



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

Electronically Delivered

January 29, 2021

Administrator  
Good Samaritan Ambassador  
8100 Medicine Lake Road  
New Hope, MN 55427

RE: CCN: 245149  
Survey Cycle Start Date: January 14, 2021

Dear Administrator:

On January 14, 2021 a survey was completed at your facility by the Minnesota Department of Health to investigate complaint(s) 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(s) were 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.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Douglas Larson'.

Douglas Larson, Enforcement Specialist  
Minnesota Department of Health  
Licensing and Certification Program

*An equal opportunity employer.*

Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4118 Fax: 651-215-9697  
Email: [doug.larson@state.mn.us](mailto:doug.larson@state.mn.us)

cc: Licensing and Certification File

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

PRINTED: 01/29/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245149</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/14/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN AMBASSADOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>8100 MEDICINE LAKE ROAD</b> <b>NEW HOPE, MN 55427</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	
F 000	<p><b>INITIAL COMMENTS</b></p> <p>On 1/12/21-1/14/21 an abbreviated survey was conducted at your facility to complete complaint investigations. Your facility was found to be in compliance with the requirements at 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were found to be substantiated no deficiency sited: H5149048C H5149049C H5149050C H5149051C H5149052C H5149053C</p> <p>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, it is required that you acknowledge receipt of the electronic documents.</p>	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.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/14/2021</b>
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NAME OF PROVIDER OR SUPPLIER  <b>GOOD SAMARITAN AMBASSADOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427</b>
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(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) COMPLETE DATE
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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p><b>NH LICENSING CORRECTION ORDER</b></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><b>INITIAL COMMENTS:</b> On 1/12/21-1/14/21, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure.</p> <p>The following complaint was found to be <b>SUBSTANTIATED:</b></p>	2 000		
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Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00898</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/14/2021</b>
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2 000	<p>Continued From page 1</p> <p>H5149048C H5149049C H5149050C H5149051C H5149052C H5149053C</p> <p>NO licensing orders were issued.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		