DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

April 24, 2026

Administrator
CASS CO PUBLIC HEALTH SERVICES
BOX 519, 400 MICHIGAN AVENUE
WALKER, MN 56484

Re: Event ID: 1F344C-H1

Dear Administrator:

A partial extended survey was completed at your agency on April 15, 2026, for the purpose of assessing compliance with Federal certification.
At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division, noted one or more deficiencies. Electronically attached is a copy of the Statement of Deficiencies (CMS-2567).

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

A provider or supplier is expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original to the following address within ten calendar days of your receipt of this notice:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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 On 4/14/26 and 4/15/26, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance.	E0000		
G0000	INITIAL COMMENTS On 4/14/26 and 4/15/26, a recertification survey was conducted. This resulted in a partial extended survey at Cass County Public Health Services. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care. Unduplicated census previous 12 months: 39 Total home visits conducted: 3 List Parent Location visited: Cass County Public Health Services Box 519, 400 Michigan Avenue Walker, MN 56484 Other Branch offices: NONE Hours of Operation: 8:00 a.m. to 4:30 p.m. Total number of records reviewed: 07	G0000		
G0372	Encoding and transmitting OASIS CFR(s): 484.45(a) Standard: An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.	G0372		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0372	Continued from page 1 This STANDARD is NOT MET as evidenced by: Based on interview and document review the agency failed to encode and electronically transmit completed Outcome and Assessment Information Set (OASIS) assessments to the Center of Medicare and Medicaid (CMS) system within 30 days of completing the assessment for 4 of 4 (P1, P5, P6, P8) patients reviewed. Findings include: The Center of Medicare and Medicaid (CMS) Outcome and Assessment Information Set (OASIS) Error Detail Report dated 2/1/25 through 4/14/26, identified four patients whose OASIS assessment records were submitted more than 30 days after the assessment had been completed. P1's plan of care (POC) identified a start of care date (SOC) of 7/1/25. P1's recertification OASIS assessment with completion date 8/18/25, was submitted to CMS 9/19/25, 32 days after completion of the assessment. P5's POC identified a SOC of 4/30/25. P5's recertification OASIS assessment with completion date 12/15/25, was submitted to CMS 2/13/26, 60 days after completion of the assessment. P6's POC identified a SOC of 12/23/24. P6's discharge OASIS assessment with completion date 10/18/25, was submitted to CMS 12/1/25, 43 days after completion of the assessment. P8's POC identified a SOC of 10/16/24. P8's discharge OASIS assessment with completion date 7/8/25, was submitted to CMS 8/13/25, 36 days after completion of the assessment. During interview on 4/14/26, at 2:50 p.m. the public health supervisor (PHS) stated most of the late oasis assessments were completed late by a nurse that had previously been employed by the agency. PHS was unsure why the nurse had completed the oasis assessments late and when they were finally completed the submissions ended up late. The nurse no longer was employed by the agency. The oasis should have been completed timelier and PHS felt the late completion and submission of the oasis was due to the nurses having other duties and variable work schedules. PHS was responsible to submit the oasis when they were completed. PHS submitted oasis to CMS either every week or every other week. PHS thought there might be late submissions related to other work duties and not being able to submit them	G0372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0372	Continued from page 2 weekly as well. The Center for Medicare and Medicaid Services OASIS E Manual, updated 1/1/24, identified OASIS data was collected as part of the comprehensive assessment required by the Medicare Conditions of Participation. The CMS Home Health Conditions of Participation required a home health agency electronically transmit accurate, completed, and encoded OASIS data to a centralized data submission system within 30 days of the completion of the assessment (M0090 Date Assessment Completed).	G0372		
G0514	RN performs assessment CFR(s): 484.55(a)(1) A registered nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician or allowed practitioner - ordered start of care date. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure a registered nurse completed an initial assessment visit within 48 hours of a referral for home care services for 1 of 7 patients (P5) reviewed. Findings include: P5's plan of care (POC) 2/24/26 to 4/24/26, identified a start of care (SOC) date 4/30/25. Diagnoses included hypertension, and heart disease. Skilled nurse visits (SNV) were ordered one time per month and as needed (PRN) for 60 days for various assessment, disease management, medication teaching and monitoring. P5's medical record identified the agency had received a referral for home care services for nursing and home health aide on 4/8/25. P5's SOC assessment visit was completed on 4/30/25, 22 days after receiving the medical referral for services. P5's medical record lacked documentation P5's physician had been notified of the late SOC or the reason the SOC had not been completed within 48 hours of referral, as required. When interviewed on 4/15/26, at 1:49 p.m. the public	G0514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0514	Continued from page 3 health supervisor (PHS) stated P5's SOC for home services had been completed late and should have been done within 48 hours of receiving the referral orders. PHS thought the referral may have been on P5's social services case manager's desk and not handed off to the agency as timely as it should have. The agency should have notified P5's primary provider of the late SOC. A policy on home care referrals was requested; however, none was received.	G0514		
