

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF REMOVAL OF CONDITIONAL LICENSE

Electronic Delivery

November 29, 2022

Administrator Global Home Health Care, Inc. 1032 15th Avenue Southeast Rochester, MN 55904

RE: Conditional License Number 404883

Health Facility Identification Number (HFID) 21537

Project Number SL21537016

Dear Administrator:

On November 3, 2022, The Minnesota Department of Health (MDH) completed a follow-up evaluation of your agency to determine correction of orders found on the licensing evaluation completed April 29, 2022. The follow-up evaluation found the agency to be in substantial compliance. Based on these findings, the condition(s) on the license were removed effective November 29, 2022.

Furthermore, The follow-up evaluation determined your agency had not corrected all of the state licensing orders issued pursuant to the April 29, 2022 initial evaluation.

The details of the violations noted at the time of this follow-up evaluation completed on November 3, 2022 are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, no immediate fines are assessed.

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minn. Stat. § 144A.474, subd. 8(c), by the correction order date, the licensee 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 evaluations, upon a complaint evaluations, and as otherwise needed. The licensee is not required to submit a plan of correction for approval.

IMPOSITION OF FINES:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism

Global Home Health Care, Inc. November 29, 2022 Page 2

authorized in § 144A.475.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

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 assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please <a href="mailto:emai

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should addressed to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact Jodi Johnson, Supervisor, at 507-344-2730.

Sincerely,

Maria King, RN **Division Director**

naria King

Minnesota Department of Health Health Regulation Division

PMB

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED	(X3) DATE SURVEY COMPLETED	
		1104507			R	
NAME OF I	PROVIDER OR SUPPLIER	H21537	l .	STATE, ZIP CODE	11/03/2022	<u>'</u>
		1032 15TL	, ,	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	ROCHES1	TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE APPROPRIED	D BE COMP	LETE
{0 000}	Initial Comments		{0 000}			
	In accordance with 144A.43 to 144A.45 have been issued pure requirements provide indicated below. With contains several ite of the items will be compliance. INITIAL COMMENT SL# 21537016-2 On October 31, 202 the Minnesota Departments of the follow-up receiving services to Comprehensive lice.	VIDER LICENSING DER Minnesota Statutes, section 32, these correction order(s) bursuant to a survey. hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute ms, failure to comply with any considered lack of TS: 22, through November 3, 2022, artment of Health conducted a rsuant to a survey completed and August 12, 2022. At the p, there were 168 clients under the provider's ense. As a result of the the following correction order(s)		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far-left column entity Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TOUR SUBMIT A PLAN OF CORRECTIONS OF MINNESOTA STATUTES. THE LETTER IN THE LEFT COLUMSED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144A.47	oftware. to e Care ber led "ID ber and Statute les" the e state This as eyors' rection. DING OF THIS ON FOR TATE JMN IS ES AND VEL	
{01035} SS=D	144A.4793, Subd. 3 Treatment/Therapy		{01035}	SUBDIVISION 11 (b)(1)(2).		

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

(X6) DATE TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/ AND PLAN OF CORRECTION IDENTIFICAL	SUPPLIER/CLIA TION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		A. BUILDING:		.	R	
H21537		B. WING		1	3/2022	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GLOBAL HOME HEALTH CARE INC	1032 15TH ROCHES	H AVE SE FER, MN 559	904			
(X4) ID SUMMARY STATEMENT OF DEFINENCE (EACH DEFICIENCY MUST BE PRECE REGULATORY OR LSC IDENTIFYING I	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
Subd. 3.Individualized treatment of management plan. For each client management of ordered or prescor therapy services, the comprehencare provider must prepare and in service plan a written statement or therapy services that will be proclient. The provider must also deviate maintain a current individualized therapy management record for emust contain at least the following (1) a statement of the type of serviced; (2) documentation of specific client relating to the treatments or there administration; (3) identification of treatment or the will be delegated to unlicensed per problem arises with treatments or services; and (5) any client-specific requirement documentation of treatment and the received, verification that all treat therapy was administered as present monitoring of treatment or therapy possible complications or adverse treatment or therapy management be current and updated when the changes. This MN Requirement is not met by: Based on interview and record re	at receiving ribed treatments ensive home include in the of the treatment ovided to the velop and treatment and each client which g: vices that will be int instructions app in the resonnel; stered nurse or essional when a retherapy in the repy in the repy in the repy in the reactions. The interest in the record must re are any in the reactions. The interest in the record in t	{01035}				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 2 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
						R	
		H21537	B. WING		11/0	03/2022	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GLOBAL	GLOBAL HOME HEALTH CARE INC 1032 15TI ROCHES			904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
{01035}	treatment or therap developed to include of six clients (C3) remanagement. This practice result violation that did not safety but had the policient's health or sa cause serious injury was issued at an is limited number of colimited number of situation has occurred. The findings included C3's records lacked or therapy manager following: - a statement of the provided; - documentation of relating to the treatment administration; - identification of trewill be delegated to procedures for not appropriate license problem arises with services; and - any client-specific documentation of trewill that all the treatment of the procedures for not appropriate license problem arises with services; and	nsure an individualized by management plan was let the required content for one ecciving treatment or therapy ed in a level two violation (a st harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and clated scope (when one or a dients are affected or one or a taff are involved or the red only occasionally). e: d an individualized treatment ment plan to include the etype of services that will be specific client instructions ments or therapy eatment or therapy tasks that a unlicensed personnel; tifying a registered nurse or d health professional when a nate treatment and therapy received treatment and therapy was escribed, and monitoring of by to prevent possible	{01035}				
	On October 31, 203	22 at 11:00 a m. during the					

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 3 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		R 11/03/2022	
	PROVIDER OR SUPPLIER - HOME HEALTH CAF	1032 15TH	H AVE SE	STATE, ZIP CODE	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETE DATE
{01035}	entrance conference (DO)-Q stated the I management service C3's RN (registered Form dated Septemused a BiPap (bileve type of ventilator to (oxygen)/ two liters C3's Service Plan: 2022, indicated the personnel (ULP) seup to 84 hours 7 (see C3's Service Plan: September 13, 202 included dressing, toileting, bathing, metransfers, light hous BiPap assist with personnel daily or C3's Service Plan: September 13, 202 included dressing, toileting, bathing, metransfers, light hous BiPap assist with personnel daily or C3's Service Plan: September 13, 202 (mechanical) lift, let emptying, however the BiPap/O2 treated C3 lacked prescribed catheter bag empty On November 2, 20 stated unlicensed see "health related" document. DO-Q to treatment plan for coindicated there should be confered to the company of	se, director of operations icensee provided treatment ces. Id nurse) Baseline Assessment inber 13, 2022, identified C3 rel positive airway pressurehelp with breathing)/O2 per nasal cannula at night. Part 2 dated September 13, client received unlicensed ervices per attached care plan even) days per week. Part 5 - Care Plan dated 2, indicated services provided positioning, grooming, iteal prep/set-up/supervision, sekeeping, mobility, laundry, lacement at night, suprapubic ras needed, and bilateral leg ras needed. Part 3 - Treatment Plan dated 2, included Hoyer g wraps, and catheter bag g C3's treatment plan lacked	{01035}			

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 4 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		H21537	B. WING		11/0	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL HOME HEALTH CARE INC			H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	The licensee's Con Therapy Records p indicated the client' following informatic and therapies that on ursing assessment and therapy managere-assessments of therapy managemed documentation registris assessment, at therapy management been developed by electronic prescript	this one had been missed. Intent of Client's Treatment and policy dated May 10, 2022, its record "must contain the pon about the client's treatment our agency is managing: A not of the need for treatment gement services and all the client's treatment and ent services and, if applicable, arding the client's refusal of an individualized treatment and ent plan for the client that has at the RN, and written or clions that are complete and attent and therapy the agency e client.	{01035}			
{01040} SS=E	Subd. 4.Administra Ordered or prescrik must be administer other licensed heal perform the treatmedelegated or assign the licensed health appropriate practice assignment. When or therapy is delegated personnel, the hom that the registered health professional	overtion of treatments and therapy. Interpretation of treatments or therapies ared by a nurse, physician, or the professional authorized to the ent or therapy, or may be used to unlicensed personnel by professional according to the estandards for delegation or administration of a treatment ared or assigned to unlicensed the care provider must ensure unurse or authorized licensed				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.		 	,
		H21537	B. WING			3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	GLOBAL HOME HEALTH CARE INC 1032 157 ROCHES			904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{01040}	Continued From pa	nge 5	{01040}			
	the unlicensed pers ability to competen (2) specified, in wri	th respect to each client and sonnel has demonstrated the tly follow the procedures; ting, specific instructions for				
	the client's record;	cumented those instructions in and				
		with the unlicensed personnel I needs of the client.				
	by: Based on interview licensee failed to e (RN) had specified for each client and in the client's recor unlicensed personneeds of the client C3, C11) who were management; and proper methods to therapy manageme (ULP-E, ULP-F, UL ULP-T, ULP-U) had competently follow	ent is not met as evidenced and record review, the nsure the registered nurse, in writing, specific instructions documented those instructions ds and communicated with the nel (ULP) about the individual for four of six clients (C1, C2, receiving treatment or therapy had instructed the ULP in the administer the treatment or ent, and eight of eight ULP LP-V, ULP-G, ULP-H, ULP-S, d demonstrated the ability to the procedures.				
	safety but had the parties to client's health or sa cause serious injur was issued at a partimited number of a limited number of a limited number of	potential to have harmed a afety, but was not likely to y, impairment, or death), and ttern scope (when more than a clients are affected, more than f staff are involved, or the red repeatedly; but is not ive).				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 6 of 25

Minnesota Department of Health

	IT OF DEFICIENCIES		(V2) MI II TIDI	E CONSTRUCTION	(V2) DATE	CLIDVEV
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DOILDING.			
		H21537	B. WING		R 11/03/2022	
NAME OF				CTATE ZID CODE	, 1170	
NAME OF	PROVIDER OR SUPPLIER	1032 15Ti		STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{01040}	Continued From pa	ge 6	{01040}			
	September 11, 202: compression stocki edema (swelling). C1's Service Plan: 2022, indicated the per attached care pseven days per wee C1's Service Plan: September 11, 202: included compressi days or as needed. identified C1's care C1's Service Plan: September 11, 202: stocking up to seve by ULP.	Part 5 - Care Plan dated 2, indicated services provided on socks apply up to seven The document further giver was ULP-E. Part 3 - Treatment Plan dated 2, included compression n days per week or as needed				
	prescriber for signa	ted October 17, 2022, sent to ture, for caregiver to assist ocks daily as needed.				
	September 14, 202 (continuous positive airway open by pro- wear while you slee C2's Service Plan: 1 2022, indicated the	Assessment Form dated 2, identified C2 used a CPAP e airway pressure-keeps viding air through a mask you ep) at night. Part 2 dated September 14, client received ULP services lan up to 66.5 hours seven				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		H21537	B. WING	B. WING		₹ 3/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GI OBAI	. HOME HEALTH CAR	F INC 1032 15TH	_			
OLODAL	Г	ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
{01040}	Continued From pa	ge 7	{01040}			
	September 14, 202 included CPAP assi at night. The docum caregivers were UL	Part 5 - Care Plan dated 2, indicated services provided ist with placement as needed nent further identified C2's P-F and ULP-V. Part 3 - Treatment Plan dated 2, included CPAP at night or				
	as needed.					
	C2's prescriber order dated October 17, 2022, included: Caregiver to assist with placing and cleaning CPAP as needed.					
	C3 C3's RN Baseline Assessment Form dated September 13, 2022, identified C3 used BiPap (bilevel positive airway pressure- type of ventilator to help with breathing)/oxygen 2 liter per nasal cannula at night.					
	2022, indicated the	Part 2 dated September 13, client received ULP services lan up to 84 hours seven days				
	September 13, 202 included BiPap ass suprapubic cathete bilateral leg wraps of	Part 5 - Care Plan dated 2, indicated services provided ist with placement at night, r bag empty as needed, and once daily or as needed. The lentified C3's caregivers were				
	September 13, 202 (mechanical) lift, leg	g wraps, and catheter bag C3's treatment plan lacked				

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		 F		
		H21537	B. WING			3/2022	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GLOBAL	GLOBAL HOME HEALTH CARE INC			004			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	TER, MN 55	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	COMPLETE DATE	
{01040}	Continued From pa	ge 8	{01040}				
	C3 lacked prescriber orders for BiPap/O2, catheter bag emptying, and leg wraps.						
	September 16, 202	Assessment Form dated 2, identified C11 used Oxygen ring the day and CPAP at					
	2022, indicated the	Part 2 dated September 16, client received ULP services lan up to 66.5 hours seven					
	C11's Service Plan: Part 5 - Care Plan dated September 16, 2022, indicated services provided included hoyer lift, Oxygen, nebulizer, and CPAP. The document further identified C11's caregivers were ULP-S, ULP-T, and ULP-U.						
	September 16, 202 oxygen/CPAP and I however, the treatn	: Part 3 - Treatment Plan dated 2, included C11 managed nebulizer independently; nent plan identified ULP ateral leg wraps and Hoyer lift					
	included: Caregive lift, application of bi	der dated October 18, 2022, or to provide transfer by Hoyer lateral leg wraps, assist with d, assist with CPAP and l.					
	written instructions treatment or therap	11's records lacked specific for the administration of the y management services and ne instructions in the client					
	ULP Training/Comp	petency					

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 9 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		H21537	B. WING		1	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC ROCHEST	I AVE SE TER, MN 559	204		
(X4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTI	ON.	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	COMPLETE DATE
{01040}	Continued From pa	ge 9	{01040}			
	provided direct care ULP-F had a hire d provided direct care ULP-V had a hire d provided direct care ULP-G had a hire d provided direct care ULP-H had a hire d provided direct care ULP-S had a hire d provided direct care ULP-T had a hire d provided direct care ULP-U had a hire d provided direct care	ate of September 8, 2011, and e services to C2. ate of August 27, 2020, and				
	(DO)-Q stated there competency for the indicated the treatm family members ratindicated the paper that. A-A further stand competency te the service as an e	and director of operations e was no documented ULP as listed above. A-A nents might be done as live-in ther than employees, but work and orders did not reflect ated the nurse should instruct st the ULP prior to providing mployee.				
	Therapy by Unlicen May 10, 2022, indic treatments or thera	ninistration of Treatment or used Personnel policy dated cated "ordered or prescribed pies must be administered by or other licensed health				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 10 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			71. 501251110.		 F	2
		H21537	B. WING		11/0	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TH	HAVE SE FER, MN 559	20.4		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	ON.	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
{01040}	Continued From pa	ge 10	{01040}			
	or therapy or may be unlicensed personner professional accordant standards for delegent Unlicensed person requirements, have to follow the proceed delegated the responsation in the treat the treat of the standard personner professional accordant pro					
{01045} SS=D	144A.4793, Subd. 5 Documentation of Treatment/Therapy Subd. 5.Documentation of administration of treatments and therapies. Each treatment or		{01045}			
	care provider must record. The docume signature and title of administered the treinclude the date and treatment or therap ordered or prescribe document the reason and any follow-up promeet the client's. This MN Requirements.	eatment or therapy and must d time of administration. When ies are not administered as ed, the provider must on why it was not administered procedures that were provided				
	licensee failed to er therapy administere	nsure each treatment or ed by the comprehensive staff was documented in the				

