



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
March 14, 2024

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: January 31, 2024

Dear Administrator:

On March 6, 2024, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 15, 2024

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

RE: CCN: 245455
Cycle Start Date: January 31, 2024

Dear Administrator:

On January 31, 2024, 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.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Lisa Krebs, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Rochester District Office
18 Woodlake Drive, Rochester MN, 55904
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by May 1, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by July 31, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/lrc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Good Samaritan Society - Jackson

February 15, 2024

Page 4

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "H. Zahler". The signature is written in a cursive, flowing style.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



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February 15, 2024

Administrator
Good Samaritan Society - Jackson
601 West Jackson
Jackson, MN 56143

Re: Event ID: Z0J11

Dear Administrator:

The above facility survey was completed on January 31, 2024, 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 contact me with any questions.

Sincerely,

A handwritten signature in black ink that reads 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

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

PRINTED: 03/04/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245455	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/31/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - JACKSON			STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143		
(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	
F 000	INITIAL COMMENTS On 1/29/24 and 1/31/24, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H54559245C (MN00100313, MN00100242) and H54559246C (MN00100243) with a deficiency cited at F609. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2	F 609		3/1/24	

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

TITLE

(X6) DATE

Electronically Signed

02/23/2024

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.

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F 609	<p>Continued From page 1</p> <p>hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.</p> <p>§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview and document review the facility failed to report allegations of abuse timely to the State Agency (SA) for 3 of 4 residents (R1, R3, and R4) reviewed for allegations of abuse.</p> <p>Findings include:</p> <p>An anonymous Vulnerable Adult Maltreatment report submitted to the State Agency (SA) on 1/23/24 at 5:44 p.m., alleged caregiver abuse when employee (E)-A was observed on top of R1 with both knees pressed into R1's chest to hold her down. Further noted the alleged incident occurred on 12/30/23 at approximately 6:30 p.m. The report further noted (unidentified) staff reported the incident to the administrator, but no action was taken to protect the residents.</p>	F 609	<p>Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p> <p>F609</p>	

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F 609	<p>Continued From page 2</p> <p>An anonymous Vulnerable Adult Maltreatment report submitted to the SA on 1/25/24 at 6:05 p.m., alleged caregiver abuse when E-A was observed forcing R1 to stay in her chair by pinning her down and restraining her with full body weight. Further indicated the incident was reported to the director of nursing (DON) but no protections were put into place for R1, and E-A continued to work with R1. The alleged incident occurred on 12/30/23 at approximately 9:00 p.m.</p> <p>R1's quarterly Minimum Data Set (MDS) dated 10/5/23, indicated R1 had moderately impaired cognition and no behaviors. The MDS further indicated R1 required assistance with toileting and transferring. R1's diagnoses included dementia, essential tremors, restless legs syndrome, and an overactive bladder.</p> <p>During an interview on 1/29/24 at 3:15 p.m., E-B indicated awareness of the alleged abuse incident that occurred on 12/30/23. Further stated the incident was reported to the administrator and the DON but, did not know if it was reported to the SA. Further stated it would have been a reportable incident to the SA.</p> <p>During an interview on 1/29/24 at 3:30 p.m., E-C indicated E-A was witnessed holding or restraining R1. Notified administration but did not know if any further action was taken.</p> <p>During an interview on 1/29/24 at 3:45 p.m., E-D indicated she was aware of the incident between E-A and R1 but was not sure if it had been reported.</p> <p>During an interview on 1/29/24 at 4:15 p.m., E-E verified confirmed witnessing the alleged abuse</p>	F 609	<ol style="list-style-type: none"> 1. Staff that brought up the concerns for abuse were all verbally educated on reporting concerns for abuse immediately during the conversation. 2. All residents identified as potential for abuse were interviewed and visually assessed for any signs of injury. None were found to have concerns and were complementary of the care they were receiving 3. For any reports of abuse in the future: all resident will be immediately assessed for injury, a skin assessment will be completed, and staff members involved will be immediately removed from the facility to ensure resident safety. 4. Formal education was provided by administrator and human resources to all staff and facility leadership on GSS policy and procedure and federal regulations for abuse and neglect and timely reporting on 2/27/24. The process for timely notification to the DNS and administrator was included in the formal education. Yearly education regarding abuse and neglect and mandated reporting will be provided upon hire to all staff. 5. Five random staff audits will be conducted via interview asking questions about mandated timely reporting by DNS or designee weekly X4 and monthly X3 to ensure staff are compliant with GSS policy and procedure for reporting. <p>Date of correction: 3/1/24</p>	