G0536	A review of all current medications CFR(s): 484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This ELEMENT is NOT MET as evidenced by: Based on observation, interview and document review, the agency failed to ensure a comprehensive review of all medications a patient was taking was completed for 1 of 3 patients (P2) whose medications were reviewed during home visits. Findings include: P2's plan of care (POC) 3/20/26 to 5/18/26, identified a start of care date 8/17/22. Diagnoses included diabetes, chronic kidney disease, tachycardia and depression. Ordered services included skilled nurse visits (SNV) one time per week and as needed (PRN) for 60 days for various assessments, education, disease management and medication management, including medication setup. A number of P2's medications were listed which included bupropion (an antidepressant) 150 milligrams (MG) every day, Lasix (for water retention) 40 mg in two times per day-with a notation to take 40 mg in the morning and 20 mg in the afternoon per cardiology on 11/14/23, Lantus insulin 30 units every morning and Novolog insulin 10 units at breakfast, 15 units with lunch and supper and 4 units with snacks. During a home visit on 4/15/26 at 9:45 a.m., registered nurse (RN)-A was observed setting up P2's oral medications in a seven-day pill minder container. RN-A setup bupropion 300 mg tabs in the morning boxes and setup Lasix 20 mg tabs two tabs in the morning. RN-A stated P2 took his afternoon Lasix on his own as	G0536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0536	Continued from page 4 needed. P2 knew when he needed it and when he did not. When asked, P2 stated he took his long-acting insulin (Lantus) 60 units every evening and he took his short asking insulin (Novolog) 20 units with meals. P2 stated he had been taking his insulin at the reported doses for quite some time. P2 stated he used a pen and dialed up the required number on the pen and injected. P2 denies any problem or concerns with his insulin administration. P2 stated he had never taken his Lasix in the afternoon and only took the medications that were setup for him by the nurse. During interview on 4/15/26 at 12:50 p.m., RN-A stated she was not aware P2's bupropion bottle was 300 mg tablets. The last order she had on record was for 150 mg tablet one time per day. P2 confirmed via telephone call, the bupropion bottle read 300 mg, one tablet daily. RN-A stated she would have to contact P2's primary care provider (PCP) to reconcile the medication. RN-A stated P2 was not reliable when reporting what dose of insulin he was taking. RN-A had not heard P2 report he was taking 60 units of Lantus insulin every evening and 20 units of Novolog with each meal, and she had not clarified the dosages with him during the visit. RN-A stated she knew he was taking both insulins daily as she refilled them every two weeks for him. RN-A stated she always setup 40 mg of Lasix every am and he took the 20 mg on his own in the afternoon. RN-A confirmed she had not checked to see if he was actually taking the medication every afternoon, nor had she verified with him what he was taking for insulin, and she should have done. RN-A stated P2's PCP would need to be notified if he was not taking the medications as ordered and P2's medication list needed to be updated to reflect what P2 was actually taking. RN-A stated she had not done a good job with P2's medication reconciliation and should have. During interview on 4/15/26 at 1:00 p.m., the public health supervisor (PHS) stated if the medication list and medication administration record (MAR) were not correct in a patient record, the medications should be clarified and corrected. The physician signed the patient's POC with the medications listed per our medication list. If the nurse was not setting the medications as listed, then the nurse was out of compliance and not following physician orders. Verbal orders were needed when medication changes were made. PHS placed a call to the office of P2's PCP and requested a current medication list, in order to reconcile P2's medication and clarify dosages. The clinic nurse indicated she would fax P2's orders to the agency, however, was not received.	G0536		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0536	Continued from page 5 The agency policy Medication Management-Home Care dated 12/12/22, identified for each client receiving medication management services, the clinician must prepare and include in the service plan, a written statement of the medication management services that would be provided to the client. The individualized medication management plan would identify any client specific requirements related to documenting medication administration, verifications that all medications were administered as prescribed and monitoring of medication use to prevent possible complications or adverse reactions. The medication management record must be current and updated when there was and changes. Verbal prescription orders from an authorized prescriber must be recorded and placed in the client's record. The agency policy Medication Reconciliation-Home Care dated 3/13/19, identified the purpose was to comply with state and federal requirements for medication reconciliation and to notify the physician when problems arose related to findings with the results of the medication reconciliation. The drug regimen review would be completed minimally every 60 days and as new or changed drug therapy was noted. All clients would be monitored on an ongoing basis for medication effectiveness and actual or potential medication related problems. The physician would be promptly notified of any medication problems. Medication problems would be recognized, reported, documented, tabulated and evaluated for the purpose of minimizing risk for patients and improved quality of care. Medication problems would be promptly reported to the physician, documented in the clinical record and reported according to established procedure.	G0536		