Minnesota Department of Health

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND FLAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		H21537	B. WING		F 11/0	3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15T	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
{01045}	Continued From page 11		{01045}			
	client's record for two of four clients (C2, C11) who were receiving treatment or therapy management.					
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an is- limited number of c limited number of s	ed in a level two violation (a t harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and colated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally).				
	The findings include	e:				
		ds lacked documentation of f treatment or therapies being				
	Form dated Septem used a CPAP (continues pressure-keeps air	I nurse) Baseline Assessment aber 14, 2022, identified C2 inuous positive airway way open by providing air u wear while you sleep) at				
	2022, indicated the personnel (ULP) se	Part 2 dated September 14, client received unlicensed rvices per attached care plan ven days per week.				
	September 14, 202	Part 5 - Care Plan dated 2, indicated services provided ist with placement as needed				
		Part 3 - Treatment Plan dated 2, included CPAP at night or				

Minnesota Department of Health STATE FORM

6899 If continuation sheet 12 of 25 31V013

Minnesota Department of Health						
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		R 11/03/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1032 15Ti				
GLOBAL	. HOME HEALTH CAR	PE INC	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPL	ETE
{01045}	Continued From pa	ge 12	{01045}			
	as needed.					
		er dated October 17, 2022, or to assist with placing and needed.				
		documentation of the eatment being provided.				
	September 16, 202 liters (L) of oxygen	Assessment Form dated 2, identified C11 used two during the day and a CPAP at nent did not include leg wraps.				
	2022, indicated the	Part 2 dated September 16, client received ULP services plan up to 66.5 hours seven				
	September 16, 202	Part 5 - Care Plan dated 2, indicated services provided echanical) lift, oxygen, P.				
	September 16, 202 wraps by ULP and The treatment plan	: Part 3 - Treatment Plan dated 2, included daily bilateral leg Hoyer lift as needed by ULP. identified C11 managed nebulizer independently.				
	included: Caregive lift, application of bi	der dated October 23, 2022, or to provide transfer by Hoyer lateral leg wraps, assist with d, assist with CPAP and l.				
		d documentation of the eatment being provided.				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		11/0	₹ <mark>3/2022</mark>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01045}	On November 2, 20 operations (DO)-Q documentation of the under "health related record lacked documentation of which was a second lacked document lacked l	222, at 9:39 a.m. director of and administrator (A)-A stated ne treatment services is noted ed" and verified C2 and C11's mentation of treatments or why it was not administered. 222, at 10:15 a.m. A-A nents might be done as live-in ther than employees, but work and orders did not reflect umentation of Treatment and ent Services in the Client d May 10, 2022, noted staff ach treatment and therapy mmediately after the task has	{01045}			
{01050} SS=D	Orders Subd. 6.Treatment must be an up-to-directorded order from all treatments and to contain the name of the treatment or the frequency, duration needed to administ Treatment and them at least every 12 minus.	and therapy orders. There ate written or electronically an authorized prescriber for herapies. The order must f the client, a description of erapy to be provided, and the , and other information er the treatment or therapy. apy orders must be renewed onths.	{01050}			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING			R 03/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	H AVE SE TER, MN 559	004		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{01050}	Continued From pa	ge 14	{01050}			
	licensee failed to er electronically record obtained with the re	and record review, the nsure an up-to-date written or ded order or prescription was equired content for all y provided for one of five				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an is- limited number of c limited number of s	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and polated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally).				
	The findings include	e:				
	Form dated Septen used BiPap (bilevel of ventilator to help per nasal cannula a	I nurse) Baseline Assessment nber 13, 2022, identified C3 positive airway pressure- type with breathing)/oxygen 2 liter at night. The assessment B required assistance with a r.				
	2022, indicated the	Part 2 dated September 13, client received ULP services lan up to 84 hours seven days				
	September 13, 202 included dressing, ptoileting, bathing, mtransfers, light hous BiPap assist with pl	Part 5 - Care Plan dated 2, indicated services provided positioning, grooming, real prep/set-up/supervision, sekeeping, mobility, laundry, acement at night, suprapubic as needed, and bilateral leg				

Minnesota Department of Health

Minnesota Department of Health					
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BUILDING.		R
		H21537	B. WING		11/03/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GI ORAI	. HOME HEALTH CAR	1032 15TI	H AVE SE		
GLOBAL	TIOWE HEALTH CAN	ROCHES.	TER, MN 559	904	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
{01050}	Continued From page 15		{01050}		
	September 13, 202 (mechanical) lift, leg emptying; however, the BiPap/O2 treatr C3's record lacked recorded prescription treatment or therap On November 2, at operations (DO)-Q documented the Bill the timesheet/activithere were no order indicated there should be sho	g wraps, and catheter bag , C3's treatment plan lacked ment. written or electronically ons for the above administered			
	be done as live in fa	022, at 10:15 a.m. indicated the treatments might amily members rather than cated the paperwork did not			
	Therapy Records d the "client's record information about th therapies that our a electronic prescripti	tent of Client's Treatment and ated May 10, 2022, indicated must contain the following ne client's treatment and agency is managing: Written or ions that are complete and tment and therapy our agency client."			
	No further informati	ion was provided.			
{01080} SS=E	144A.4794, Subd. 3	3 Contents of Client Record	{01080}		

6899

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		11/0	R 3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TH ROCHEST	HAVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETE DATE
{01080}	Continued From pa	ge 16	{01080}			
	client record include (1) identifying inform	f client record. Contents of a the following for each client: nation, including the client's address, and telephone				
	(2) the name, addre	ess, and telephone number of act, family members, client's ny, or others as identified;				
	the client's health a	es, and telephone numbers of nd medical service providers re providers, if known;				
	(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;					
	(5) client's advance	directives, if any;				
	(6) the home care passessments and s	provider's current and previous ervice plans;				
	(7) all records of co client's home care s	mmunications pertinent to the services;				
	client's status and a	of significant changes in the actions taken in response to ent including reporting to the sor or health care				
	and actions taken in	of incidents involving the client in response to the needs of the prting to the appropriate in care professional;				

6899

Minnesota Department of Health

	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R	
		H21537	B. WING			3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CI OPAI	HOME HEALTH CAR	E INC 1032 15TH	AVE SE			
GLUBAL	. HOME HEALTH CAR	ROCHEST	TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01080}	Continued From pa	ge 17	{01080}			
	,	that services have been ed in the service plan;				
	,	that the client has received ome care bill of rights;				
	provided the statem	that the client has been nent of disclosure on es under section 144A.4791,				
	(13) documentation resolution;	of complaints received and				
		mary, including service and related documentation, and				
		ntation required under this nt to the client's services or				
	by: Based on interview licensee failed to er	ent is not met as evidenced and record review the asure documentation for d in the service plan for two of				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an iso limited number of co- limited number of so	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and plated scope (when one or a dients are affected or one or a taff are involved or the red only occasionally).				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H21537	B. WING			R 03/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE	-	
GI OBAI	. HOME HEALTH CAR	RE INC	H AVE SE			
OLODAI	TOME HEALTH GAIN	ROCHES	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
{01080}	Continued From pa	ge 18	{01080}			
	The findings include	e:				
	entrance conference (DO)-Q stated unlice treatments on the ti	22, at 11:00 a.m. during the se, director of operations sensed personnel documented me and activity sheet under less otherwise directed per				
	September 14, 202 included dressing, pathing, bathing, mousekeeping, laur positive airway presproviding air throug	Part 5 - Care Plan dated 2, indicated services provided cositioning, grooming, cobility, transfers, light dry, and CPAP (continuous ssure-keeps airway open by h a mask you wear while you lacement as needed at night.				
		Part 3 - Treatment Plan dated 2, included CPAP at night or				
	dated October 17, 2 2022, lacked docur	vity Documentation sheet 2022, through October 23, nentation of "health related" ssistance was provided with				
	September 16, 202 included dressing, (light housekeeping,	Part 5 - Care Plan dated 2, indicated services provided grooming, toileting, bathing, mobility, laundry, Hoyer lift, and CPAP. The care plan did leg wraps.				
	September 16, 202	Part 3 - Treatment Plan dated 2, included daily bilateral leg Hoyer lift as needed by ULP.				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 19 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		H21537	B. WING		11/0	3/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC 1032 15T	_			
		ROCHES	TER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01080}	Continued From pa	ige 19	{01080}			
	The treatment plan identified C11 managed oxygen/CPAP and nebulizer independently.					
	dated October 17, 2 2022, lacked docur assistance or "heal	tivity Documentation sheet 2022, through October 23, mentation of dressing th related" activities to show an provided with C11's leg				
	operations (DO)-Q documentation of the under "health related record lacked documents"	022, at 9:39 a.m. director of and administrator (A)-A stated ne treatment services is noted ed" and verified C2 and C11's mentation of treatments or why it was not administered.				
	indicated the treatm family members rat	022, at 10:15 a.m. A-A nents might be done as live-in ther than employees, but work and orders did not reflect				
	No further informat	ion was provided.				
{01150} SS=D	144A.4795, Subd. 7 Evals Comp Staff	7(c) Training/Competency	{01150}			
	competency evalua	ragraph (b), training and attion for unlicensed personnel ensive home care services				
	(1) observation, rep client status;	porting, and documenting of				
	changes in body ful	e of body functioning and nctioning, injuries, or other that must be reported to				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 20 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
						٦
		H21537	B. WING		11/0	03/2022
NAME OF I	PROVIDER OR SUPPLIER		ADDRESS, CITY, S STH AVE SE	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	PINC:	STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{01150}	Continued From pa	ge 20	{01150}			
	appropriate personi	nel;				
	(3) reading and recand respirations of	ording temperature, pulse, the client;				
		sical, emotional, cognitive, needs of the client;				
	(5) safe transfer ted	chniques and ambulation;				
	(6) range of motion	ing and positioning; and				
	(7) administering m required.	edications or treatments as				
	This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure training and competency evaluations as required prior to providing direct care for one of seven unlicensed personnel (ULP-P).		ey			
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an is- limited number of c limited number of s	ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and olated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally).	1			
	The findings include	e:				
		ate of January 6, 2020, and e and services to C16.				
	ULP-P's record lack training for the follo	ked evidence of documented wing topics:				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 21 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) A. BUILDING:			SURVEY LETED	
		1104507			F	
		H21537	<u> </u>		11/0	3/2022
NAME OF I	PROVIDER OR SUPPLIER	1032 15Ti		STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01150}	Continued From pa	ge 21	{01150}			
	-reading and recording temperature, pulse, and respirations of the client; ULP-P's record lacked evidence of documented competency evaluation for the following topics: -reading and recording temperature, pulse, and respirations of the client.					
	operations (DO)-Q ULP-P's supervision	022, at 3:00 p.m. director of stated she did not know why n form dated September 21, he documented training and				
	No further informati	on was provided.				
{01245} SS=D	144A.4798, Subd. 1	1 TB Infection Control	{01245}			
	(a) A home care promaintain a comprehence control program act tuberculosis infection the United States Cand Prevention (CE Elimination, as publiand Mortality Week include a tuberculos covers all paid and contractors, studen commissioner shall regarding implement (b) The home care evidence of compliants of the complin	rculosis (TB) infection control. by order must establish and mensive tuberculosis infection cording to the most current on control guidelines issued by tenters for Disease Control DC), Division of Tuberculosis lished in the CDC's Morbidity ly Report. This program must sis infection control plan that unpaid employees, ts, and volunteers. The provide technical assistance intation of the guidelines. provider must maintain written ance with this subdivision.				
	by:	and record review, the				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI AND PLAN OF CORRECTION IDENTIFICATION N	IMPED:	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	A. BOILDING		R
H21537	B. WING		11/03/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY,	STATE, ZIP CODE	
GLOBAL HOME HEALTH CARE INC	1032 15TH AVE SE ROCHESTER, MN 55	5904	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIENCY PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY TAG REGULATORY OR LSC IDENTIFYING INFORM	Y FULL PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
licensee failed to ensure the provider e and maintained a tuberculosis (TB) pre program, based on the most current gu issued by the Centers for Disease Con Prevention (CDC) which included requi information for TB testing for one of founlicensed personnel (ULP-P). This practice resulted in a level two vio violation that did not harm a client's heat safety but had the potential to have har client's health or safety, but was not like cause serious injury, impairment, or de was issued at a widespread scope (whe problems are pervasive or represent a failure that has affected or has potential a large portion or all of the clients). The findings include: The licensee's TB facility risk assessmenthe licensee's Rochester office and Windows branch office completed May 23, 2022, the licensee was a low risk. ULP-P had a hire date of January 6, 20 provided direct care and services to C1 ULP-P's record included the following: -Yearly Tuberculosis Screening Question dated September 19, 2022. -TB Annual Symptom Review (for those on PPD TB skin test) dated April 26, 20 -QuantiFERON dated March 23, 2017, The review indicated "negative chest X (CXR) dated March 6, 2017, "no sympt -Exam chest "TB" clinic dated March 6, "Impression: low lung volumes. Probab atelectasis [partial or complete collapse lung] left base. Chest otherwise: negative.	evention didelines trol and red ur lation (a alth or med a ely to ath), and en systemic al to affect ents for nona indicated 220, and 6. connaire e positive 222. "negative"ray" coms." , 2017, ele e of the		

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 23 of 25

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		11/0	R 3/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{01245}	Continued From pa	ge 23	{01245}			
	(A)-A stated he mis deficiency. A-A indi employees need a recomplete the control of the control of acility TB risk asses indicate an employee starts working with a recomplete the control of the control	display the control of the control of the completed. The control of the completed of the complete of				
	dated May 10, 2022 with clients, each st TB. A two-step skin gamma release ass (e.g., QuantiFERON	Prevention and Control policy c, indicated prior to contact aff person will be screened for test or single interferon say (IGRA) for M. tuberculosis N® TB Gold or TB DT TB) will be administered				
	unless the person's that a TB skin test i	past medical history indicates s contraindicated. The RN will dance in 06-009 regarding				

Minnesota Department of Health

STATE FORM 6899 31V013 If continuation sheet 24 of 25

Minnesota Department of Health

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			D. WING		R	
		H21537	B. WING		11/0	3/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	FINC	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01245}	Continued From pa	ge 24	{01245}			
	current positive TS documented history latent TB infection (loyees with a previous or Γ or TB blood test or with a γ of previous treatment for LTBI) or active TB disease. he RN will contact the MDH				
	No further informati	on was provided.				



