Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

September 17, 2025

Administrator
GOOD SAMARITAN SOCIETY HOME CARE ST PETER
600 SOUTH FIFTH STREET #211
SAINT PETER, MN 56082

RE: Event ID: 1D3BB9-H1

Dear Administrator:

On September 4, 2025, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal certification regulations requirements. The survey revealed that your facility was in substantial compliance with participation requirements and no deficiencies were cited. The findings from this survey are documented on the electronically delivered form CMS 2567.

No additional action is required on the facility's part. Thank you for your cooperation.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

September 17, 2025

Administrator
GOOD SAMARITAN SOCIETY HOME CARE ST PETER
600 SOUTH FIFTH STREET #211
SAINT PETER, MN 56082

Re: Event ID:1D3BB9-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on September 4, 2025, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached 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 call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248084 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 09/04/2025 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| GOOD SAMARITAN SOCIETY HOME CARE ST PETER | 600 SOUTH FIFTH STREET #211 , SAINT PETER, Minnesota, 56082 |

| (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 |
|---|---|---|---|---|
| E0000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 9/2/25-9/4/25 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. | E0000 | | |
| G0000 | INITIAL COMMENTS<br><br>On 9/2/25-9/4/25 a recertification survey was conducted. This resulted in a standard survey at Good Samaritan Society Home Care St. Peter. The agency was found to have met the requirements at 42 CFR. Part 484 for Home Health Agencies.<br><br>Unduplicated census previous 12 months: 462<br><br>Total home visits conducted: 4<br><br>No branch offices for this agency.<br><br>Hours of Operation: 8:00 a.m. to 4:30 p.m.<br><br>Total number of records reviewed: 10 | G0000 | | |

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 reverse for further 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.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |

Minnesota State Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br>B. WING | (X3) DATE SURVEY COMPLETED<br>**09/04/2025** |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **GOOD SAMARITAN SOCIETY HOME CARE ST PETER** | **600 SOUTH FIFTH STREET #211 , SAINT PETER, Minnesota, 56082** |

| (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 |
|---|---|---|---|---|
| 00000 | Initial Comments<br><br>On 9/2/25-9/4/25 a recertification survey was conducted. No licensing orders were issued during this survey. | 00000 | | |

Office of Primary Care and Health Systems Management

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| | | |