G0542	Incorporate OASIS items CFR(s): 484.55(c)(8) Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary. The OASIS data items determined by the Secretary must include: clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only. This ELEMENT is NOT MET as evidenced by:	G0542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0542	Continued from page 6 Based on interview and document review, the agency failed to complete an updated comprehensive assessment for home care recertification, which included completion of Outcome and Assessment Information Set (OASIS) assessment every 60 days for 1 of 4 patients (P1) reviewed for recertification assessments. Findings include: P1's plan of care (POC) 2/27/26 to 4/7/26, identified a start of care (SOC) date 8/31/25. Diagnoses included chronic obstructive pulmonary disease (COPD), occlusion and stenosis of left carotid artery (blockage or narrowing of artery), diabetes and hydronephrosis (unable to release urine from kidneys to bladder). Skilled nurse visits (SNV) were ordered one time per month and as needed (PRN) for various assessments, educations and medication and urinary catheter management. P1's medical record identified a recertification and an updated POC was completed for the certification period 8/31/25 to 10/29/25, with a recertification visit and Oasis assessment completed on 8/28/25. P1's medical record identified recertification and updated POC was completed for the certification period 10/30/25 to 12/28/25, however P1's medical record lacked documentation of a completed recertification visit or Oasis assessment. Further, P1's medical record lacked documentation of an Oasis submission to the Center of Medicare and Medicaid (CMS) system as required. During interview on 4/14/26, at 2:50 p.m. the public health supervisor (PHS) stated she was unable to find a recertification and Oasis skilled nurse visit documented to complete home care recertification of services for P1 for the period 10/30/25 to 12/28/25. A visit had never been completed. The agency had a new registered nurse employed at the time who was not proficient with home care regulations. A visit had not been made, so the Oasis assessment had not been completed or submitted to CMS, as required. The nurse had completed the POC and obtained physician orders for the episode of care but had not completed an assessment visit, so the Oasis assessment had not been completed or submitted to CMS, as required. The nurse was no longer employed with the agency. The Center for Medicare and Medicaid Services OASIS E Manual, updated 1/1/24, identified OASIS data was collected as part of the comprehensive assessment required by the Medicare Conditions of Participation.	G0542		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0542	Continued from page 7 The CMS Home Health Conditions of Participation required a home health agency electronically transmit accurate, completed, and encoded OASIS data to a centralized data submission system within 30 days of the completion of the assessment (M0090 Date Assessment Completed).	G0542		
G0544	Update of the comprehensive assessment CFR(s): 484.55(d) Standard: Update of the comprehensive assessment. The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than- This STANDARD is NOT MET as evidenced by: Based on interview and document review, the agency failed to update the comprehensive assessment every 60 days for 1 of 4 patients (P1) reviewed for recertification assessments. Findings include: P1's plan of care (POC) 2/27/26 to 4/7/26, identified a start of care (SOC) date 8/31/25. Diagnoses included chronic obstructive pulmonary disease (COPD), occlusion and stenosis of left carotid artery (blockage or narrowing of artery), diabetes and hydronephrosis (unable to release urine from kidneys to bladder). Skilled nurse visits (SNV) were ordered one time per month and as needed (PRN) for various assessments, educations and medication and urinary catheter management P1's medical record identified an initial certification period and POC was completed for the certification period 7/1/25 to 8/29/25. P1's medical record identified recertification and an updated POC was completed for the certification period 8/31/25 to 10/29/25. The POC identified a new SOC date of 8/31/25, however, a SOC had not been completed. The Outcome and Assessment Information Set (OASIS) that was submitted to the center of Medicare and Medicaid (CMS) system was identified as a recertification assessment. P1's medical record lacked a POC and orders for continued home care services for 8/30/25. During interview on 4/14/26 at 3:26 p.m., the public	G0544		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0544	Continued from page 8 health supervisor (PHS) stated she did not know why the SOC date had been changed on P1's recertification assessments and POC's. P1's electronic medical record still identified a SOC date 7/1//25. They had a new agency nurse in employ at the time, and the nurse did not complete P1's assessment timely and so it was entered late. A recertification visit and assessment had been completed and not a SOC assessment. Because of the lapse in orders on 8/30/25, with recertification started 8/31/25 and not 8/30/25, as it should have been, all of P1's recertification and Oasis were out of sequence. The agency policy Medical and Scope of Services Policies, dated 3/20/23, identified written medical orders and a plan of treatment must be renewed at least every 60 days with the physician responsible for care. Service would be provided according to medical direction to help achieve the goals.	G0544		
