DON) and registered nurse (RN)-A had voiced in agreement that new hires should have TB screening and testing completed upon hire and noted there was no documentation to support DA-A had received a 2nd TB test as required. Review of January 2025 Tuberculosis Control Plan and Screening for Employees, Senior Living, Rehab/Skilled, Home Health, Child Day-Enterprise policy identified new employees was to have a baseline TB screening and testing, prior or upon hire. If, the facility was to provide a two-step Mantoux TST, the first step was to be read within 48 to 72 hours and the second step should be given in 1 to 3 weeks.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and document review the facility failed to complete a comprehensive assessment for continued use of antibiotics for 1 of 3 sampled residents (R16) reviewed for antibiotic stewardship. Findings include: Review of the current, undated, Centers for Disease Control (CDC): The Core Elements of Antibiotic Stewardship for Nursing Homes, Appendix A: Policy and Practice Actions to Improve Antibiotic Use, located at https://www.cdc.gov/antibiotic-use/core-elements/pdfs/core-elements-antibiotic-stewardship-appendix-a-508.pdf, identified facilities should evaluate the clinical signs and symptoms when a resident is first suspected of having an infection. Once the resident is placed on an antibiotic, they should be comprehensively reviewed within 48-72 hours after starting the medication to ensure they have been prescribed an effective medication. This is accomplished by reviewing the resident current symptoms and any laboratory results to identify medication effectiveness. The CDC identifies this process as an antibiotic time-out [ATO]. Review of Monthly Infection Summary reports from December 2024 through March 2025 identified the columns for resident's name, infection date, date symptoms resolved, infection, medication, source of the infection and if the criteria was met. May 2025 infection control log identified R16 had been prescribed Bactrim sulfamethoxazole-trimethoprim (antibiotic medication) 800-160 milligrams (mg) for 7 days for a urinary tract infection (UTI). The onset of the infection occurred on 5/1/25 and had met criteria for the continuation of use. R16's current, undated diagnosis sheet identified R16 had a diagnoses of urinary tract infection (UTI) and sepsis (infection of tissues and organs). R16's, May 2025 Medication Record identified R16 had taken the Bactrim 800-160mg, one tablet twice a day from 5/02/25 to 5/09/25. R16's, progress note identified, on: 1)4/30/25 at 11:06 a.m., identified R16 arrived at the facility from an appointment with orders to start Bactrim medication therapy for UTI. 2)5/02/25 at 19:14 p.m., identified Bactrim was prescribed by R16's physician. 3)5/9/25 at 14:50 p.m., identified R16 had completed the antibiotic therapy with no adverse effects. R16's medical record lacked evidence of an ATO after the initiation of the Bactrim therapy between 48-72 hours after initiation. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 5/19/25 at 3:50 p.m., with director of nursing (DON) identified R16 did not exhibit any signs or symptoms according to McGreer's (infection surveillance tool criteria) the facility normally would use to begin an evaluation for potential infection. Since R16 had shown no signs or symptoms while living at the facility and had only received the medication as a result of a physician outpatient visit at the clinic, the facility had not performed an ATO as would be the normal process. The DON agreed the facility was responsible for ensuring antibiotic stewardship, even if a medication was not initiated or ordered by the facility staff or attending physicians. Review of January 2025 Identification and Reporting of Suspected Infection AL, R/S, LTC, Home Health, Hospice policy identified the nurse manager, or infection preventionist (IP) was to identify infections, collect data related to the infection, record indication of use of antibiotic therapy, and maintain infection surveillance on a continued basis.

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	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan Society - Pipestone	1311 North Hiawatha Pipestone, MN 56164

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure 1 of 5 sampled residents (R7) was offered and/or provided updated vaccinations for pneumococcal disease, in accordance with Centers for Disease Control (CDC). Findings include: Review of the current, 10/26/24, Centers for Disease Control (CDC): Pneumococcal Vaccine Recommendations, located at https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, identified based on shared clinical decision-making, adults 65 years or older have the option to get PCV20 or PCV 21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV 21 if they have received both the PCV13 (but not PCV15, PCV20, or PCV 21) at any age and a PPSV23 at or after the age of [AGE] years old. R7's 5/05/25, 5-day Minimum Data Set (MDS) identified R7 was [AGE] years old and had a diagnoses of diabetes, heart failure and pneumonia. Section O-Special Treatments and Programs identified R7 was reported to be up to date with the pneumococcal vaccine (PCV). R7's current, undated immunization report indicated R7 had received PCV 13 on 3/17/15 and PPSV-23 on 3/17/09. R7's 4/15/25, Vaccine Consent form identified R7 consented for an updated PCV dose. Interview on 5/19/25 at 4:08 p.m., with registered nurse (NA)-A and director of nursing (DON) voiced in agreement that R7 had not received the PCV vaccine after the consent was obtained. Review of November 2024 Immunizations/Vaccinations for Residents, Pneumococcal influenza, COVID-19, Other AL, R/S, LTC, HBS-Enterprise policy identified the facility was to provide residents with the PCV, per Centers for Disease Control and Prevention guidelines.