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

May 17, 2022

Administrator Global Home Health Care, Inc. 1032 15th Avenue Southeast Rochester, MN 55904

RE: Project Number(s) SL21537016 - Informal Conference Requested

Dear Administrator:

The Minnesota Department of Health completed an evaluation on April 29, 2022, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are 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 are 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"

IMPOSITION OF FINES

In accordance with Minn. Stat. § 144A.474, Subd. 11(a), fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

- Level 1: no fines or enforcement.
- Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144A.475 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

Global Home Health Care, Inc. May 17, 2022 Page 2

In accordance with Minn. Stat. § 144A.474, Subd. 11(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. Subd. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144A.474, Subd. 11(a)(6), when a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, the following fines are assessed pursuant to this evaluation:

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St - 0 - 0265 - 144a.44, Subd. 1(a)(2) - Up-To-Date Plan/accepted Standards Practice = $3,000 St - 0 - 1252 - 144a.4798, Subd. 3 - Infection Control Program = $500.00
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The total amount you are assessed is \$3,500. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

DOCUMENTATION OF ACTION TO COMPLY

Per Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document any action taken to comply with the correction order by the correction order date. A copy of the provider's records documenting those actions may be requested for follow-up evaluations. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minn. Stat. § 144A.474, Subd. 12, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days of the correction order date.

A state licensing order under Minn. Stat. § 144A.44 Subd. 1(14), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process

Global Home Health Care, Inc. May 17, 2022 Page 3

under Minn. Stat. § 626.557. Please <u>email</u> general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general reconsideration requests to:
Reconsideration Unit
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration requests should be addressed to:

Reconsideration Unit

Health Regulation Division

Minnesota Department of Health

P.O. Box 64970

85 East Seventh Place

St. Paul, MN 55164-0970

REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144A.474, subd. 11 (g), a home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144A.475, subd 4 and subd. 7, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days of the correction order receipt date. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. <u>Please note that you may request a reconsideration or a hearing, but not both.</u>

INFORMAL CONFERENCE REQUESTED

At any time, the Commissioner of Health is authorized by Minn. Stat. 144A.475, subd. 8 to hold an informal conference to exchange information, clarify issues, or resolve issues. The Department wants to schedule an informal conference with you. Please contact Jodi Johnson, Supervisor, at 507-344-2730 or jodi.johnson@state.mn.us within five (5) days of your receipt of this letter to schedule an informal conference to discuss the noncompliance and action(s) as authorized by law.

Please be prepared to let us know who at your agency we need to include in the informal conference and provide their contact information. We anticipate your cooperation as we work through this critical time.

Global Home Health Care, Inc. May 17, 2022 Page 4

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jodi Johnson, Supervisor Health Regulation Division State Evaluation Team 85 East Seventh Place, Suite 220 P.O. Box 3879

St. Paul, MN 55101-3879

Telephone: 507-344-2730 Fax: 651-215-9697

PMB

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
H21537		H21537	B. WING		04/29	0/2022		
NAME OF F	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GLOBAL	HOME HEALTH CAR	RE INC 1032 15TH ROCHEST	TER, MN 55	904				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE		
0 000	Initial Comments		0 000					
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			Minnesota Department of Health is documenting the State Licensing Correction Orders using federal stag numbers have been assigned Minnesota State Statutes for Homeroviders. The assigned tag numappears in the far-left column entiperefix Tag." The state Statute number the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficient column. This column also include findings which are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the survifindings is the Time Period for Concorrection." The FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES. THE LETTER IN THE LEFT COLUSED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144A.47 SUBDIVISION 11 (b)(1)(2).	oftware. If to the Care tiber itled "ID the Statute cies" s the the state 'This as eyors' rrection. DING OF TO THIS TO ON FOR TATE UMN IS SES AND EVEL			
0 265 SS=I	144A.44, Subd. 1(a Plan/Accepted Star		0 265					

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

TITLE (X6) DATE Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
	H21537		B. WING		04/2	9/2022
GLOBAL HOME HEALTH CARE INC.			STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 265	Subdivision 1.State receives home care in an assisted living chapter 144G has t (2) receive care an suitable and up-to-caccepted health car standards and pers	ment of rights. (a) A client who services in the community or facility licensed under hese rights: d services according to a date plan, and subject to re, medical or nursing on-centered care, to take an oping, modifying, and	0 265			
	by: Based on observati review, the licenses services were provi health care and me two of two clients (0 records reviewed. correction order on This practice result violation that harme not including seriou or a violation that h serious injury, impa issued at a widespr are pervasive or rep has affected or has portion or all of the The findings include	,				
	C2 C2 began receiving services on August 1, 2017, with diagnoses including spinal stenosis and deafness.					

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING:		COMPLETED		
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE		
OL ODAL	LIOME LIEALTH OAF	1032 15TH	1 AVE SE			
GLUBAL	. HOME HEALTH CAR	ROCHEST	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 265	Continued From pa	ige 2	0 265			
0 200	On April 27, 2022, a visit, C2 was observunlicensed personre bed had one-half sit on the upper left and side rails were secultated the side rails and help me to get he assisted C2 with to take medications cares, which was veries of the control of	at 12:45 p.m. during a home ved lying in bed and nel (ULP)-F was present. C2's ide rail in the upright position nd right sides of the bed. The urely attached to the bed. C2 s "help me to roll over in bed up out of bed." ULP-F stated in dressing, showers, reminders s, transfers, toileting and peri				
	C3 C3 began receiving services on January 1, 2015, with diagnoses including paraplegia. On April 27, 2022, at 3:30 p.m. during a home visit, C3 was observed lying in bed with ULP-G present. C3's bed had full length side rails in the upright position on the left and right sides of the bed. The side rails were securely attached to the bed. C3 stated the side rails "help me to roll over in bed and so I don't roll out of bed, because when I roll my legs go over the side." ULP-G stated he assisted C3 with dressing, showers, transfers C3 utilizing ceiling lifts (mechanical) and Hoyer lift (mechanical), toileting, peri cares, grooming, catheter cares and repositioning in bed, which was verified by C3. C3's record lacked evidence of a side rail assessment including side rail measurements, and documentation of education to the client and/or representative on the risks and benefits to					

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 3 of 140

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
H21537		B. WING		04/:	04/29/2022				
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE					
GLOBAL	GLOBAL HOME HEALTH CARE INC 1032 15TH AVE SE								
GLOBAL	HOWE HEALTH CAN	ROCHES	TER, MN 559	904					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE			
0 265	Continued From pa	ge 3	0 265						
	side rail use.								
	(RN)-B stated "No" assessments included documentation of elements regarding stores for C2 and C3. RN for C2 and C3 woul side rails. RN-B fur anything to do with	ling side rail measurements, ducation on the risk and side rails use were completed -B stated the case managers d do what was required for ther stated, "We don't have							
	The Food and Drug Administration (FDA) guidelines titled Recommendations for Health Care Providers about Bed Rails, dated July 9, 2018, indicated health care providers should base the use of bed rails on individual resident assessments to ensure the individual is an appropriate candidate to reduce the risk of entrapment. Recommendations made for health care providers to evaluate the individual's need, to use the guidance documented "Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment" to have knowledge that not all bed rails, mattresses, and bed frames are interchangeable; check the manufacturer's instructions, health care providers are to avoid the routine use of adult bed rails without first conducting an individual patient or resident assessment, and restrict the use of physical restraints including restrictive use of bed rails, or chest, abdominal, wrist, or ankle restraints of any kind on individuals in bed. When installing and using bedrails, select the appropriate bed rail, follow the health care provider's procedures, or manufacturer's recommendations, inspect.								

6899

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLOBAL	. HOME HEALTH CAR	1032 15TH	AVE SE			
GLOBAL	. NOWE REALIN CAN	ROCHEST	TER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE COMP		(X5) COMPLETE DATE
0 265	Continued From pa	ge 4	0 265			
0 200	evaluate, and regul appropriately match needs considering identify and remove hazards. Be aware movement or comp may be caused by position, or by using The FDA identifies "who have problem incontinence, pain,	arly check bedrails are ned to equipment and patient all relevant risk factors, to e potential fall and entrapment that gaps can be created by pression of the mattress, which patient weight, movement, bed g a specialty mattress. vulnerable patients as those s with memory, sleeping, uncontrolled body movement	0 200			
	or who get out of bed and walk unsafely without assistance." These patients most often have been frail, elderly, or confused. FDA guidelines titled Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment, dated 2006, identified key body parts at risk for life-threatening entrapment of the head, neck, and chest in the seven zones of a hospital bed system, focusing on the most common zones for risk of entrapment - zones 1-4. Zone 1 - within the rail is any open space with the perimeter of the rail. Recommended space be					
	less than 4 ¾ inches representing head breadth. Zone 2 - under the rail, between the rail supports or next to a single rail support. This space is the gap under the rail between a mattress compressed by the weight of a patient's head and the bottom edge of the rail at the location between the rail supports or next to a single rail support. Recommended space limit for entrapment in this space is less than 4 ¾ inches. Zone 3 - between the rail and the mattress. The space between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment. Recommended space between the area between the inside surface of the rail and compressed					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TH ROCHEST	I AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 265	mattress should be Zone 4 - under the space poses a risk neck. In this space, mattress compress lowermost portion of Recommended dimboth less than 60 m degrees in angle. Zone 5, 6, and 7 are entrapment with the area between the end of head or footboard, shead of footboard at No further information. TIME PERIOD FOR On May 4, 2022, at removed as confirm with evaluation supremains.	of less than 4 ¾ inches. rail at the ends of the rail. This for entrapment of a patient's a gap forms between the ed by the patient, and the of the rail, at the end of the rail. The rail at the end of the rail. The rail are some measure are in size and greater than 60 are identified as potential for e least reporting. Zone 5 is the plit of bedrails, zone 6 is the rail and the side edge of the and zone 7 is between the at the end of the mattress.	0 265			
0 475 SS=F	144A.472, Subd. 3 Subd. 3.License rer in section 144A.475	License Renewal newal. (a) Except as provided 5, a license may be renewed year if the licensee satisfies	0 475			
		ication for renewal in the the commissioner at least 30 ion of the license;				

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GI ORAI	. HOME HEALTH CAR	1032 15T	H AVE SE			
GLOBAL	HOWE HEALTH CAN	ROCHES	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 475	Continued From pa	ge 6	0 475			
	(2) submits the renewal fee in the amount specified in subdivision 7;					
	(3) has provided home care services within the past 12 months;					
	(4) complies with sections 144A.43 to 144A.4798;(5) provides information sufficient to show that the applicant meets the requirements of licensure, including items required under subdivision 1;					
	(6) provides verification that all policies under subdivision 1 are current; and					
	(7) provides any oth necessary by the co	ner information deemed ommissioner.				
	•	ne care license must also that policies listed under				
	by: Based on interview licensee failed to er officials who were in operations; and res care services, unde provider regulations	and record review, the assure the management of charge of the day-to-day ponsible for the clients' home erstood all of the home care is; and the licensee failed to procedures were developed das required.				
	violation that did no safety but had the p client's health or sa	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 7 of 140

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	RE INC 1032 15TH		20.4		
240.15	CUIMMA DV CTA		TER, MN 559		DNI.	(2/5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 475	Continued From pa	ge 7	0 475			
	are pervasive or rep	spread scope (when problems present a systemic failure that the potential to affect a large clients).				
	The findings include	e:				
	During the entrance conference on April 26, 2022, at 2:11 p.m. administrator (A)-A stated he was familiar with current home care laws and regulations.					
	policies and proced implemented: - requirements in somaltreatment of vul - orientation, trainin evaluations of staff: - conducting initial and assessments a condition are identificommunicated to sproviders as approproviders as approprovided in the conducting approprovided in the conducting approprovided in the current United State and Prevention starent United State and Prevention starent united State and Prevention and transcription of task licensed health processing appropriation of unlidelegated tasks.	g, and competency; and ongoing client evaluations and how changes in a client's fied, managed, and taff and other health care oriate; implementation of the frights; ractices; oriate screenings, or rior screenings, to show that erculosis, consistent with es Centers for Disease Control ndards; eatment management; s by registered nurses or fessionals; and icensed personnel performing				
		urvey, the following orders 0805, 0810, 0825, 0855, 0860,				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/29/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 475	0900, 0905, 0920, 0 1035, 1040, 1045, 1 1185, 1225, 1245, 1 licensee's understa statutes were limite compliance with Mi 144A.43 to 144A.47	0930, 0935, 0965, 1015, 1030, 1050, 1145, 1150, 1155, 1170, 1252, 2015, indicating the nding of the Minnesota d, or not evident for nnesota Statutes, sections 798.	0 475			
0 805 SS=D	Vulnerable Adults/M Subd. 6.Reporting r adults and minors. must comply with re of maltreatment of uthe requirements for maltreatment of vul 626.557. Each hom and implement a wi all cases of suspect	maltreatment of vulnerable (a) All home care providers equirements for the reporting minors in section 626.556 and	0 805			
	violation that did no	ed in a level two violation (a t harm a client's health or potential to have harmed a				

