

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245591	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Society - Pipestone		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and document review, the facility failed to ensure infection control measures were followed during observation of 1 of 1 meal service. This had the potential to affect all 52 residents who dined in the facility. Findings include: Observation on 7/29/26 at 11:29 a.m., identified cook-A completed preparation of the noon meal consisting of chicken with mushroom gravy, noodles, and broccoli. Cook-A was placing the food items onto the steam table when she turned and went to the cabinet, opened the door, removed a saltshaker, and shook salt into her bare hand. After filling the palm of her hand with salt she returned to the stove, where she dumped the salt from her hand into the cooking noodles. When questioned as to her action, she replied she had measured the salt to add to the noodles. She then stated that was how she always did it. Cook-A then set the pot into the sink and prepared a fresh pot of noodles which were placed onto the steam table. As she was pouring the noodles into the steamtable pan several noodles landed on the counter in front of the pan. Cook-A used her bare hand and tossed the noodles from the counter back into the pan of noodles in the steamtable. At no time did cook-A perform hand hygiene in between tasks or put on gloves. Observation on 7/29/26 at 11:42 a.m. identified cook-A washed her hands and returned to the counter across from the steamtable where she picked up a tray containing 2 paper meal slips. She then picked up the slips and identified the resident meals, turned back to the steamtable, picked up 2 plates, and began placing food items onto the plates. She used a large, slotted spoon to scoop noodles onto the plates, then placed the slotted spoon on the side of the steamtable and went around the steamtable to a drawer which she opened with her bare hand. Cook-A then removed a green handle scoop spoon and returned to plating the meal without performing hand hygiene or donning gloves. As she was scooping noodles onto the plate, there were noted to be several noodles were noted to be hanging off the side of the plate. Cook-A then used her bare hand to scoop them back onto the plate. Cook-A then placed the filled plates onto the tray and pushed them into the window for staff to serve to residents in the dining room. Cook-A continued the same process of serving several plates and again used her bare hand to scoop noodles hanging off the side of the plate back onto the plate being served, without performing hand hygiene or putting on gloves. Interview on 7/29/26 at 12:05 p.m. with cook-A reported she had always measured seasonings using her hand and was not aware there was a problem doing it that way. When asked about serving of the noodles and handling them with her bare hands, reported she did not realize she had done that and reported she should have, tossed the noodles that landed on the counter in front of the steam pan, and used the scoop to position noodles on to plates instead of her hand. Interview on 7/29/26 at 12:15 p.m. with the certified dietary manager (CDM) identified her expectation was for appropriate infection control practices to be followed in the kitchen. She reported she was not aware cook-A used her bare hand to measure spices, and she should have used measuring spoons, not her hand. Touching food with bare hands was not acceptable (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 245591

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	practice, and she expected staff to use utensils and appropriate hand hygiene practices. She identified anytime staff left the steam table area, staff needed to perform hand hygiene and/or don gloves before returning to serving food after changing tasks. Interview on 7/29/26 at 1:30 p.m., with the infection preventionist (IP) identified her expectation was for all departments to follow appropriate infection control practices by utilizing hand hygiene practices. Review of the 7/14/26, Food Handling-Food and Nutrition policy identified prevention of food related illness to a highly susceptible population in the facility. This was identified as the need for handling of food in a manner to decrease the risk of contamination. Food items were not to be touched using bare hands. Utensils including tissue, spatulas, tongs and single-use gloves were to be utilized when handling food items. Hand hygiene was identified as washing with soap and water and gloves were to be utilized when indicated due to needing to touch a food item.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review and interview, the facility failed to obtain informed consents including risk and benefit for 1 of 5 residents (R4) reviewed for psychotropic medications. Finding include: R4's comprehensive Minimum Data Set (MDS) dated [DATE] indicated R4 had intact cognition and was admitted on [DATE]. R4 diagnoses included dependence on renal dialysis, type 2 diabetes, and insomnia. R4's current Order Summary Report indicated R4 was currently prescribed clonazepam (anti-anxiety) 1 milligram (mg) tablet by mouth daily every Monday, Wednesday, and Friday. Give on dialysis days started on 04/03/26 and Temazepam (hypnotic) 30 mg by mouth at bedtime started on 04/3/26. R4's medical record lacked evidence of informed consents regarding risk and benefits for any of the above listed medications. The director of nursing (DON) attempted to locate signed consent and was unsuccessful. During an interview on 08/05/2026 9:46 a.m., DON stated, any resident admitted with a psychotropic medication in use needed a consent form signed for that medication on admission day. Facility policy titled Psychotropic Medications- Rehab/Skilled indicated, a consent form must be signed for use of an Antipsychotic medication. The Permission for use of Psychotropic Medications (GSS#478) will be used to obtain consent.		

