

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 16, 2021

Administrator Good Samaritan Society - Mountain Lake 745 Basinger Memorial Drive Mountain Lake, MN 56159

RE: CCN: 245549

Cycle Start Date: December 8, 2021

Dear Administrator:

On December 8, 2021, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

We are pleased to inform you that this survey resulted in no deficiencies being issued.

The CMS-2567 is being electronically delivered.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

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

PRINTED: 12/16/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	, ,	ATE SURVEY OMPLETED
		245549	B. WING _			C 2/08/2021
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		2/00/2021
GOOD S	AMARITAN SOCIETY	- MOUNTAIN LAKE		745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159		
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	Infection Control surfacility by the Minner determine compliar Preparedness regurfacility was found to Because you are ensignature is not requage of the CMS-2 correction is require acknowledge receip The facility's plan or as your allegation of Department's accepenrolled in ePOC, y	nrolled in ePOC, your uired at the bottom of the first 567 form. Although no plan of				
F 000	onsite revisit of you validate substantial regulations has been INITIAL COMMENTO On 12/07/21 and 1 abbreviated survey to conduct a complewas found to be IN	2/08/21, a standard was completed at your facility aint investigation. Your facility compliance with 42 CFR Part	F 00	00		
	The following compuNSUBSTANTIATE	for Long Term Care Facilities. Plaint was found to be ED: H5549019C MN78982. Plaints were found to be H5549018C MN78173 and				

Electronically Signed

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

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

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F 000	H5549017C MN64 were cited due to a facility prior to surv The facility is enrol signature is not recopage of the CMS-2 correction is require	636, however NO deficiencies actions implemented by the	FC			



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 16, 2021

Administrator Good Samaritan Society - Mountain Lake 745 Basinger Memorial Drive Mountain Lake, MN 56159

Re: Event ID: DXUS11

Dear Administrator:

The above facility survey was completed on December 8, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

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

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior

Program Assurance | Licensing and Certification

Minnesota Department of Health

M. Paig

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: melissa.poepping@state.mn.us

PRINTED: 12/16/2021 **FORM APPROVED** 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 00755 12/08/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 745 BASINGER MEMORIAL DRIVE **GOOD SAMARITAN SOCIETY - MOUNTAIN LAP MOUNTAIN LAKE, MN 56159** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE 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

INITIAL COMMENTS:

On 12/07/21 and 12/08/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.

The following complaint was found to be

notice of assessment for non-compliance.

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

PRINTED: 12/16/2021 FORM APPROVED

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
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	UNSUBSTANTIATI	ED: H5549019C MN78982.				
	SUBSTANTIATED:	plaints were found to be H5549018C MN78173 and 636, however NO licensing				
	the State Licensing Federal software. The facility is enroll	nent of Health is documenting Correction Orders using led in ePOC and therefore a juired at the bottom of the first				
		f correction is required, it is cility acknowledge receipt of ments.				

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Minnesota Department of Health STATE FORM

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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

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Surveyor Id Number	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (H)	Off-Site Report Preparation Hours (I)
Team Leader 1. 40946	12-07-2021	12-08-2021	1.00	0.00	3.25	0.00	1.75	0.75
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Type of Survey (select all that apply): A Complaint Investigation B Dumping Investigation C Federal Monitoring D Follow-up Visit H Life safety Code L Chow Extent of Survey (Select all that apply): A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA) D Other Survey SURVEY TEAM AND WORKLOAD DATA Please enter the workload information for each surveyor. Use the surveyor's information number. Surveyor Id Number Pate Date Arrived (B) C Partial Extended Survey (HHA) Date Date Arrived (B) C Partial Extended Survey (HHA) D On-Site On-Site Hours Hours Hours Hours (F) Hours Hours Hours (F) Hours Hours (F) C Partial Extended Surveyor's information number. Surveyor Id Number Pate (B) C Partial Extended Survey (HHA) D On-Site Hours Hours Hours (F) C Partial Extended Surveyor's information number. Surveyor Id Number Pate (B) C Partial Extended Survey (HHA) D On-Site Hours Hours (F) C Partial Extended Surveyor's information number. Surveyor Id Number Pate (B) C Partial Extended Survey (HHA) D On-Site (In Min) C Preparation Hours (F) C Partial Extended Survey (HHA) D On-Site (In Min) C Preparation Hours (F) C Partial Extended Survey (HHA) D On-Site (In Min) C Preparation Hours (F) C Partial Extended Survey (HHA) D On-Site (In Min) C Preparation Hours (F) C Partial Extended Survey (HHA) D On-Site (In Min) C Preparation Number (F) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extended Survey (HHA) D On-Site (In Min) C Partial Extende	A Complaint Investigation B Dumping Investigation F Inspection of Care J Sanction/Hearing G Validation K State License D Follow-up Visit H Life safety Code L Chow Extent of Survey (Select all that apply): D	Provider/Supplier : 245549	Number		vider/Supplie DD SAM MOUNTAI					
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