6899

Minnesota Department of Health STATE FORM

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING			
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	TH AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 805	cause serious injur was issued at an is limited number of situation has occur. The findings includ C9's record include incident dated Febrindicated C9's familinto the office with a employee (unlicenshad security camer review of the camer money out of her d\$800 in total has been to the money if orm VA's [vulnerate putting the money if form further identified "submitted" to MAA days later, instead On April 28, 2022, a representative/cool licensee became a February 16, 2022. resources (HR)-K if MAARC on Februar can submit to MAA stated she knew the reported to MAARC of reporting.	afety, but was not likely to cy, impairment, or death), and colated scope (when one or a clients are affected or one or a staff are involved or the red only occasionally). The eta documented notes from an arruary 16, 2022. The notes ily member (FM)-F had "came a complaint" about an sed personnel (ULP)-G). FM-F as installed and reported eras identified ULP-G "took arawer." FM-F "estimated that een stolen from their home." Indicated "video recordings or [ULP-G] removing money ole adult] personal bag and in their front shirt pocket." The fied the incident was ARC on February 21, 2022, five of immediately as required. The indicated "video recordings and in their front shirt pocket." The fied the incident was ARC on February 21, 2022, five of immediately as required. The indicated "video recordings and in their front shirt pocket." The fied the incident was ARC on February 21, 2022, five of immediately as required. The incident on the incident to incident on the incident on the incident on the incident on the incident to incident needed to be considered the incident needed to be considered the incident remediately incident incident incident incident incident needed to be considered the incident inci				
		at 12:24 p.m. administrator e incident had not been				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 10 of 140

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING	B. WING		9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 805	reported to MAARC The licensee's Vuln indicated a mandate believe that a vulne been maltreated, or vulnerable adult had which was not reass immediately report [common entry poir No further information of the common common entry poir the comm	erable Client policy undated, ed reporter who had reason to rable adult was being or had who had knowledge that a d sustained a physical injury onably explained "shall the information to the CEP at]."	0 805			
0 810 SS=F	(b) Each home care implement an indivieach vulnerable mir care services are provider. The plants review or assessment susceptibility to abuincluding other vuln person's risk of abuor minors; and state measures to be tak abuse to that person minors. For purpulan, the term abuse the term abus	e provider must develop and dual abuse prevention plan for nor or adult for whom home rovided by a home care shall contain an individualized	0 810			

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
GLOBAL HOME HEALTH CARE INC. 1032 15TI				STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 810	susceptibility to abuincluding other vulnof the specific meathe risk of abuse for six of six clients (Corecords reviewed. This practice result violation that did not safety but had the polient's health or sacause serious injurning was issued at a wide problems are pervertailure that has affer a large portion or a l	use by another individual, perable adults and statements sures to be taken to minimize or identified vulnerabilities for 1, C2, C3, C4, C5, C6) with ed in a level two violation (a st harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic ected or has potential to affect II of the clients). The clients of the clients of the clients of the vulnerable adults. In sment lacked a statement of the for the identified vulnerability and ADL's [activities of daily we or assessment of the clients of the clients of the identified vulnerability and ADL's factivities of daily we assessment of the clients of the	0 810			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 810	C3's Vulnerable Ad April 7, 2022, lacker review or assessme susceptibility to abuincluding other vulnerable Ad November 19, 2019 individualized revier person's susceptibility individual, including addition, the assess the specific measurisk of abuse to C4 of "Physical Health" C5's start of care do C5's record lacked abuse prevention por C6's Vulnerable Ad January 28, 2021, lindividual, including addition, the assess the specific measurisk of abuse to C6 of "Physical Health" On April 29, 2022, a (A)-A and registered above and all of the Adult Risk Assessmindividual, including person's susceptibility individual, including addition, the assess the specific measurisk of abuse to C6 of "Physical Health" On April 29, 2022, a (A)-A and registered above and all of the Adult Risk Assessmindividualized revier person's susceptibility individual, including the person's susceptibility individual the p	ult Risk Assessment dated ed evidence of an individualized ent of the person's use by another individual, nerable adults. ult Risk Assessment dated 9, lacked evidence of an wor assessment of the ility to abuse by another gother vulnerable adults. In sment lacked a statement of res to be taken to minimize the for the identified vulnerability and ADL's." ate was January 21, 2021. evidence of an individual elan. ult Risk Assessment dated acked evidence of an wor assessment of the ility to abuse by another gother vulnerable adults. In sment lacked a statement of res to be taken to minimize the for the identified vulnerability and ADL's." at 10:15 a.m. administrator d nurse (RN)-B verified the elicensee's clients' Vulnerable	0 810			
		ee would develop an individual				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 13 of 140

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA LAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TI ROCHES	HAVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 810	abuse prevention preceiving services. individualized assessusceptibility to abua statement of the sto minimize the risk.	lan for each vulnerable client The plan would contain an esment of the person's se (including self abuse), and especific measures to be taken of abuse to that person.	0 810			
0 825 SS=C	Subdivision 1.Home to client. (a) The ho the client or the clien notice of the rights the date that service client. The provider efforts to provide no or the client's reprecient or cl	HBOR Notification to Client e care bill of rights; notification me care provider shall provide nt's representative a written under section 144A.44 before es are first provided to that shall make all reasonable of the rights to the client sentative in a language the resentative can understand. The text of the home care bill of AA.44, subdivision 1, the nation the following statement le a complaint with these complaint with these of Health Facility to the Office of Health Facility is to Department of Health. It is of the Office of Ombudsman and Developmental	0 825			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF PRO	VIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL HO	OME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 55!	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
The number of Decomposition of Decomposi	amber, website adailing address, an Health Facility Compartment of Health Bracility Compartment of Health Bracility Compartment of Health Bracility Compartment of Health Bracility Compartment of the Ombudsman evelopmental Disasso include the horest oblems or complasso include a state ovider will not retain the compartment of the care bill of right can be also missed on interview the client's representation of the home of the current billication of the home of compartments (C3) and are bill of rights incompartments (C3) and are bill of rights (C3) and are	ge 14 Ild include the telephone ldress, e-mail address, d street address of the Office omplaints at the Minnesota th, the Office of the ng-Term Care, and the Office for Mental Health and abilities. The statement should me care provider's name, ephone number, and name or the provider to whom aints may be directed. It must ment that the home care aliate because of a complaint. Provider shall obtain written the client's receipt of the latts or shall document why an annot be obtained. The ay be obtained from the client sentative. Acknowledgment of sined in the client's record. Pent is not met as evidenced and record review, the ovide one of six clients (C2) of rights (November 2019); ten acknowledgment for care bill of rights for one of failed to ensure the home cluded all required content for Ly, C2, C3, C4, C5, C6) with the client and does not affect the divided and a level one violation (a potential to cause more than a the client and does not affect the was issued at a widespread the sare pervasive or represent				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 15 of 140

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
GLOBAL	HOME HEALTH CAR	RE INC	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 825	Continued From pa	ge 15	0 825			
		nat has affected or has large portion or all of the				
	Findings include:					
	C2's start of care date was August 1, 2017. C2's record lacked evidence the current bill of rights (November 2019) was provided to C2.					
	C3's written acknowledgment for receipt of the home care bill was dated April 13, 2021, and was unsigned by C3. The acknowledgement indicated on the signature line "compromised by COVID-19." C3's record lacked documentation of why written acknowledgment could not be obtained or the acknowledgement was mailed to obtain signature.					
		vledgment for receipt of the ghts was signed October 27,				
		vledgment for receipt of the ghts was signed July 7, 2021.				
		vledgment for receipt of the ghts was signed January 21,				
		vledgment for receipt of the ghts was signed January 28,				
	Licensed Only Hom C1, C2, C3 C4, C5 statement of "If you provider or the pers	e Bill of Rights for Clients of ne Care providers provided to and C6 lacked the required have a complaint about the son providing your home care call, write, or visit the Office of				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 16 of 140

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/29/2022	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TH ROCHEST	I AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 825	Continued From page 16		0 825			
	Office of Ombudsm Office of Ombudsm Developmental Disa On April 29, 2022, a (A)-A and registered above and the bill of licensee's clients w statement.	ith. You may also contact the nan for Long-Term Care or the nan for Mental Health and abilities." at 10:15 a.m. administrator d nurse (RN)-B verified the original of the ould lack the above required				
	No further informati	on provided.				
	TIME PERIOD FOR (21) days	R CORRECTION: Twenty-one				
0 830 SS=C	144A.4791, Subd. 2 Dementia/Alzheime	2 Notice of Services for er's	0 830			
	Alzheimer's disease home care provider clients with dement electronic form, to opersons who reque training program ar including the categorequency of trainin covered. This information in the care of the covered of the care	ervices for dementia, e, or related disorders. The that provides services to ia shall provide in written or clients and families or other st it, a description of the nd related training it provides, pries of employees trained, the g, and the basic topics mation satisfies the disclosure ction 325F.72, subdivision 2,				
	by: Based on interview licensee failed to pr	ent is not met as evidenced and record review, the rovide in written or electronic families or other persons who				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 17 of 140

TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 0 830 Continued From page 17 requested it, a description of the dementia training program and related training it provides, including the categories of employees trained, the frequency of training and the basic topics covered. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
GLOBAL HOME HEALTH CARE INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 0 830 Continued From page 17 requested it, a description of the dementia training program and related training it provides, including the categories of employees trained, the frequency of training and the basic topics covered. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has			H21537	B. WING		04/	29/2022
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (S4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICE TO	NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) O 830 Continued From page 17 requested it, a description of the dementia training program and related training it provides, including the categories of employees trained, the frequency of training and the basic topics covered. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has	GLOBAI	HOME HEALTH CAR	RE INC	_	104		
requested it, a description of the dementia training program and related training it provides, including the categories of employees trained, the frequency of training and the basic topics covered. 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 widespread scope (when problems are pervasive or represent a systemic failure that has affected or has	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETE
potential to affect a large portion or all of the clients). The findings include: On April 26, 2022, at 2:11 p.m. administrator (A)-A stated the licensee provided services to clients with dementia. On April 27, 2022, at 2:47 p.m. A-A stated, "I'm not sure we have it. I will have to ask [supervisor (S)-C]. We do extensive training." when asked if the licensee had a written or electronic form including training on services for dementia, Alzheimer's disease, or related disorders it in written or electronic form as required. On April 29, 2022, at 12:24 p.m. A-A confirmed the licensee did not have a notice of services for dementia, Alzheimer's disease, or related disorders in written or electronic form as required. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 830	requested it, a descraining program an including the categor frequency of trainin covered. This practice result violation that has not a minimal impact of health or safety), ar scope (when proble a systemic failure the potential to affect a clients). The findings included On April 26, 2022, and (A)-A stated the lice clients with dement On April 27, 2022, anot sure we have it. (S)-C]. We do extend the licensee had a vincluding training or Alzheimer's disease written or electronic On April 29, 2022, athe licensee did not dementia, Alzheimed disorders in written No further information.	cription of the dementiand related training it provides, ories of employees trained, the gand the basic topics ed in a level one violation (a popotential to cause more than in the client and does not affect and was issued at a widespread ems are pervasive or represent that has affected or has large portion or all of the estate 2:11 p.m. administrator ensee provided services to ia. at 2:47 p.m. A-A stated, "I'm. I will have to ask [supervisor insive training." when asked if written or electronic form in services for dementia, e., or related disorders it in a form as required. at 12:24 p.m. A-A confirmed thave a notice of services for er's disease, or related or electronic form as required. R CORRECTION:				

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE FER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 835	Continued From pa	ge 18	0 835			
0 835 SS=C	,		0 835			
	to the date that servicent, a home care client or the client's statement which ide basic or compreher services the provide which services the the scope of the procare provider shall acknowledgment from provider has provided document why the packnowledgment.	om the clients that the ed the statement or must provider could not obtain the				
	by: Based on interview licensee failed to er home care services provided under the license for six of six C6); in addition the	and record review, the nsure the written statement of sidentified all services licensee's comprehensive clients (C1, C2, C3, C4, C5, licensee failed to provide the f hom care services to one of records reviewed.				
	violation that has no a minimal impact of health or safety), ar scope (when proble a systemic failure the potential to affect a clients).	ed in a level one violation (a potential to cause more than the client and does not affect and was issued at a widespreadems are pervasive or represent nat has affected or has large portion or all of the				
	The findings include	e:				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 19 of 140

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	HAVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 835	Continued From pa	ge 19	0 835			
	Comprehensive Ho October 27, 2021. On April 27, 2022, a personnel (ULP)-E physical therapy (P' had exercises to co therapist. ULP-E sta C1 before C1 starte	Home Care Services: me Care Provider was signed at 11:45 a.m. unlicensed stated C1 was receiving T) two times a week and C1 mplete per the physical ated she placed a gait belt on ad the exercises, monitored C1 as so he does not fall and alking exercise.				
	C2 C2's record lacked licensee provided the representative a wridentified the providence care license, authorized to provide provider could not provide could not provide care license.	documented evidence the ne client or the client's itten statement which er had a comprehensive the services the provider was le, and which services the provide under the scope of the rior to the date that services				
	"applied prescription when needed, as C	at 12:45 a.m. ULP-F stated he n creams" to C2's skin folds 2's "skin breaks out bad," azole 1% cream (antifungal) (antifungal).				
		Home Care Services: me Care Provider was signed				
	included emptying a	an dated April 13, 2022, a catheter bag and cleaned ng the overnight bag to the leg				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 20 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMI			SURVEY	
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHES	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 835	bag, clean the ends vinegar water soluti soak for about 10 m was on a bowel pro On April 27, 2022, a administered a suppone time a week or encourage bowel m transfers using Hoy dressing around su changing catheter be C4 C4's Statement of H Comprehensive Ho March 4, 2019. C4's Client Care Plaindicated "has instruexercises and stretoneeded," "TED" hos "brace on left foot," knee when goes out catheter "provide as changing from bed bags are cleaned or On April 28, 2022, a assisted C4 with put (compression mate of brace on left leg bag to a leg bag. C5 C5's Statement of H	with alcohol wipe. Put on in the overnight bag and let ninutes and then empty. C3 gram of every other day. at 3:30 p.m. ULP-G stated he pository (laxative medication) every other week to C3 to rovement, assisted C3 with er or ceiling lift, changing prapubic catheter site and bag weekly. Home Care Services: me Care Provider was signed an dated September 27, 2021, actions available to do ches; provide assistance as se (compression stocking), "assist with brace to R [right] at of the house" and urinary esistance as needed with bag to leg bag and ensuring in a regular basis."	0 835			

6899

Minnesota Department of Health
STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 835	Continued From pa	ge 21	0 835			
		Home Care Services: me Care Provider was signed				
		an dated June 3, 2021, assistance with exercises and				
	Services: Compreh provided to C1, C2, check in the box ne the licensee offered	ement of Home Care ensive Home Care Provider C3, C4, C5 and C6 lacked a ext to the service to indicate d the following services: ement services and treatment				
	(A)-A and registered Statement of Home Comprehensive Ho provided to all the li indicate the license management service therapies. In additional documented evider	me Care Provider, which was icensee's clients, failed to e was providing medication ces and treatment and on, C2's record lacked ice the licensee provided the representative the Statement				
	No further informati	on was provided.				
	TIME PERIOD FOF (21) days	R CORRECTION: Twenty-one				
0 855 SS=D		7 Basic Individualized Cleint	0 855			
	monitoring. (a) Whe	idualized client review and en services being provided are ervices, an individualized initial				