G0574	Plan of care must include the following CFR(s): 484.60(a)(2)(i-xvi) The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0574	Continued from page 9 factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician or allowed practitioner may choose to include. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure patient's plan of care included all required components in the patient's individualized care plans for 5 of 7 patients (P1, P3, P4, P5, P7) whose care plans were reviewed. Findings include: P1's plan of care (POC) 2/27/26 to 4/27/26, identified a start of care (SOC) date 8/31/25. Diagnoses included chronic obstructive pulmonary disease (COPD), occlusion and stenosis of left carotid artery, hydronephrosis and diabetes. Ordered services included skilled nurse visits (SNV) one time per month and as needed (PRN) for various assessments, education, chronic disease management and medication management, however, lacked duration of services. P1's POC listed patient specific goals, however lacked rehabilitation potential and discharge plan. P3's POC 4/9/26 to 6/7/26, identified a SOC date 4/9/25. Diagnoses included chronic pain syndrome, and fibromyalgia. Ordered services included SNV one time per week and PRN for various assessments, disease and pain management and medication education and assessment, however, lacked duration of visits. P3's POC listed patient specific goals, however lacked rehabilitation potential and discharge plan. P4's POC 4/9/26 to 6/7/26, identified a SOC date 10/3/25. Diagnoses included cerebral infarction (stroke), diabetes, urinary device, pressure ulcer stage one and kidney disease, Ordered services included SNV one time per month and PRN. P4's POC listed patient specific goals, however lacked rehabilitation potential and discharge plan.	G0574		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0574	Continued from page 10 P5's POC 2/24/26 to 4/24/26, identified a SOC date 4/30/25. Diagnoses included hypertension, and heart disease. Ordered services included SNV one time per month and PRN for 60 days for various assessments, medication education and compliance and disease management. P5's POC listed patient specific goals, however lacked rehabilitation potential and discharge plan. P7's POC 10/20/25 to 12/15/25, identified a SOC 10/20/25. Diagnoses included chronic obstructive pulmonary disease (COPD) and dependence on supplemental oxygen. Ordered services included SNV one time per week and PRN for various assessments, disease and medication management. P7's POC listed patient specific goals, however lacked rehabilitation potential and discharge plan. During interview on 4/15/26 at 11:39 a.m., the public health supervisor (PHS) stated all patient care plans should have the discharge plan and rehabilitation potential on their POC. There used to be a prompt in the system when the nurse was completing a patient's POC to do the rehabilitation potential and discharge plan but during one of the system upgrades that was lost. The nurses forgot to put it in there when the prompts were no longer there. It was an important component of the patient's POC so the agency could plan for discharge, or if the patient was a long-term patient, the rehabilitation potential was important so they could plan for services and find the right services that the patient needed. The agency's policy Medical and Scope of Services Policies dated 3/27/23, identified the POC for individual orders should be in writing and include activity permitted, mental status, durable medical equipment, safety measures, nutritional requirements, diagnoses, orders for treatment, medications, allergies, homebound status, need for services, patient goals, rehabilitation potential and discharge plan.	G0574		
G0576	All orders recorded in plan of care CFR(s): 484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure medication changes as ordered were recorded in the patient's plan of care for 1 of 4	G0576		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0576	Continued from page 11 patients (P5) whose orders were reviewed. Findings include: P5's POC 2/24/26 to 4/24/26, identified a SOC date 4/30/25. Diagnoses included hypertension, and heart disease. Ordered services included SNV one time per month and PRN for 60 days for various assessments, medication education and compliance and disease management. Numerous medications were listed on P5's POC with dose and frequency of administration. The POC listed a Report/Findings section with a brief update of P5's current condition, physical symptoms, response to treatment and living situation. The narrative identified P5's Lasix (a diuretic) had been stopped, and Lasix was not identified as one of P5's active medications. P5's medical record lacked documentation of when and who had stopped P5's Lasix and a verbal order to discontinue the medication. During interview on 4/15/26 at 12:43 p.m., the public health supervisor (PHS) stated the nurse should have written a verbal order when the Lasix had been discontinued. It was important to document which physician had given the order and what date the medication has been stopped. The agency policy Medication Reconciliation-Home Care dated 3/13/19, identified a registered nurse must perform medication reconciliation and medication regime review. The drug regimen review would be completed minimally every 60 days and as new or changed drug therapy was noted. If discrepancies and/or potential adverse effects or other problems were noted, the physician would be promptly notified, and orders would be obtained as appropriate.	G0576		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure all services were provided as ordered by patient physician and/or ensure the physician was notified when services were not provided as ordered for 3 of 7 patients (P2, P3, P5) reviewed for home health aide services (HHA).	G0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0580	Continued from page 12 Findings include: P2 P2's plan of care (POC) 3/20/26 to 5/18/26, identified a start of care date 8/17/22. Diagnoses included diabetes, chronic kidney disease, tachycardia and depression. Ordered services included skilled nurse visits (SNV) one time per week and as needed (PRN) for 60 days for various assessments, education, disease management and medication management. A home health aide (HHA) was ordered one time per week for three hours. During a home visit on 4/15/26, at 9:45 a.m. P2 stated he received nurse and aide visits weekly. P2 stated the aide did not do any personal cares at all and her time was spent cleaning his home every week. During interview on 4/15/26, at 1:49 p.m. the public health supervisor (PHS) stated P2 did not have an HHA and only had homemaker services. P2's POC did not correctly identify the services he was receiving. She did not think P2 would accept any assistance with personal care, and he should not have an HHA ordered on his POC. It should have been identified as homemaker services. P2's physician signed the POC as orders and thinks P2 has a HHA when he does not. P2's medical record lacked documentation P2's primary care provider (PCP) had been notified P2 was not receiving HHA services but was in fact only receiving home making services. P3 P3's POC 4/9/26 to 6/7/26, identified a SOC date 4/9/25. Diagnoses included chronic pain syndrome, and fibromyalgia. Ordered services included SNV one time per week and PRN for various assessments, disease and pain management and medication education and assessment. P3's referral dated 4/1/26, identified a referral for home care services for registered nurse (RN) visits and a home health aide. During a home visit on 4/15/26, at 3:30 p.m. P3 stated she did not have a HHA from the agency. P3 had a personal care attendant (PCA) who assisted her with personal care, errands and homemaking from a different agency.	