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F 609	<p>Continued From page 3</p> <p>incident on 12/30/23. Indicated E-A was yelling at R1 and holding R1's legs down. Further indicated R1 looked "panicky" and was crying. Further indicated she did not report the incident to the administrator until 1/15/24.</p> <p>Facility Reported Incident was not located in the SA system.</p> <p>R4's quarterly MDS dated 12/13/23, indicated R4 had intact cognition. R4 required assistance with toileting, transferring, dressing, and personal hygiene. R4's diagnoses included hemiplegia (paralysis of the left side), epilepsy (a brain disorder that causes seizures), and dementia.</p> <p>During an interview on 1/29/24 at 3:45 p.m., E-D stated she witnessed an incident about a month prior when E-A was upset because she had to help transfer R4 in the full body mechanical lift. During the transfer, E-A was intentionally rough while moving the lift and forcefully hit the lift on the bed which resulted in R4 swinging into the window and hitting her foot. E-D stated she did tell the DON and the administrator but not as soon as she should have.</p> <p>Facility Reported Incident was not located in the SA system.</p> <p>R3's admission MDS dated 1/15/24, indicated R3 had intact cognition. R3 required assistance with toileting, dressing, and transferring. R3's diagnoses included fractured right arm, pneumonia, chronic pain, and neuralgia (nerve pain).</p> <p>During an interview on 1/31/24 at 9:25 a.m., E-A indicated approximately two weeks prior E-F</p>	F 609		

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F 609	<p>Continued From page 4</p> <p>reported E-E was rough with R3 during a transfer. Further indicated she notified the administrator and was directed to have E-E take a break to "calm down". After E-E took a "short break", she came back in and finished the shift and worked the overnight shift.</p> <p>Facility Reported Incident was not located in the SA system.</p> <p>During an interview on 1/31/24, at 12:45 p.m., the DON indicated awareness of the incidents of alleged abuse or rough treatment. Confirmed none of the incidents were reported to the SA. Described the facility process as once administration is notified of an allegation, we interview the staff and residents and if we determine there is maltreatment of any kind or abuse, we report it to the SA within 2 hours.</p> <p>During an interview on 1/31/24 at 1:00 p.m., the administrator stated on 1/11/24, she was notified of possible abuse of R4 that occurred around 1/1/24, and immediately interviewed staff. Stated the employee should have told administration sooner. Confirmed that the alleged abuse was not reported to the SA. Further indicated on 1/13/24, she was notified of possible "rough treatment" of R3. Indicated interviewed the alleged perpetrator (AP) and the AP denied being rough. Confirmed that the alleged "rough treatment" was not reported to the SA. In addition, on 1/15/24, the administrator was notified of an allegation that occurred on 12/30/23, of E-A forcefully restraining R1. Stated there was not any mention of rough treatment or abuse. Confirmed that the incident was not reported to the SA. The administrator indicated that although not reported to the SA, the incidents</p>	F 609		

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F 609	<p>Continued From page 5 were thoroughly investigated.</p> <p>The Abuse and Neglect Policy last reviewed on 7/6/23, indicated alleged or suspected violation involving any mistreatment, neglect, exploitation, or abuse including injuries of unknown origin will be reported immediately to the administrator. In the absence of the administrator from the location, the following individuals have the administrative authority of the administrator for purposes of immediate reporting of alleged allegations: the DON or the supervisor of social services. The facility policy also indicated if the allegation is of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. If there is an allegation of abuse then it should be reported to the State Survey and Certification Agency immediately, but not later than two hours after the allegation is made.</p>	F 609		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2024
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - JACKSON	STREET ADDRESS, CITY, STATE, ZIP CODE 601 WEST JACKSON JACKSON, MN 56143
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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 notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 1/29/24 and 1/31/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found IN compliance with the MN State Licensure.</p> <p>The following complaints were reviewed</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/23/24
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00303	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/31/2024
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2 000	<p>Continued From page 1</p> <p>H54559245C (MN00100313, MN00100242) and H54559246C (MN00100243) . NO licensing orders were issued.</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		