Minnesota Department of Health

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		SURVEY PLETED
7.1.12 1 27.11 01 01		.5	A. BUILDING:			
		H21537	B. WING		04/2	29/2022
NAME OF PROVI	DER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL HON	ME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
revibe of clien must that (b) of connee from and resistele star. This by: Bass lices were last revisions safe clien cau was limit situs. The C5's excessored the connection of the connection	conducted at the nt or client's rep st be completed to home care service the completed as neededs of the client and the date of the dence or through communication and that mee so MN Requirements of the conducted not review for one cewed. So practice resulter at the part's health or sa se serious injury is issued at an iso ted number of cet ation has occurrent of findings included the ced 90 days from the certical serious for the certical serious included the certical serious included the certical serious includes the certical serious inclu	is needs and preferences must be client's residence with the resentative. This initial review within 30 days after the date vices are first provided. Ig and review must be end based on changes in the and cannot exceed 90 days a last review. The monitoring conducted at the client's he the utilization of methods based on practice to the individual client's needs. In the individual client's needs and record review, the insure client monitoring reviews to exceed 90 days from the of six clients (C5) with records and in a level two violation (and tharm a client's health or cotential to have harmed and fety, but was not likely to the individual client on the cotential to have harmed and fety, but was not likely to the individual client on the individual client or a lients are affected or one or a staff are involved or the red only occasionally).	0 855			

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC 1032 15T	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 855	grooming, light hou to client care plan;" provided within the C5's Care Plan date C5 required assistated to too and creams bathing: limited assistated to too and creams as required as required. RN-B (149 days after the 2021).	sekeeping, laundry and "refer however, no care plan was same date range. ed June 15, 2021, indicated ance with grooming: applying to areas not able to reach and sistance with bathing, needs legs, feet-especially ankles, keeping. ed the following monitoring feesional) Client Assessment; AQP" (registered fessional) Client Visits (133 review on January 21, 2021); ent Visits; 21, Client Visits; 21, Client Visits; and 21, Client Visits; of further assessments or after November 30, 2021. at 10:15 a.m. administrator d nurse (RN)-B verified C5's toring reviews every 90 days stated she saw C5 "yesterday" last review on November 30,	0 855			
0 860 SS=E		3 Comprehensive Assessment	0 860			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 24 of 140

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		H21537	B. WING		04/	29/2022
	ROVIDER OR SUPPLIER	1032 15T	DDRESS, CITY, S' TH AVE SE STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
S	and reassessment. provided are comprened in individualized inition the services are proprofessionals, the acconducted by the arthis initial assessmitive days after the clare first provided. (b) Client monitoring conducted in the cliedays after the date first provided. (c) Ongoing client must be conducted in the needs of the days from the last composition and reast the client's resident the c	nsive assessment, monitoring, (a) When the services being rehensive home care services, itial assessment must be n by a registered nurse. When existed by other licensed health assessment must be propriate health professional, nent must be completed within date that home care services are monitoring and reassessment as needed based on changes client and cannot exceed 90 date of the assessment. The seessment may be conducted ence or through the utilization on methods based on practice at the individual client's needs. The individual client's needs are failed to ensure the lient's need as essments for initial, 14 day, as in condition for five of five				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 25 of 140

	NT OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		H215	37	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	1032 15TH ROCHEST	·I AVE SE ΓER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L	/ MUST BE PRE	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 860	Continued From paragraph safety but had the provided from the provided number of a limited number of a limited number of a limited number of situation has occur found to be pervasion. The findings included the findings included the provided completed in personal required. C1 C1's Service Agreed indicated provided positioning, grooming the provided positioning, grooming the plan." C1's C1 C27, 2021, indicated the provided positioning the provided positioning the plan." C1's C1 C27, 2021, indicated the provided positioning the plan." C1's C1 was observed and unlicensed per ULP-E stated C1 restroy times a week a complete per the provided positioning the provided positioning the provided complete per the provided and the placed and t	potential to I fety, but way, impairment tern scope lients are affected repeated ve). e: to ensure an and within atte was October the same. at 11:45 a.m.	s not likely to nt, or death), and (when more than a fected, more than a fected, more than volved, or the dly; but is not ssessments were the time frames tober 27, 2021. October 27, 2021, luded dressing, s, bathing, mobility, d "refer to client lan dated October a. during a home in a wheelchair P)-E was present. Sical therapy (PT) exercises to apist. ULP-E stated afore C1 started the gleg exercises so with walking d she assisted C1 ing, transfers, dry. ing assessments:	0 860			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 26 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICATI	UPPLIER/CLIA ON NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG		ATEMENT OF DEFICI Y MUST BE PRECED SC IDENTIFYING IN	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 860	Continued From particles of the continued From particles were first - March 18, 2022, if face) (119 days from assessment on Notice C1's record lacked assessment was collacked assessment was comprehensive indicated a physical and c2's record lacked C2's Client Care Plindicated services pehavior, positioning bathing, mobility, to light housekeeping. On April 27, 2022, a visit, C2 was obserwas present. ULP-I dressing, showers, medications, transf housekeeping, meaverified by C2. ULI prescription creams needed, as C2's "s	whether complete 21, "RNQP" (regressional) Client ter the date hon provided); and RNQP Client Vision the last date ovember 19, 202 evidence if the producted in persect to be conducted in persect to be conducted and lacked a date of the assessment lacked a ividualized revidence of a series and dated August evidence of a series and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry. at 12:45 p.m. dured lying in bed and laundry.	gistered t Visits (by ne care sits (face to of the t1). initial son by the RN, ed in the client's home care acked to exceed 90 essment. In ew of C1 to 1, 2017. ervice plan. of 4, 2021, ed dressing, ansfers, ion reminders, uring a home and ULP-F isted C2 with ake eri cares, which was ed he "applied olds when	0 860			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 27 of 140

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		H21537	B. WING		04/	29/2022
	PROVIDER OR SUPPLIER HOME HEALTH CAR	1032 15T	DDRESS, CITY, S' H AVE SE TER, MN 559	,		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
0 860	were clotrimazole 1 Nystop powder (and C2. C2 stated the le check her blood sugstated the last time person was back in C2's record include assessments: - August 4, 2021, C (personal care attent Services C2's record lacked reassessment not te last date of the assess addition, the assess comprehensive indi include a physical at C3 C3's Service Agree indicated services per toileting, eating/men mobility, grooming, housekeeping, laur plan." C3's Client Care Pla included empty catt When removing the need to clean the e vinegar water soluti soak for about 10 n on a bowel program plan further indicate assistance with dre	% cream (antifungal) and tifungal) which was verified by ULP also reminded her to gar four times a day. C2 a nurse came to her home in 2019. Id the following for Elient Assessment for PCA and ant) and Homemaking evidence of monitoring and o exceed 90 days from the essment on August 4, 2021. In sment lacked a ividualized review of C2 to				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 28 of 140

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CLOBAL	HOME HEALTH CAR	1032 151	TH AVE SE			
GLUBAL	. HOME HEALTH CAR	ROCHES	STER, MN 559	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
0 860	μ-19-2		0 860			
	repositioned every his own, assist to p	a lift system (ceiling), two hours as unable to do on ropel the wheelchair, oming, eating/meal prep, laundry.				
	visit, C3 was obsercatheter bag hung of was present. ULP-suppository (laxativ week or every othe bowel movement, a transfers using Hoyshowers, cleaning I repositioning, cookichanging dressing site and changing of was all verified by Chospitalized in Marc	at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G G stated he administered a re medication) one times a reweek to C3 to encourage assisted C3 with dressing, wer or ceiling lift, grooming, iving space, laundry, and meals and cutting up food, around suprapubic catheter eatheter bag weekly, which C3. C3 stated he had been ch 2022, for suprapubic and the nurse had visited ized.				
	phone, hospital follohospitalized from N December 1, 2021, tract infection). - February 10, 2022 phone, hospital follohospitalized from Jarebruary 9, 2022. A and heart failure. C unit) and "they remediate in the spital follow up) in hospital on March 2	d the following for 1, RNQP Client Visits (by ow up) indicated was ovember 25, 2021, through for another "UTI" (urinary) 2, RNQP Client Visits (by ow up) indicated was anuary 27, 2022, through Admitted for respiratory failure 3 was in "ICU" (intensive care oved 15 liters of fluid." NQP Client Visits (by phone, ndicated discharged from 2, 2022. Admitted for bladder indwelling catheter and				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 29 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/S IDENTIFICAT	SUPPLIER/CLIA ION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	П21537	STREET AD		STATE, ZIP CODE	04/2	29/2022
	HOME HEALTH CAR	DE INC	1032 15TI		577112, Zii 0052		
GLOBAL	HOME HEALTH CAP	E INC	ROCHES	TER, MN 55	904		
(X4) ID PREFIX TAG		TEMENT OF DEFIC Y MUST BE PRECED SC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 860	Continued From pa	ige 29		0 860			
	replaced with suprapubic catheter April 7, 2022, Initial Client Assessment; and - April 13, 2022, Initial Client Assessment (lacked a nurse signature). The assessments failed to be conducted in						
	The assessments of person by the RN for requiring hospitalize of the nurse who contain the nurse who contains the nurs	ollowing a chan ation and lacke ompleted the as addition, the ass nsive individua	ge in condition d the signature ssessment for sessment lized review of				
	C4 C4's start of care d	ate was Octobe	er 9, 2017.				
	C4's Service Agreement dated July 7, 2021, indicated services provided included dressing, grooming, transfers, bathing, mobility, eating/meal prep, toileting, light housekeeping, laundry, other (doctor visit) and "refer to client care plan;" however, no care plan was provided within the same date range.						
	C4's Client Care Pl indicated "has instrexercises and stret needed;" dressing indicated "TED" ho "brace on left foot," knee when goes or grooming, bathing, toileting has a urina assistance as need bag to leg bag and a regular basis;" as laundry.	uctions availab ches; provide a requires assistate (compression "assist with braut of the house; eating/meal program catheter "program cat	le to do assistance as ance and on stocking), ace to R [right] " assist with ep, transfers; ovide ng from bed are cleaned on keeping and				
	On April 28, 2022, a visit, C4 was obser						

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 30 of 140

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Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU		` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY
				A. BOILDING.			
		H21537		B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TH ROCHES	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 860	Continued From particles of the particle	hung on the low was present. ULF utting on Tubigrip erial), putting on an anging Foley cashowers and concern the entry of the following for the following fo	P-I stated he os and removal of atheter bag to obting which was not using e. C4 stated it sited in person, how things or by phone) e may have ged to drink d Keifer into she does. C4 ections. It Visits (by e of the ated C4 now ld benefit from the catheter to Visits (by ospital stays nitted October arged with was very weak calling and she was admitted to a regain on November	0 860			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 31 of 140

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		H21537	B. WING		04/	29/2022
	PROVIDER OR SUPPLIER - HOME HEALTH CAR	1032 15T	DDRESS, CITY, ST TH AVE SE STER, MN 559			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 860	reassessment not to last date of the assessment and the assessment ladindividualized review assessment. C6 C6's Service Agree indicated services probability, toileting, ehousekeeping, laur plan." C6's Client Care Plandicated "provide a stretches;" dressing shoes; eating/meal meal prep; transfer getting into wheeled assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance to transitoilet; assistance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk very short distance with get well as on and off the walk ver	to exceed 90 days from the essment on November 29, 1, 2021. The assessments ted in person by the RN condition requiring indwelling hospitalization. In addition, sked a comprehensive w of C4 to include a physical ate was January 28, 2021. Interest of the provided included transfers, ating/meal prep, light and "refer to client care and dated June 3, 2021, provided included transfers, ating/meal prep, light and "refer to client care and dated June 3, 2021, provided included transfers, ating/meal prep, light and "refer to client care and dated June 3, 2021, provided included transfers, ating/meal prep, light assistance with exercises and graph is unable to the her prep-provide assistance with s-requires some assistance with s-requires some assistance and the shower chair; mobility-can ances with crutches and the her person; toileting- needs fer from wheelchair onto the lith housekeeping and laundry. In the following for a litial Client Assessment the following for the RNQP Client Visits (by phone)				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 32 of 140

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		H21537	B. WING		04/2	29/2022
	PROVIDER OR SUPPLIER	F INC 1032 15TI	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
0 860	assessment was collacked evidence of the client's home whome care services lacked monitoring a exceed 90 days from assessment. In addition, document the above clients whome the "client/respoon on April 29, 2022, at (A)-A and registered C2, C3, C4 and C6' At approximately 12 visits not being provided to the company of the delivery for nurse with the delivery for nurse with the delivery for nurse with the care and PC document was related for qualified profession people who received (PCA) services (On A-A stated the licent 245D).	evidence if the initial producted in person by the RN, assessment was conducted in ithin 14 days after the date is were first provided, and and reassessment not to im the last date of the dition, the assessment lacked individualized review of C4 to assessment. Entation on assessments for as "Covid-19 Compromised" insible party signature." at 10:15 a.m. administrator dinurse (RN)-B verified C1, is records lacked the above. It is recorded to lacked the above. It is recorded	0 860			
0 865 SS=E	144A.4791, Subd. 9 Implementation & F		0 865			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 33 of 140

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		H21537	B. WING		04/	29/2022
	PROVIDER OR SUPPLIER	1032 157	DDRESS, CITY, S	TATE, ZIP CODE		
GLOBAL	- HOME HEALTH CAR	ROCHES	TER, MN 559	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 865	Continued From page 33		0 865			
	revisions to service days after the date	an, implementation, and plan. (a) No later than 14 that home care services are me care provider shall finalize rvice plan.				
	include a signature home care provider client's representation the services to be must be revised, if review or reassess 8. The provider muclient about change	n and any revisions must or other authentication by the rand by the client or the ive documenting agreement be provided. The service plan needed, based on client ment under subdivisions 7 and st provide information to the es to the provider's fee for a contact the Office of the ong-Term Care.				
		provider must implement and required by the current				
	must be entered int	n and revised service plan to the client's record, including in a client's fees when				
		nome care services must be rent written service plan.				
	by: Based on observation review failed to ensign plan no later than 1 home care services of the service plan occurred and signal	ent is not met as evidenced ion, interview and record ure finalization of a service 4 days after the date that swere first provided, revision when changes in services tures for six of six clients (C1, i) with records reviewed.				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 34 of 140

