

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

January 3, 2022

Administrator Good Samaritan Society - Windom 705 Sixth Street Windom, MN 56101

RE: CCN: 245558 Survey Cycle Start Date: December 27, 2021

Dear Administrator:

On December 27, 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. At the time of survey, the complaint was substantiated but no deficiencies were issued, because corrective action was taken prior to the survey. A plan of correction is not required.

Also at the time of this survey, 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 § 144.653 and/or Minnesota Statute § 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 CMS-2567 Form and State Form.

Feel free to contact me if you have questions.

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Melissa Poepping, Health Program Representative Senior Program Assurance | Licensing and Certification Minnesota Department of Health P.O. Box 64900 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4117 Email: melissa.poepping@state.mn.us

DEPART	MENT OF HEALTH	AND HUMAN SERVICES						APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				O		0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C		
		245558	B. WING					27/2021
NAME OF F	PROVIDER OR SUPPLIER		·		DDRESS, CITY, STATE, ZIP C	ODE		
GOOD S	AMARITAN SOCIETY	- WINDOM		705 SIXTH	I, MN 56101			
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	completed at your f investigation. Your f compliance with 42 for Long Term Care The following comp SUBSTANTIATED: however NO deficie actions taken by the The facility is enroll signature is not req page of the CMS-22 correction is require acknowledge receip	Plaints were found to be H5558029C (MN77714), encies were cited due to e facility prior to the survey. ed in ePOC and therefore a uired at the bottom of the first 567 form. Although no plan of ed, the facility must ot of the electronic documents.						(V2) DATE
LABORATORY	DIRECTORS OR PROVIL	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		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.

PRINTED: 01/03/2022

Minnesc	ta Department of He	alth				1 01 01	/ I I KOVED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00085		B. WING			C 27/2021	
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - WINDOM				H STREET , MN 56101				
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	****ATTE	NTION*****						
	NH LICENSING	CORRECTIO	N ORDER					
	In accordance with 144A.10, this correc- pursuant to a surver found that the defic- herein are not correc- not corrected shall with a schedule of f the Minnesota Depa Determination of wit corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	ction order ha y. If, upon rei iency or defici ected, a fine fo be assessed i ines promulga artment of He nether a violat compliance wi rule provided ile number inc ns several iter the items will Lack of com ny item of mu ment of a fine	s been issued nspection, it is encies cited or each violation n accordance ated by rule of alth. ion has been ith all I at the tag dicated below. ms, failure to be considered pliance upon Iti-part rule will e even if the item					
	You may request a that may result fron orders provided tha the Department wit notice of assessme	n non-complia t a written req hin 15 days of	nce with these uest is made to receipt of a					
	INITIAL COMMENT On 12/27/21, a com at your facility by su Department of Hea found IN compliance Licensure.	nplaint survey irveyors from Ith (MDH). You	the Minnesota ur facility was					
	The following comp	laint was four	nd to be					
Minnesota Department of Health ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGN				NATURE	TITLE		(X6) DATE	

Electronically Signed

PRINTED: 01/03/2022 FORM APPROVED

Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA UDENTIFICATION NUMBER:				(X3) DATE SURVEY		
OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
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ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
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