G0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0580	Continued from page 13 P3's medical record lacked documentation P3's PCP had been notified the agency had not initiated an HHA as ordered. P5 P5's POC 2/24/26 to 4/24/26, identified a SOC date 4/30/25. Diagnoses included hypertension, and heart disease. Ordered services included SNV one time per month and PRN for 60 days for various assessments, medication education and compliance and disease management. P5's referral dated 4/8/25, identified orders for home health service for nursing and a home health aide. P5's medical record lacked documentation an HHA had been discussed and/or rejected by P5. The medical record also lacked documentation P5's PCP had been notified HHA services had not been initiated as ordered. During interview on 4/15/26 at 1:49 p.m., the PHS stated if a home health aide was ordered on a patient's referral it needed to be addressed with the patient at the SOC assessment visit and the patient's PCP needed to be notified if services were not started as ordered. The agency policy Medical and Scope of Services reviewed 3/3/27/23, identified the staff rendering should obtain diagnoses and written orders directly from the PCP prior to or at the time of initiating services. The PCP, in consultation with the RN and other health personnel should determine the plan of treatment for the patient. The agency policy Home Health Aide-Home Care, reviewed 4/2/26, identified all referrals for HHA services would be assigned for initial assessment to staff nurses. The primary nurse would make appropriate changes in aide assignment as the plan changes withing the scope of agency policies and Minnesota Statutes.	G0580		
G0808	Onsite supervisory visit every 14 days CFR(s): 484.80(h)(1)(i) (1)(i) If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech language pathology services— (A) A registered nurse or other appropriate skilled professional who is familiar with the	G0808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0808	Continued from page 14 patient, the patient's plan of care, and the written patient care instructions described in paragraph (g) of this section, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days; and (B) The home health aide does not need to be present during the supervisory assessment described in paragraph (h)(1)(i)(A) of this section. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure onsite home health aide (HHA) supervision was completed every fourteen days as required for 1 of 1 patient (P1) reviewed who received HHA services. Findings include: P1's plan of care (POC) 2/27/26 to 4/27/26, identified a start of care (SOC) date 8/31/25. Ordered services included skilled nurse visits (SNV) one time per month and as needed (PRN) for various assessments, education, chronic disease management and medication management. A home health aide was ordered four hours per week. Diagnoses included chronic obstructive pulmonary disease (COPD), occlusion and stenosis of left carotid artery, hydronephrosis and diabetes. P1's medical record was reviewed 10/1/25 through 4/15/26, and identified home health aide supervision occurred on 10/1/25, 10/29/25, 11/13/25, 12/10/25, 12/24/25, and 1/7/26. Home health aide supervision did not occur after 1/7/26, despite continued home health aide services. During interview on 4/15/26, at 8:30 a.m. the public health supervisor (PHS) stated the agency had at first thought P1 was a maintenance only client with no skilled nurse need and so were only doing HHA supervision every 60 days. PHS realized P1 was a skilled need patient, as he needed scheduled nurse visits for his urinary catheter care and changes. PHS stated the agency was out of compliance with most of P1's HHA supervision as it should have been done every 14 days and no HHA supervision had been completed in the last three months. PHS stated they were out of practice as they had not had home health aide services	G0808		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G0808	Continued from page 15 in several years and now just getting back in to having one. The agency policy Home Health Aide-Home Care dated 4/2/26, identified a patient's primary nurse would provide ongoing supervision at least every two weeks to patients with skilled level of care.	G0808		
G1022	Discharge and transfer summaries CFR(s): 484.110(a)(6)(i-iii) (i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer. This ELEMENT is NOT MET as evidenced by: Based on interview and document review, the agency failed to ensure discharge summaries contained all required medical information for 2 of 2 patients (P6, P7) reviewed for discharge records. Findings include: P6: P6's plan of care (POC) 8/20/25 to 10/18/25, identified a start of care (SOC) date 12/23/24. Services were ordered for skilled nurse visits (SNV) one time per week for one week then one visit every two weeks for 60 days for various assessments, education, disease management and medication management. Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease (COPD) and dysuria. P6's Verbal Order-discharge summary dated 10/20/25, identified P6's diagnoses, last visit date of 10/13/25 and a notation patient requested to manage medications through a different resource. P6's discharge summary	G1022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 247047	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484