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			D WING			
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD 1032 15T		STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	PE INC	TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	Continued From pa	ge 34	0 865			
	This practice result violation that did no safety but had the p client's health or sa cause serious injur was issued at a partimited number of a limited number of situation has occur found to be pervasion. The findings include C1 C1's Service Agree indicated provided dressing, positionin bathing, mobility, lig "refer to client care"	ed in a level two violation (a of harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than is staff are involved, or the red repeatedly; but is not ve).				
	On April 27, 2022, a visit, C1 was obser with unlicensed per ULP-E stated C1 re two times a week a complete per the placed a gait be exercises, monitore prevent falling, and exercise. ULP-E fu with medication rendressing, transfers, laundry. C1's Service Agree	at 11:45 a.m. during a home ved seated in a wheelchair sonnel (ULP)-E present. eceived physical therapy (PT) and C1 had exercises to hysical therapist. ULP-E stated elt on C1 before C1 started the ed C1 during leg exercises to assisted C1 with walking of the stated she assisted C1 minders, showering, toileting, housekeeping, meals and ment lacked revision for se for exercises, toileting and				

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUIDENTIFICATIO		` '	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
GLOBAL	HOME HEALTH CAR	RE INC	1032 15TI ROCHES	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIE Y MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 865	Continued From particles of C2 C2's start of care decay C2's Client Care Plindicated provided behavior, positioning bathing, mobility, to light housekeeping. On April 27, 2022, a visit, C2 was obserpresent. ULP-F standressing, showers, medications, transf housekeeping, meaverified by C2. ULI prescription creams needed, as C2's "s clotrimazole 1% crepowder (antifungal) stated the ULP also blood sugar four tintime a nurse came 2019. C2's record lacked plan no later than 1 were first provided. C3 C3's Service Agree indicated provided toileting, eating/me mobility, grooming, laundry and "refer the area for signatures on had docume COVID-19." C3's Client Care Pl	ate was August 1 an dated August services included ng, grooming, trai pileting, medication and laundry. at 12:45 p.m. dur ved lying in bed we ted he assisted of reminders to take fers, toileting, per als and laundry, we p-F further stated services included to reminded her to the assisted of reminded her to the assisted of reminders to take the and laundry, we p-F further stated to reminder her to the care for the characteristic of the days after the of the client of the client/re tented "compromi-	4, 2021, d dressing, nsfers, on reminders, ing a home with ULP-F 22 with e i cares, which was d he "applied lds when ad," to include and Nystop ed by C2. C2 o check her ated the last erson was in alized service date services 13, 2022, d dressing, ng, bathing, ousekeeping, n." In addition, esponsible ised by	0 865			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 36 of 140

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15Th	I AVE SE TER, MN 559	201		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
0 865	indicated to empty when removing the clean the ends with water solution in the for about 10 minute a bowel program extended to with dressing and with transfers using system (ceiling), reunable to do on his propel the wheelche eating/meal prep, hor April 27, 2022, a visit, C3 was observed the catheter bag hung was present. ULP-suppository (laxative week or every othe bowel movement, a transfers using Hoy showers, cleaning I repositioning, cookic changing dressing site and changing overified by C3. C3 hospitalized in Marcatheter placement after being hospital used a catheter leg. C3's Service Agree lacked revision for suprapubic cathete administration of mencourage bowel movement is signature by C3 or	catheter bag and clean daily. covernight bag to the leg bag, alcohol wipe. Put vinegar covernight bag and let soak as and then empty. C3 was on very other day. The care plan and needed complete assistance andressing, bathing, total assist a Hoyer (mechanical lift) or lift positioned every two hours as own, needed someone to air, assistance with grooming, ousekeeping and laundry. at 3:30 p.m. during a home and ULP-G at 3:30 p.m. during a home and bed frame and ULP-G at at 3:30 p.m. during a home are week lying in bed with a Foley on the bed frame and ULP-G as tated he administered a and e medication) one time a are week to C3 to encourage assisted C3 with dressing, are or ceiling lift, grooming, iving space, laundry, and meals and cutting up food, around suprapubic catheter atheter bag weekly which was astated he had been and the nurse had visited ized. C3 stated he no longer	0 865			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 37 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF IDENTIFICATION		` ′	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/2	29/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN / MUST BE PRECEDED SC IDENTIFYING INFO	NCIES D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
	provided. C4 C4's Service Agree indicated provided grooming, transfers eating/meal prep, to laundry, other (doctore plan;" howeve within the same data c4's Client Care Plindicated "has instrexercises and strett needed;" dressing indicated "TED" how brace on left foot,"	services included by bathing, mobility bileting, light house for visit) and "refer, no care plan water range. an dated Septem uctions available ches; provide assistants (compression)	dressing, y, sekeeping, or to client as provided ber 27, 2021, to do sistance as ce and stocking),				
	knee when goes ou grooming, bathing, toileting has a urina assistance as need bag to leg bag and a regular basis;" as laundry. On April 28, 2022, a visit, C4 was obser Foley catheter bag walker and ULP-I wassisted C4 with pu (compression mater removal of brace of catheter bag to a leg	at of the house;" a eating/meal prepary catheter "provided with changing ensuring bags arsist with houseked at 7:30 a.m. during ved seated in a clauding on the lower as present. ULP-atting on Tubigrips erial), putting on a nothe left leg, change bag dressing, s	assist with , transfers; ide from bed e cleaned on eping and g a home hair with a er bar of a el stated he and the nging Foley showers and				
	cooking which was was not using the banymore. C4 stated nurse visited in per and asked how thir	orace to her right led it had been awh son, but the nurse ags were going.	knee ile since the e had called				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 38 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	H AVE SE	20.4		
040.15	CLIMMA DV CTA		TER, MN 559		TION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 865	Continued From page 38		0 865			
	changes in services for Tubigrips on both lower extremities and no use of TED hose and brace to right knee.					
	2021, indicated pro grooming, light hou	ment Plan dated January 21, vided services included sekeeping, laundry and "refer however, no care plan was same date range.				
	C5's Care Plan dated June 15, 2021, indicated C5 required assistance with grooming: applying lotions and creams to areas not able to reach and bathing: limited assistance with bathing, needed help washing back, legs, feet-especially ankles, laundry and housekeeping.					
		at 4:12 p.m. C5 stated ULP oplying lotion, shower, laundry weekly.				
	C5's Service Agree changes in services	ment lacked revision for s for bathing.				
	C6 C6's start of care da	ate was January 28, 2021.				
	indicated provided s mobility, toileting, each housekeeping, laun plan." In addition, t	ment dated June 3, 2021, services included transfers, ating/meal prep, light dry and "refer to client care he area for signature of the erson had documented COVID-19."				
	indicated "provide a stretches;" dressing	an dated June 3, 2021, assistance with exercises and g-she is unable to tie her prep-provide assistance with				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 39 of 140

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION	(X3) DATE S COMPLI	
			A. BUILDING:			
		H21537	B. WING		04/29	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RF INC	TH AVE SE STER, MN 55	904		
(V4) ID	SHIMMADV STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT	ION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 865	Continued From pa	age 39	0 865			
	meal prep; transfer getting into wheelch assistance with get well as on and off the walk very short districts assistance of anothe assistance to transtoilet; assistance with the word lacked plan no later than 1 were first provided lacked signature by documenting agree provided for Service 2021.	rs-required some assistance hair from bed and needs ting on and off the toilet as the shower chair; mobility- can tances with crutches and the ner person; toileting- needs fer from wheelchair onto the with housekeeping and laundry evidence of a finalized services on January 28, 2021, and y C6 or C6's representative ement on the services to be see Agreement dated June 3,	e			
	On April 29, 2022, at 10:15 a.m. administrator (A)-A and registered nurse (RN)-B verified C1, C2, C3, C4, C5 and C6's records lacked the information listed above. At approximately 12:24 p.m., A-A stated reason for visits not being provided in person were related to COVID-19 and the legislature extended remote delivery for nurse visits. A-A provided a document Home Care and PCA Services; however the document was related to allowing remote delivery of qualified professional (QP) services for all people who receive personal care attendant (PCA) services (On April 27, 2022, at 10:16 a.m. A-A stated the licensee did not have a license for 245D). No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days		e			
0 870 SS=F	144A.4791, Subd. 9	9(f) Content of Service Plan	0 870			

6899

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	PE INC	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 870	Continued From pa	ige 40	0 870			
	(f) The service plan	n must include:				
	(1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences;					
	(2) the identification staff who will provide	n of the staff or categories of le the services;				
	(3) the schedule an reviews or assessn	nd methods of monitoring nents of the client;				
	(4) the schedule an providing home car	nd methods of monitoring staff re services; and				
	(5) a contingency p	lan that includes:				
	provider and by the	caken by the home care client or client's e scheduled service cannot be				
	` '	a method for a client or ive to contact the home care				
	client wishes to have	tact information of persons the ve notified in an emergency or ant adverse change in the nd				
	(iv) the circumstances in which emergency medical services are not to be summoned consistent with chapters 145B and 145C, and declarations made by the client under those chapters.					

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1032 15TH AVE SE ROCHESTER, MN 55904 [X4] ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to ensure the service plan included all the required content for isx of six clients (C1, C2, C3, C4, C5, C6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include:		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED
GLOBAL HOME HEALTH CARE INC (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY) DEFICIENCY) 0 870 Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to ensure the service plan included all the required content for six of six clients (C1, C2, C3, C4, C5, C6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).			H21537	B. WING		04/	29/2022
CAJ ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) COMPLETE DEFICIENCY	NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 0 870 Continued From page 41 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to ensure the service plan included all the required content for six of six clients (C1, C2, C3, C4, C5, C6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).	GLOBAL	L HOME HEALTH CAF	SE INC	_	904		
This MN Requirement is not met as evidenced by: Based on observation, interview and document review the licensee failed to ensure the service plan included all the required content for six of six clients (C1, C2, C3, C4, C5, C6) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
C1 C1's Service Agreement dated October 27, 2021, indicated provided services included dressing, positioning, grooming, transfers, bathing, mobility, light housekeeping, laundry and "refer to client care plan." C1's Client Care Plan dated October 27, 2021, indicated the same. C1's Service Agreement lacked provision of services for exercises, toileting and medication reminders. On April 27, 2022, at 11:45 a.m. during a home visit, C1 was observed seated in a wheelchair with unlicensed personnel (ULP)-E present. ULP-E stated C1 received physical therapy (PT) two times a week and C1 had exercises to complete per the physical therapist. ULP-E stated she placed a gait belt on C1 before C1 started the exercises, monitored C1 during leg exercises to prevent falling and assisted C1 with walking exercise LII P.= further stated she assisted C1	0 870	This MN Requirem by: Based on observat review the licensee plan included all the clients (C1, C2, C3 reviewed. This practice result violation that did no safety but had the polient's health or sa cause serious injur was issued at a wide problems are pervate failure that has affer a large portion or an	ent is not met as evidenced ion, interview and document e failed to ensure the service e required content for six of six, C4, C5, C6) with records ted in a level two violation (a ot harm a client's health or potential to have harmed a afety, but was not likely to ry, impairment, or death), and despread scope (when asive or represent a systemic ected or has potential to affect all of the clients). The entry and "refer to client lient Care Plan dated October I the same. C1's Service provision of services for and medication reminders. The entry and the present. The eceived physical therapist. ULP-E state and C1 had exercises to hysical therapist. ULP-E state and C1 during leg exercises to assisted C1 with walking	x , y,			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 42 of 140

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
GLOBAL	- HOME HEALTH CAR	TE INC 1032 15T	H AVE SE			
GLOBAL	TIOME HEALTH CAN	ROCHES	TER, MN 559	04		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 870	Continued From pa	ge 42	0 870			
		ninders, showering, toileting, housekeeping, meals and				
	"qualified professio PCAs [personal car plan of care. Private less than every 90 require a visit no less than every 90 require a visit no less than every 90 require a visit must be and the responsible order to ensure proto complete the docrequired by the stat Plan: If we are unall as agreed upon, the client; arrange for a the client with the nalternative home he vicinity and make reclient in contacting	nent/care plan indicated nal visits are mandatory for all re attendant] and oversee the pay clients require a visit no days. Other payer sources as than every 60 days. The with recipient of the services party if one is assigned in per provision of services and cumentation/assessments e of Minnesota." "Contingency ole to meet your current needs en [the licensee] will notify the another appointment; provide ames and numbers of ealth agencies within the easonable effort to assist the an alternative provider." The indicated "CPR/attempt"				
	October 27, 2021, v Service Agreement where an unforesed to be unable to pro- the plan will be that in every way to sec If the company is u replacement staffin available the plan is caregiver(s) who wi [person was listed]. are not available to care, and the comp	ency Backup Plan dated was not referenced on the and indicated "In the situation en event causes the company vide adequately trained staff, : a. The company will attempt ure immediate trained staff. b. nable to secure immediate g and no other trained staff is a to notify the following backup ill provide backup care: c. if the backup caregiver(s) provide immediate backup vany is unable to locate aff the plan is to admit the				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 43 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC 1032 15TI	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
	adequately trained client at home." C1's Service Agree - a description of the provided, the fees for each service, acreview or assessmenthe identification of staff who will providenthe schedule and	spital [was checked]. Until staff is ready to care for the sment lacked the following: we home care services to be for services, and the frequency cording to the client's current ent and client preferences; of the staff or categories of the services; methods of monitoring ments of the client (initial, 14				
	day, 90 day and ch- the schedule and providing home car a contingency pla (i) the action to be to provider and by the representative if the provided; (iv) the circumstance medical services and consistent with chat declarations made	ange in condition); methods of monitoring staff re services; and n that includes: taken by the home care				
	C2's record lacked plan no later than 1 were first provided. C2's Client Care Pl indicated provided behavior, positionir	an dated August 4, 2021, services included dressing, ng, grooming, transfers, oileting, medication reminders,				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 44 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			א. שטונטוואט:			
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC 1032 15TI	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO	JLD BE	(X5) COMPLETE DATE
17.00		,	1,10	DEFICIENCY)		
0 870	Continued From pa	ige 44	0 870			
	visit, C2 was obser was present. ULP-I dressing, showers, medications, transf housekeeping, med verified by C2. ULF prescription creams needed, as C2's "s were clotrimazole 1 Nystop powder (an C2. C2 stated the check her blood su stated the last time person was in 2019	ers, toileting, peri cares, als and laundry which was 2-F further stated he "applied s" to C2's skin folds when kin breaks out bad," which % cream (antifungal) and tifungal) which was verified by ULP also reminded her to gar four times a day. C2 a nurse came to her home in 3.				
	following: - a description of the provided, the fees of of each service, actively of each service, actively of each service, actively of each service the identification of staff who will provide the schedule and reviews or assessed day, 90 day and chorous of the schedule and providing home cares a contingency pla (i) the action to be provider and by the representative if the provided; (ii) information and client's representative provider; (iii) names and continued of the provider; (iii) names and continued of the provider; (iii) names and continued of the provided of the provider; (iii) names and continued of the provider of the provider; (iii) names and continued of the provided of the pro	methods of monitoring nents of the client (initial, 14 ange in condition); methods of monitoring staff re services; and n that includes: taken by the home care				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 45 of 140

