



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

Electronically delivered

December 1, 2020

Administrator  
Good Samaritan Society - Stillwater  
1119 Owens Street North  
Stillwater, MN 55082

RE: CCN: 245207  
Cycle Start Date: November 24, 2020

Dear Administrator:

On November 24, 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 'Melissa Poepping'.

Melissa Poepping, Health Program Representative Senior  
Program Assurance | Licensing and Certification  
Minnesota Department of Health  
P.O. Box 64970  
Saint Paul, Minnesota 55164-0970  
Phone: 651-201-4117  
Email: melissa.poepping@state.mn.us

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

PRINTED: 12/01/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245207</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/24/2020</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN SOCIETY - STILLWATER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1119 OWENS STREET NORTH STILLWATER, MN 55082</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  A COVID-19 Focused Infection Control survey was conducted on 11/24/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility is IN compliance. 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 the facility acknowledge receipt of the electronic documents.	E 000			
F 000	INITIAL COMMENTS  A COVID-19 Focused Infection Control survey was conducted on 11/24/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was IN full compliance.  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 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.