(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
G1022	Continued from page 16 lacked documentation of P6's admission date, reason for admission to home health, type and frequency of services received, medications at time of discharge, laboratory data, discharge condition, patient outcomes and post discharge instructions. P7: P7's POC 10/20/25 to 12/18/25, identified a SOC date 10/20/25. Services were ordered for SNV one time per week and as needed (PRN) for various assessments, education, disease management and medication education and assessment. Diagnoses included COPD, lower respiratory infection, and dependence on supplemental oxygen. P7's Verbal Order dated 10/27/25, identified physical therapy was initiated and planned to continue two times per week for eight weeks. P7's Verbal Order-discharge summary dated 12/9/25, identified P7's diagnoses and discharge date with a notation P7 was discharged to another facility due to need for higher level of care. P7's discharge summary lacked documentation of P7's admission date, reason for admission to home health, type and frequency of services received, medications at time of discharge, laboratory data, discharge condition, patient outcomes and post discharge instructions. During interview on 4/15/26 at 1:49 p.m., the public health supervisor (PHS) stated the P6 and P7's discharge summaries were not completed, and each should have been done. It was the agency's practice to do a short summary narrative within the physician discharge orders and that was not done. By the time the agency realized the lack of documentation, it was too late to correct it. The agency policy Termination of Home Care Patient Services dated 3/15/23, identified the home care nurse would inform the primary provider for the patient of the pending discharge and provide a discharge summary to the provider.	G1022		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Via Email