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED	
		H21537	B. WING		04/	29/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	TH AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
0 870	client's condition; and (iv) the circumstance medical services are consistent with chard declarations made chapters (code state directive). C3 C3's Service Agree indicated provided stoileting, eating/mea mobility, grooming, laundry and "refer to the area for signature person had docume COVID-19." C3's Client Care Plaindicated C3 needed cleaned daily. When to the leg bag, cleaned daily. When to the leg bag, cleaned to the leg bag, cleaned cleaned daily. When to the leg bag, cleaned cleaned daily. When to the leg bag, cleaned daily. When to the leg bag, cleaned cleaned daily. When the leg	ant adverse change in the nd ces in which emergency re not to be summoned pters 145B and 145C, and by the client under those cus/living will/health care ment dated April 13, 2022, services included dressing, al prep, positioning, bathing, transfers, light housekeeping o client care plan." In addition are of the client/responsible ented "compromised by an dated April 13, 2022, and catheter bag emptied and an removing the overnight bag out 10 minutes and then a bowel program every other further indicated C3 needed		DELIGIONE I I		
	On April 27, 2022, a	at 3:30 p.m. during a home				

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Minnesota Department of Health

STATEMENT OF DEFIC			DER/SUPPLIER/CLIA FICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE	SURVEY PLETED
				A. BUILDING:			
		H215	37	B. WING		04/2	29/2022
NAME OF PROVIDER (OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL HOME H	EALTH CAF	RE INC	1032 15TI ROCHES	HAVE SE FER, MN 559	904		
PRÉFIX (EAC	H DEFICIENC		DEFICIENCIES ECEDED BY FULL NG INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
visit, C3 catheter was pre supposi week or bowel m transfer showers reposition changed site and verified hospital catheter after being used a compact of the seminary of the seminary of the part of the seminary of the semin	bag hung sent. ULP-tory (laxative every other overment, a red using heart changed of the sent ing hospital catheter legal vice agreer d profession oversee equire a visat assigned in of service assigned in of service intation/assigned in of service intation assigned in of service intation assigned in of service intation assigned in other intation and interior indicate inte	ved lying in on the bed G stated here medication week to Consisted C3 loyer or ceil iving space ed meals a around support atheter bag stated he had been consisted and the nutized. C3 stated he had been consisted in the plan of sit no less the sand to consiste and the nutices and to consiste and the sand numbers and numbers and numbers within the fort to assistant of consistence of consi	nd cut up food, rapubic catheter y weekly which was	0 870			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H2153	37	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	1032 15TI ROCHES	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
0 870	Continued From paran unforeseen ever unable to provide a plan will be that: a. every way to secure the company is unareplacement staffin available the plan is caregiver(s) who w [persons were listerare not available to care, and the compadequate trained stabove client to: hos adequately trained client at home." C3's Service Agree - a description of the provided, the fees for each service, acreview or assessment of each service, acreview or assessment identification of staff who will provided. The schedule and providing home care a contingency pla (i) the action to be the provided; (iv) the circumstant medical services and consistent with chadeclarations made chapters (lacked in care directive).	nt causes the dequately transparent lacked and lacked la	ained staff, the ny will attempt in trained staff. b. If the immediate ner trained staff is e following backup ackup care: backup caregiver(s) nediate backup le to locate is to admit the necked]. Until y to care for the If the following: e services to be and the frequency ne client's current at preferences; r categories of les; monitoring client (initial, 14 dition); monitoring staff and les: home care ent's service cannot be emergency summoned and 145C, and a under those	0 870			

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DAT COM		
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	TH AVE SE	0.4		
(VA) ID	SLIMMADV STA	TEMENT OF DEFICIENCIES	STER, MN 559	PROVIDER'S PLAN OF	COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 870	C4 C4's Service Agree indicated provided grooming, transfers eating/meal prep, to laundry, other (door care plan;" howeve within the same date C4's Client Care Plandicated "has instrexercises and stret needed;" dressing indicated "TED" how "brace on left foot," knee when goes ou grooming, bathing, toileting has a urina assistance as need bag to leg bag and a regular basis;" as laundry. C4's Serv provision of service extremities. On April 28, 2022, a visit, C4 was obsert Foley catheter bag walker and ULP-I wassisted C4 with put (compression mater brace on left leg, challeg bag dressing, was verified by C4. the brace to her righad been awhile sin but the nurse had owere going.	ment dated July 7, 2021, services included dressing, s, bathing, mobility, bileting, light housekeeping, tor visit) and "refer to client r, no care plan was provided the range. an dated September 27, 2021 auctions available to do ches; provide assistance as requires assistance and se (compression stocking), "assist with brace to R [right] at of the house;" assist with eating/meal prep, transfers; any catheter "provide led with changing from bed ensuring bags are cleaned or sist with housekeeping and ice Agreement lacked as for Tubigrips on both lower at 7:30 a.m. during a home wed seated in a chair with a hung on the lower bar of a was present. ULP-I stated he	of			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 49 of 140

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:				LETED
	H21537	B. WING		04/2	9/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CLOBAL HOME HEALTH CAR	1032 15TH	I AVE SE			
GLOBAL HOME HEALTH CAR	ROCHEST	ER, MN 559	904		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 870 Continued From page	Continued From page 49				
"qualified profession PCAs and oversee clients require a visi Other payer sources every 60 days. The recipient of the servifi one is assigned in provision of services documentation/asses state of Minnesota.' unable to meet your upon, then [the licer arrange for another client with the name home health agenci make reasonable ercontacting an altern agreement indicated. C4's Client Emerge 2021, was not referr Agreement and indicate an unforeseen ever unable to provide act plan will be that: a. every way to secure the company is una replacement staffing available the plan is caregiver(s) who will person(s) were listed caregiver(s) are not immediate backup of unable to locate add to admit the above of circled) hospital/nur	nal visits are mandatory for all the plan of care. Private pay it no less than every 90 days. It is require a visit no less than RNQP visit must be with rices and the responsible party is order to ensure proper is and to complete the essments required by the responsible party in order to ensure proper is and to complete the essments required by the recurrent needs as agreed in see] will notify the client; appointment; provide the ess and numbers of alternative it is within the vicinity and affort to assist the client in the recurrent needs as agreed in the service of received "CPR/attempt resuscitation." Incy Backup Plan dated July 7, enced on the Service of the causes the company to be dequately trained staff, the The company will attempt in the immediate trained staff, the The company will attempt in the immediate trained staff is to notify the following backup and no other trained staff is to notify the following backup available to provide care, and the company is equate trained staff the plan is client to: (no listed place or sing home/skilled nursing until adequately trained staff	0 870			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 50 of 140

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	N OF CORRECTION	IDENTIFICATION NUMBER:	` ′			LETED
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GI ORAI	L HOME HEALTH CAR	1032 15TH	I AVE SE			
GLOBAI	L HOWE REALTH CAN	ROCHEST	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 870	Continued From pa	ge 50	0 870			
	- a description of the provided, the fees for each service, acceptive or assessment in identification of staff who will provide the schedule and reviews or assessment as a contingency plant (i) the action to be the provider and by the representative if the provided; (iv) the circumstant medical services are consistent with chadeclarations made	e home care services to be for services, and the frequency cording to the client's current ent and client preferences; of the staff or categories of the staff or categories of the services; methods of monitoring nents of the client (initial, 14 ange in condition); methods of monitoring staff re services; and in that includes: taken by the home care				
	2021, indicated pro grooming, light hou to client care plan;" provided within the C5's Care Plan data needed assistance lotions and creams bathing: limited asshelp washing back, laundry and housel Agreement lacked bathing.	ed June 15, 2021, indicated with grooming: applying to areas not able to reach and istance with bathing, needed legs, feet-especially ankles, seeping. C5's Service provision of service for				
	reviews or assessinday, 90 day and chi- the schedule and providing home car- a contingency plai (i) the action to be the provider and by the representative if the provided; (iv) the circumstant medical services and consistent with chard declarations made chapters (lacked in care directive). C5 C5's Service Agree 2021, indicated progrooming, light hou to client care plan; provided within the C5's Care Plan data needed assistance lotions and creams bathing: limited assistance lotions and creams bathing and housely Agreement lacked bathing.	nents of the client (initial, 14 ange in condition); methods of monitoring staff re services; and in that includes: aken by the home care client or client's escheduled service cannot be sees in which emergency re not to be summoned pters 145B and 145C, and by the client under those dication if had living will/health ment Plan dated January 21, vided services included sekeeping, laundry and "refer however, no care plan was same date range. ed June 15, 2021, indicated with grooming: applying to areas not able to reach and distance with bathing, needed legs, feet-especially ankles, seeping. C5's Service				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 51 of 140

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING: AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
H21537 B. WING	04/29/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1032 15TH AVE SE ROCHESTER, MN 55904	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR. PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLET
assisted her with applying lotion, shower, laundry and housekeeping weekly. The service agreement/care plan indicated "qualified professional visits are mandatory for all PCAs and oversee the plan of care. Private pay clients require a visit no less than every 90 days. Other payer sources require a visit no less than every 60 days. The RNQP visit must be with recipient of the services and the responsible party if one is assigned in order to ensure proper provision of services and to complete the documentation/assessments required by the state of Minnesota." "Contingency Plan: If we are unable to meet your current needs as agreed upon, then [the licensee] will notify the client; arrange for another appointment; provide the client with the names and numbers of alternative home health agencies within the vicinity and make reasonable effort to assist the client in contacting an alternative provider." The service agreement indicated "CPR/attempt resuscitation." C5's Service Agreement lacked the following: - a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessments of the client (initial, 14 day, 90 day and change in condition); - the schedule and methods of monitoring reviews or assessments of the client (initial, 14 day, 90 day and change in condition); - the schedule and methods of monitoring staff providing home care services; and - a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) the circumstances in which emergency medical services are not to be summoned	

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 52 of 140

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH				
		ROCHEST	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 870	Continued From pa	ge 52	0 870			
	consistent with chapters 145B and 145C, and declarations made by the client under those chapters (lacked indication if had living will/health care directive).					
	indicated provided a mobility, toileting, e housekeeping, laur plan." In addition, t client/responsible p "compromised by C Agreement lacked	ment dated June 3, 2021, services included transfers, ating/meal prep, light adry and "refer to client care he area for signature of the erson had documented COVID-19." The Service signature by C6 or C6's umenting agreement on the ided.				
	indicated "provide a stretches;" dressing shoes; eating/meal meal prep; transfer getting into wheelch assistance with get well as on and off the walk very short dist assistance of anoth assistance to transitoilet; assistance with the service agreen "qualified professio PCAs and oversee clients require a vison Other payer source every 60 days. The recipient of the servif one is assigned in provision of service	an dated June 3, 2021, assistance with exercises and g-she is unable to tie her prep-provide assistance with s-requires some assistance nair from bed and needs ting on and off the toilet as the shower chair; mobility-can ances with crutches and the per person; toileting- needs fer from wheelchair onto the with housekeeping and laundry. The plan of care. Private pay it no less than every 90 days, as require a visit no less than RNQP visit must be with vices and the responsible party in order to ensure proper is and to complete the essments required by the				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 53 of 140

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUI IDENTIFICATIO		1 ' '	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAI	- HOME HEALTH CAF	RE INC	1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIE / MUST BE PRECEDE SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
0 870	Continued From pastate of Minnesota. unable to meet you upon, then [the lice arrange for another client with the name home health agence make reasonable econtacting an alternagreement indicate. C6's Service Agreetenthe fees for service, according assessment and clean the schedule and reviews or assessment and clean the schedule and providing home carea contingency pla (i) the action to be provider and by the representative if the provided; (iv) the circumstance medical services and consistent with chard declarations made chapters (lacked in care directive). On April 29, 2022, (A)-A and registere C2, C3, C4, C5 and information listed a did not have an agriprovider for provision was unable to prov A-A and RN-B verifications would lack the same	" "Contingency Procurrent needs ansee] will notify the appointment; process and numbers are seen and numbers and responsible to the client's current preferences; methods of monitoring ange in condition methods of monitoring eservices; and in that includes: taken by the homological condition of the client or client's escheduled services in which emerge not to be summit to be summit to be summit to the client under the client under the client or client under the client under the client of the client under the client of the client under the client	as agreed the client; ovide the of alternative inity and client in The service resuscitation." following: lency of each rent review or itoring t (initial, 14); itoring staff te care lice cannot be lice cannot be lice cannot be lice those ling will/health ministrator rerified C1, cked the the licensee other the licensee for the clients. lice plans	0 870			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 54 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	I AVE SE ER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 870	methods of monitor the client and the so monitoring staff pro No further informati	ing reviews or assessments of chedule and methods of viding home care services.	0 870			
0 880 SS=D	Investigative Process Subd. 11.Client comprocess. (a) The howritten policy and syinvestigating, report complaints from its representatives. The the process by which or concern about he explicit statement the not discriminate or expressing concern provider must have investigations of country the client's represented client's plan that or other items cover bill of rights. This correasonable accommeds of the client or requested. (b) The home care complaint, name of resolution of each of provider must main regarding complaint.	nplaint and investigative ome care provider must have a ystem for receiving, ing, and attempting to resolve	0 880			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
A. BOLDING.	
H21537 B. WING	04/29/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
GLOBAL HOME HEALTH CARE INC 1032 15TH AVE SE ROCHESTER, MN 55904	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHITTED TRANSPORT TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPLICATION TO T	OULD BE COMPLETE
O 880 Continued From page 55 provider's investigation and resolution of the complaint. This complaint record must be kept for each event for at least two years after the date of entry and must be available to the commissioner for review. (c) The required complaint system must provide for written notice to each client or client's representative that includes: (1) the client's right to complain to the home care provider about the services received; (2) the name or title of the person or persons with the home care provider to contact with complaints; (3) the method of submitting a complaint to the home care provider; and (4) a statement that the provider is prohibited against retaliation according to paragraph (d). (d) A home care provider must not take any action that negatively affects a client in retaliation for a complaint made or a concern expressed by the client or the client's representative. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to give complaint notice to one of six clients (C2) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety, but was not likely to cause serious injury, impairment, or death), and	

