



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered

December 29, 2020

Administrator  
Good Samaritan Ambassador  
8100 Medicine Lake Road  
New Hope, MN 55427

RE: CCN: 245149  
Cycle Start Date: December 7, 2020

Dear Administrator:

On December 7, 2020, 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,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist  
Minnesota Department of Health  
Licensing and Certification Program  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4118 Fax: 651-215-9697  
Email: doug.larson@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 12/29/2020  
FORM APPROVED  
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                     |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>245149</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>12/07/2020</b> |
|--|---|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br><b>GOOD SAMARITAN AMBASSADOR</b> |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>8100 MEDICINE LAKE ROAD<br/>NEW HOPE, MN 55427</b>                  |                      |   |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |   |
| E 000  | Initial Comments<br><br>A COVID-19 Focused Infection Control survey was conducted 12/7/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was in full compliance<br><br>Because you are enrolled in ePOC, your 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. | E 000   |   |                      |   |
| F 000  | INITIAL COMMENTS<br><br>A COVID-19 Focused Infection Control survey was conducted 12/7/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was in full compliance .<br><br>Because you are enrolled in ePOC, your 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.                       | F 000   |   |                      |   |

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

TITLE

(X6) DATE

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.