

November 15, 2021

Administrator Good Samaritan Society - Battle Lake 105 Glenhaven Drive Battle Lake, MN 56515

RE: CCN: 245403 Cycle Start Date: November 3, 2021

Dear Administrator

On November 3, 2021, a survey was completed at your facility by the Minnesota Department of Health to investigate a complaint 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. The investigation resulted in no deficiencies being issued.

Also at the time of the investigation, the investigator also assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, found no violations of these rules promulgated under Minnesota Statute section 144.653 and/or Minnesota Statute section 144A.10.

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. Electronically attached is your copy of the Federal Form CMS-2567 stating that no violations were noted at the time of this investigation.

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
						С	
		245403	B. WING			11/	03/2021
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 5 GLENHAVEN DRIVE		
GOOD S	AMARITAN SOCIETY	- BATTLE LAKE			ATTLE LAKE, MN 56515		
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	survey was comple complaint investiga to be in compliance Requirements for L The following comp substantiated: H5403024C (MN77 H5403025C (MN75 H5403026C (MN74 H5403027C (MN72 No deficiencies wer by the facility prior to The facility's plan of as your allegation of Department's accep enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substa	5950) 528) 5427) re cited due to actions taken to the survey. f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will					

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

TITLE

(X6) DATE

PRINTED: 11/15/2021

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.

Minnesota Department of Health						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00146	B. WING		C 11/03/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
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	*****ATTENTION******					
	NH LICENSING CORRECTION ORDER					
	144A.10, this correpursuant to a surver found that the defice herein are not corrected shall with a schedule of fit the Minnesota Depu- Determination of wit corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit notice of assessme INITIAL COMMENT On On 11/2/21 and was conducted at y the Minnesota Dep	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance. TS: 11/3/21, a complaint survey your facility by surveyors from artment of Health (MDH). You N compliance with the MN	-			
Minnacata		plaints were found to be				
viinnesota D	epartment of Health					

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

TITLE

(X6) DATE

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00146     B. WING     11/03/2021       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     11/03/2021       GOOD SAMARITAN SOCIETY - BATTLE LAKE     105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515     105 GLENHAVEN DRIVE       (X4) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL     ID PREFIX     PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE     (X2 COMPI	AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C 11/03/2021	
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