April 24, 2026

Administrator
CASS CO PUBLIC HEALTH SERVICES
400 MICHIGAN AVENUE
BOX 519
WALKER, MN 56484

Re: Enclosed State Licensing Orders
Event ID: 1F344C-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on April 15, 2026, 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 one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.482.

In accordance with Minnesota Statute section 144A.477, for home care providers that are licensed to provide home care services and are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, with survey and enforcement by the Minnesota Department of Health as an agent for the United States Department of Health and Human Services, the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) are considered equivalent to the federal requirements. Because your facility is a certified home health agency, violations of the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) may lead to enforcement actions under Minnesota Statute section 144A.474. If your facility fails to comply with all the federal deficiencies issued as a result of this Department's survey completed on April 15, 2026, the findings supporting the federal violations shall be considered violations of the applicable licensure requirements. The

notice of termination from the Medicare program by the Centers for Medicare and Medicaid Services (CMS) or the failure to attain compliance with the federal regulations within the time periods approved by CMS may constitute grounds for the revocation, suspension or nonrenewal of the license.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for home care providers.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN requirement is not met as evidenced by."

We urge you to review these orders carefully. If you have questions, please contact the supervisor listed below. When all orders are corrected, the order form should be signed and returned to this office at:

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine(s) assessed.

The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date.

The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the 15 calendar days will not be considered. You are required to send your written request and all supporting documents to Health.Homecare@state.mn.us; or, if you prefer you can mail it to:

Home Care Correction Order Reconsideration Process

Minnesota Department of Health
Health Regulation Division
625 Robert St. N
St. Paul, MN 55164-0975
Telephone 651-201-4200
Health.CM-Cert@state.mn.us

Failure to correct state licensing correction orders may result in enforcement actions in accordance with the provisions of Minnesota Statutes, sections 144A.43 to 144A.482.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	**BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484**

(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 On 4/14/26 through 4/15/26, a recertification was conducted. Licensing orders are being issued as a result of the survey *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.	00000		
01175	Verification/Documentation of Orientation CFR(s): 144A.4796, Subd. 3 Each home care provider shall retain evidence in the employee record of each staff person having completed the orientation required by this section. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the licensee failed to ensure documentation was retained of employee home health orientation in each employee file for 1 of 1 employee (E1) reviewed for orientation to home care. S/S-B This practice resulted in a level one violation (a violation that has no potential to cause more than a minimal impact on the client and does not affect health or safety), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly, but is not found	01175		

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 A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **04/15/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CASS CO PUBLIC HEALTH SERVICES	**BOX 519, 400 MICHIGAN AVENUE , WALKER, Minnesota, 56484**

(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
01175	Continued from page 1 to be pervasive). Findings include: Employee 1 (E1)'s employee file identified a hire date of 11/8/23, it lacked documentation of orientation to home care upon hire. During interview on 4/15/26, at 8:30 a.m. the public health supervisor (PHS) stated she remembered providing E1 with the necessary orientation when she was hired. PHS had spoken with E1 and E1 stated she remembered having the orientation sheet and it was completed but she was unable to locate it now. PHS stated it was important to have all employee files in their human resources folder to ensure they had been orientated to their role within the agency, licensing requirements, safety, abuse reporting and any other specific tasks. The licensee's policy Home Health Aide-Home Care reviewed 4/2/26, identified training requirements would be followed per Minnesota Statute 144A.4795, Subdivision 7 Home Care Provider Responsibilities. Fifteen training and competency evaluations for all unlicensed personnel were listed to be completed. Time Period to Correct: Twenty-One (21) days	01175		