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and document review, the facility failed to provide the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) to 1 of 3 sampled residents (R1) when their Medicare Part A skilled services with days remaining. Findings include: R1's CMS-10123 Notice of Medicare Non-Coverage (NOMNC) form identified R1's services ended on 7/17/26. R1 was not provided with the CMS-10055 Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) that identified the estimated cost of services if R1 would have chosen to continue with the skilled services on her own. Interview on 8/4/26 at 10:30 a.m., with the director of nursing (DON) identified that she had taken over providing the beneficiary notices after a recent staffing change. The DON stated she did not think that she needed to provide the CMS-10055 notice as R1 had Medicaid pending so she had only provided the CMS-10123 notice. Review of the 5/12/26, Advance Beneficiary Notice of Non-Coverage (ABN) policy identified the ABN informed the beneficiary of potential non-coverage and shift of financial liability for those items or services if Medicare denies the claim. The ABN notice was evidence that the beneficiary had knowledge about the likelihood of Medicare denial, and for purpose of determining financial liability for expenses incurred for services which Medicare does not pay.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and document review, the facility failed to monitor controlled narcotic medications in 1 of 1 emergency kit (E-kit) to prevent potential diversion. Findings include: Observation and interview on 8/5/26 at 2:45 p.m., with trained medication aide (TMA)-A and registered nurse (RN)-A of the 400/500 wing medication room and medication cart identified the E-kit was stored in the medication cart. Inside the locked box was a small plastic E-kit box that housed the controlled narcotic medications. When asked about monitoring the plastic numbered tags that secured the E-kit, RN-A stated the nurses did not monitor the tag of the E-kits daily. The plastic numbered tag was not documented anywhere that would confirm the correct tag remained in place in order to easily identify potential diversion. Both TMA-A and RN-A stated there would be no way to know if someone had opened it and took narcotics out until the nurse accessed the E-kit for medication that was needed. RN-A agreed that the E-kit and E-kit small box with narcotics inside the locked box on the medication cart was not opened on a regular basis so medication could be missing for quite some time before anyone would notice. Review of the E-kit medication list identified that the kit contained controlled narcotic medications of Tramadol 50 mg: 6 tablets, Hydrocodone/APAP 5/325 mg: 6 tablets, Lorazepam 0.5 mg: 6 tables, and Morphine solution 20mg/ml (unknown amount). Interview on 8/5/26 at 3:19 p.m., with director of nursing identified that the staff should have been monitoring the number of the plastic tag on the E-kit and the E-kit located inside the locked box on the medication cart with the narcotics. A policy on monitoring controlled narcotic medications to prevent diversion was requested but not provided.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to provide evidence of 1 of 1 required Performance Improvement Project (PIP), which focused on high-risk or problem-prone areas with identified interventions and analysis to track performance to ensure improvement after implementing actions. Findings include: Review of the QAPI meeting minutes provided identified on:9/23/25, the current PIP project was pressure ulcers. The goal was to decrease their percentage to be at or less than 2%. Last year's August report was used for comparison at 4.4%. Actions were to monitor and report monthly and reviewed by wound nurse weekly. There was no mention of what the current rate was, nor how the facility planned to reach their goal, if they were auditing, etc. 12/16/25, QAPI meeting minutes identified pressure ulcers were listed, but not as a PIP , with goal of zero new facility acquired pressure ulcers, with current data listed as 0. The plan was to continue with prevention. The current PIP section was completely blank on the form, so it was unclear if the facility had dropped the current PIP and replaced it with another or had not addressed it at all. 3/30/26, QAPI meeting minutes Appendix IV 2026 Performance Improvement Priorities listed a PIP project for pressure ulcers. The facility was at 10.6%, with national and state comparisons at 5.7% and 6.1% respectively. The target was reported to be at or less than 5.97%, however, there were no actions noted as to how the facility would reach this goal, analysis of current facility practices, or any resident data supplied to identify what was the cause of the increased PU percentage in their facility. 6/26/26, QAPI meeting minutes identified new or worsening pressure ulcers and there was noted to be an increase in pressure ulcers. The current intervention was Great work team! with a goal of NA and 2.3% and current data was listed as 0%. There was a note for short stay residents at 0% but longer stay residents or the facility as a whole was not mentioned. The follow up was listed as ongoing each meeting. No analysis or data was included with the minutes in that section. Further down as another section for pressure ulcers/trends. The goal listed was 6 residents triggered for pressure ulcers, and at 14.6% with an average of 5.7%. The action was to continue with prevention however, there was no identified actions as to how the facility would accomplish their goal. They had another section labeled Current PIP-Pressure Ulcers in their short stay residents at a goal of 0% but current data was also 0%. There was no mention why the facility was separating out their facility into short term or long term stay residents. They listed the current PIP as going well however there was no action to identify what the facility had implemented to reach their goal, or if this was an accurate portrayal of how the facility was doing overall, etc. Interview on 8/5/26 at 3:51 p.m., with the director of nursing (DON) and the administrator identified the DON stated there had been some staff turnover and a new person had started taking care of the minutes and had not put the data in. The committee was reviewing information and having discussion; however, she was unable to show that information was included in the minutes. The DON confirmed the facility PIP project of pressure ulcers had no identified interventions and the facility had no documentation that they had analyzed any data related to the PIP project. The DON was only able to identify that the facility was completing some audits as interventions for reducing long stay pressure ulcers. She stated, We have nothing laid out in a plan such as what were are going to do and how we are going to do that. we need to work on our PIP and documentation of our meetings. Review of the November 2025, QAPI plan identified The Quality Assurance Performance Improvement (QAPI) Plan was designed to outline a comprehensive and data driven QAPI program that focused on improving the outcomes and experiences of those served. The QAPI program was to address the complexity and uniqueness of the care and services provided. The (continued on next page)		

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