

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

February 3, 2022

Administrator Good Samaritan Society - Mary Jane Brown 110 South Walnut Avenue Luverne, MN 56156

RE: CCN: 245568

Survey Cycle Start Date: January 7, 2022

Dear Administrator:

On January 7, 2022 a survey was completed at your facility by the Minnesota Department of Health to investigate complaints 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 complaints were found to be both unsubstantiated and substantiated. However, the facility was found to be in compliance because corrective action was taken prior to the on-site investigation. Therefore, at the time of the investigation, the facility was found to meet federal requirements. 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.

Sincerely,

Kamala Fiske-Downing

Minnesota Department of Health Licensing and Certification Program

Kumalu Fiske Downing

Program Assurance Unit Health Regulation Division

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

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

PRINTED: 01/12/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
245568		245568	B. WING		01	01/07/2022	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - MARY JANE BROWN				110 SOUTH WALNUT AVENUE			
GOOD SA	AWARITAN SUCIETY	- WART JANE BROWN		LUVERNE, MN 56156			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORREX (EACH CORRECTIVE ACTION SHIPM CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	0 INITIAL COMMENTS		FO	000			
	INITIAL COMMENTS On 1/6/22 through 1/7/22, a standard abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found to be IN compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5568040C (MN70837). The following complaints were found to be SUBSTANTIATED: H5568038C (MN76660), and H5568039C (MN73661), however NO deficiencies were cited due to actions taken by the facility prior to the survey. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, the facility must acknowledge receipt of the electronic documents.						
I ABORATORY	' DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE	

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 (X° AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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2 000	Initial Comments			2 000				
	*****ATTE	NTION*****						
	NH LICENSING CORRECTION ORDER							
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the number and MN Ruwhen a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	ected, a fine for each be assessed in accordines promulgated by artment of Health. The rether a violation has compliance with all a rule provided at the alle number indicated as several items, fail the items will be concluded by item of multi-part	issued tion, it is cited violation ordance vrule of s been tag below. ure to sidered e upon rule will if the item					
	You may request a that may result from orders provided that the Department with notice of assessme	hearing on any asse n non-compliance wi t a written request is nin 15 days of receip nt for non-compliand	essments th these s made to ot of a ce.					
	conducted at your fa	1/7/22, a complaint s acility by surveyors f ent of Health (MDH I compliance with th	rom the). Your					
	The following comp	laint was found to be	е					

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		, ,	E CONSTRUCTION		E SURVEY IPLETED
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Minnesota Department of Health