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 56 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	FINC	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
0 880	Continued From pa	ge 56	0 880			
	limited number of s	lients are affected or one or a taff are involved or the red only occasionally).				
	The findings include	e:				
	C2's start of care da	ate was August 1, 2017.				
	provided written not	e licensee's complaint and				
	(A)-A and registered record lacked evide written notice to C2	at 10:15 a.m. administrator d nurse (RN)-B verified C2's ence the licensee had provided or C2's representative of the t and investigative process.				
	No further informati	on was provided.				
	TIME PERIOD TO days	CORRECT- Twenty-one (21)				
0 885 SS=F	144A.4791, Subd. 1 Preparedness Plan	12 Disaster/Emergency ning	0 885			
	preparedness plan. have a written plan management of the response to a natur storms, or other em the home care provservices. The licens	planning and emergency The home care provider must of action to facilitate the client's care and services in al disaster, such as flood and tergencies that may disrupt ider's ability to provide care or see must provide adequate ning of staff on emergency				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED
	H21537	B. WING		04/	29/2022
NAME OF PROVIDER OR SUPPLI	ER STREET.	ADDRESS, CITY, S	TATE, ZIP CODE		
GLOBAL HOME HEALTH C	ARF INC	TH AVE SE STER, MN 559	04		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
by: Based on intervilicensee failed to procedures related flood and storms disrupt the home care or services. This practice residuation that did safety but had the client's health or cause serious in was issued at a problems are perfailure that has a large portion on the findings included from the findings from the findings from the findings for interview for the findings for interview for work place violety for work place violety for work place violety for process from the findings from the findings for interview for the findings fo	ement is not met as evidenced ew and document review the ensure written plan of action for ed to natural disaster, such as or other emergencies that may care provider's ability to provide ulted in a level two violation (a not harm a client's health or e potential to have harmed a safety, but was not likely to lury, impairment, or death), and widespread scope (when revasive or represent a systemic ffected or has potential to affect all of the clients).	d d			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 58 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 885	sudden loss of lead was moderate; Oth high and Other for tinternal and external The licensee provid Suspect or Confirm COVID-19, but lack written plan of action identified emergency Hazard Vulnerability On April 29, 2022, a (A)-A verified the alternal for policies related to the No further information of the policies related to the policies	dership, fuel shortage (gas) eer for supply shortage was eransportation failure, fire al was low. Ided a Interim Policy for ed Cases and Exposure to ed evidence of any other in for procedures for the above sies identified in the licensee's y Analysis as above. at 12:24 p.m. administrator bove. A-A stated he would look to emergencies. Ion was provided. R CORRECTION:	0 885			
0 900 SS=F	Subdivision 1.Media comprehensive hor subdivision applies with a comprehensiprovide medication clients. Medication not be provided by a basic home care (b) A comprehensive provides medication develop, implement medication manage procedures. The possible of the subdivision of the provides medication manage procedures.	I Medication Management; cation management services; ne care license. (a) This only to home care providers ive home care license that management services to management services may a home care provider who has license. The home care provider who management services must t, and maintain current written	0 900			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 59 of 140

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health

MILLIOSC	na Department of Tie	, aitii				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u> </u>	COMP	LETED
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1032 15TH	HAVE SE			
GLOBAL	. HOME HEALTH CAR	RE INC	ΓER, MN 55	904		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	 N	(X5)
PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF	RIATE	DATE
				,		
0 900	Continued From pa	ige 59	0 900			
	a registered nurse.	licensed health professional,				
		istent with current practice				
	standards and guid					
		cies and procedures must				
	for medications; pre	and receiving prescriptions				
		ng that prescription drugs are				
		escribed; documenting				
		ement activities; controlling				
		tions; monitoring and				
		ion use; resolving medication				
		ting with the prescriber,				
		ent and client representative, if				
		nused medications; and				
		nd client representatives about controlled substances are				
		ored, and secured by the				
		ne care provider, the policies				
		ust also identify how the				
		security and accountability for				
		ment, control, and disposition				
		s in compliance with state and				
	federal regulations	and with subdivision 22.				
	This MN Requirem	ent is not met as evidenced				
	by:					
		and record review, the				
		evelop, implement and				
	maintain up-to-date					
		es and procedures as				
	required.					
	This practice result	ed in a level two violation (a				
		ot harm a client's health or				
		ootential to have harmed a				
	client's health or sa	fety, but was not likely to				
		y, impairment, or death), and				
		despread scope (when				
	problems are perva	sive or represent a systemic				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 60 of 140

winnesc	ita Department of He	eaith				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 900	Continued From pa	ge 60	0 900			
	failure that has affe a large portion or al	cted or has potential to affect ll of the clients).				
	The findings include	e:				
	visit, C2 was obserwas present. ULP-Freminders to take numbers of take numbers of the prescription creams needed, as C2's "sluwere clotrimazole 1 Nystop powder (and C2.	at 12:45 p.m. during a home wed lying in bed and ULP-F stated he assisted C2 with nedications and he "applied s" to C2's skin folds when kin breaks out bad," which % cream (antifungal) and tifungal) which was verified by				
	visit, C3 was obser- catheter bag hung of was present. ULP-0 suppository (laxativ	at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G 3 stated he administered a re medication) one time a reweek to C3 to encourage				
	management polici addressed the follor - requesting and re- medications; - controlling and storal - communicating with and client and client - disposing of unuser	ceiving prescriptions for				
		at 9:00 a.m., administrator I no further policies than what				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 61 of 140

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION (X3) DATE S BUILDING:		
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHES	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 900	Continued From pa	ge 61	0 900			
	No further informati	on was provided. CORRECT- Seven (7) days.				
0 905 SS=D		Provision of Medication Mgt	0 905			
	services. (a) For ea medication manage comprehensive hon providing medication a registered nurse, or authorized presc conduct an assess medication manage provided and how the This assessment mover the client. The identification and reclient is known to be identification must in medications, side eallergic or adverse address these issue	ne care provider shall, prior to n management services, have licensed health professional, riber under section 151.37 ment to determine what ement services will be ne services will be provided. The services will be provided and the conducted face-to-face assessment must include an exiew of all medications the exaking. The review and include indications for ffects, contraindications, reactions, and actions to ess.				
		tions needed in management				
		revent diversion of medication ers who may have access to ad				
	representative on in	ons to the client or client's aterventions to manage the and prevent diversion of				

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 905	theft, or illegal or in medications. This MN Requiremaby: Based on observation review, the licensed providing medication registered nurse (Rassessment, which information for two receiving medication. This practice result violation that did not safety but had the polient's health or sacause serious injurning was issued at an islimited number of situation has occur. The findings including deafness. On April 27, 2022, a visit, C2 was observas present. ULP-I reminders to take many applied prescription when needed, as Camedications were contacted.	cations" means the misuse, approper disposition of the sent is not met as evidenced ion, interview and record a failed to ensure prior to an management services, the sent included all of the required of two clients (C2, C3) ans, with records reviewed. The sent is not met as evidenced ion, interview and records an included all of the required of two clients (C2, C3) ans, with records reviewed. The sent is not met as evidenced an included all of the required of two clients (C2, C3) ans, with records reviewed. The sent is not met as evidenced an included all of the required of two clients are alient's health or contential to have harmed a sent included scope (when one or a sent included scope (when one or a sent included or the red only occasionally).		DELIVORY)		

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 63 of 140

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	RE INC	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 905	Continued From pa	ge 63	0 905			
	C3 C3 had an admission with diagnoses inclived with diagnoses inclived on April 27, 2022, a visit, C3 was observed the catheter bag hung was present. ULP-compository (laxatived week or every other bowel movement, which with the client, which review of all medications of interesting for the following for the client or others medications, and actional cidentity intervention medications; and provide instruction representative on inclient's medications medications. On April 26, 2022, a (A)-A and registere licensee did not provide instructions.	on date of January 1, 2015, uding paraplegia. at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G a stated he administered a re medication) one time a reweek to C3 to encourage which was verified by C3. Is lacked a medication RN conducted face-to-face the included identification and ations the client was known to llowing: dications for medications, side ations, allergic or adverse ons to address these issues; ons needed in management of went diversion of medication by who may have access to the set and prevent diversion of manage the set and prevent diversion of management of the client or client's and prevent diversion of management they provided the service of				
	and C3 lacked a massessment. RN-E	at 10:15 a.m. RN-B verified C2 edication management stated she was not aware the the above medication				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 64 of 140

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	I AVE SE [ER, MN 55!	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 905	administration. The licensee's Med undated, indicated the assessment include the patient is currer any potential adversinteractions, ineffects side effects, significal duplicate drug therapy. The nucompleted by an RN No further information.	ication Administration policy the comprehensive medication as a review of all medications atly using in order to identify se effects and drug tive drug therapy, significant that drug interactions, apy and non compliance with medication review was N.	0 905			
0 920 SS=D	Mgt Plan Subd. 5.Individualiz plan. (a) For each of management service care provider must service plan a writte management service client. The provider current individualize record for each client assessment that must be management services (2) a description of on the client's need.	ed medication management elient receiving medication ees, the comprehensive home prepare and include in the en statement of the medication ees that will be provided to the must develop and maintain a ed medication management ent based on the client's east contain the following: cribing the medication ees that will be provided; storage of medications based is and preferences, risk of istent with the manufacturer's	0 920			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		H2153	7	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	1032 15TI ROCHES	Η AVE SE ΓER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 920	Continued From partial (3) documentation relating to the admit (4) identification of monitoring medicate medication refills at (5) identification of tasks that may be opersonnel; (6) procedures for an an appropriate when a problem are management service (7) any client-specifications that all as prescribed, and to prevent possible reactions. (b) The medication current and update changes. (c) Medication recomben a licensed nuprofessional, or automedication managements and update changes. This MN Requirem by: Based on observative review, the licensed include all the requirements (C2, C3) which is the admits a prescribed and the requirements (C2, C3) which is the admits a prescribed and the all the requirements (C2, C3) which is the admits a prescribed and the admits a prescribed and the all the requirements (C2, C3) which is the admits a prescribed and the	of specific clinistration of persons respicion supplies re ordered or medication in delegated to use taff notifying te licensed he ises with medication administration administration administration administration management discontinuity medication multiples, licensed thorized prespication interview the failed to decation managined content for the content of the co	medications; consible for and ensuring that a timely basis; management unlicensed y a registered ealth professional dication ents relating to istration, are administered f medication use as or adverse at record must be are any est be completed if health criber is providing et as evidenced y, and record velop a current gement plan to for two of two	0 920			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 66 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	H AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
0 920	Continued From pa	ge 66	0 920			
	records reviewed.	records reviewed.				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an iso limited number of c limited number of s situation has occurr	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and polated scope (when one or a lients are affected or one or a taff are involved or the red only occasionally).				
	The findings include	9:				
		on date of August 1, 2017 with g spinal stenosis and				
	visit, C2 was observant was present. ULP-Freminders to take multiple prescription creams needed, as C2's "sk medications were compared to the	at 12:45 p.m. during a home wed lying in bed and ULP-F stated he assisted C2 with nedications and he "applied s" to C2's skin folds when kin breaks out bad." The lotrimazole 1% cream stop powder (antifungal) which				
	C3 C3 had an admission with diagnoses included	on date of January 1, 2015, uding paraplegia.				
	visit, C3 was observed the catheter bag hung of was present. ULP-C suppository (laxative week or every other	at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G stated he administered a e medication) one time a r week to C3 to encourage which was verified by C3				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 67 of 140

STATEMENT	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMP	
AND LEAN	5. JOHNLOHON	DENTIFICATION NOWIDER.	A. BUILDING:			
		H21537	B. WING		04/2	9/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TI	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 920	Continued From pa	ge 67	0 920			
	C2 and C3's record medication manage following: - a statement descrimanagement service a description of st on the client's need diversion, and considerations; - documentation of relating to the admitication refills are identification of monitoring medicat medication refills are identification of methat may be delegated a procedures for state or appropriate licentation appropriate licentation appropriate licentation appropriate licentation appropriate licentation appropriate licentations appropriate licentations and to prevent possible reactions On April 26, 2022, at (A)-A and registered licensee did not proservices, but provided to appropriate licensee did not proservices, but provided to April 29, 2022, and C3's records lashe was not aware above medication and The licensee's Medications.	is lacked an individualized ement plan to include the ribing the medication ces that will be provided; orage of medications based is and preferences, risk of instent with the manufacturer's specific client instructions instration of medications; ersons responsible for ion supplies and ensuring that re ordered on a timely basis; edication management tasks ted to unlicensed personnel; aff notifying a registered nurse sed health professional when ith medication management requirements relating to cation administration, medications are administered monitoring of medication use complications or adverse at 2:11 p.m. administrator dinurse (RN)-B stated the vide medication reminders. at 10:15 a.m. RN-B verified C2 cocked the above. RN-B stated the ULP were providing the				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 68 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
0 920	Continued From pa	ge 68	0 920			
	completed by an RN.					
	No further information was provided.					
	TIME PERIOD TO	CORRECT- Seven (7) days.				
0 930 SS=D	144A.4792, Subd. 7 Administration	Delegation of Medication	0 930			
	When administration to unlicensed person	of medication administration. on of medications is delegated onnel, the comprehensive must ensure that the s:				
	proper methods to and the unlicensed	nlicensed personnel in the administer the medications, personnel has demonstrated tently follow the procedures;				
		ing, specific instructions for umented those instructions in and				
		with the unlicensed personnel needs of the client.				
	by: Based on observation review, the licenseed registered nurse (Respecific instructions documented those records and community personnel (ULP) and client for two of two medications, and has	on, interview and record e failed to ensure the N) had specified, in writing, for each client and instructions in the client's unicated with the unlicensed out the individual needs of the clients (C2, C3) who received ad instructed the ULP in the administer the medications,				

Millinesc	ota Department of He	aiti				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		1032 15Th	AVE SE	,		
GLOBAL	. HOME HEALTH CAR	EINC	ΓER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPROPROPERTY)	D BE	(X5) COMPLETE DATE
0 930	Continued From pa	ge 69	0 930			
	and the ULP had demonstrated the ability to competently follow the procedures for two of four unlicensed personnel (ULP-G and ULP-F) with records reviewed.					
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).					
	The findings include	e:				
		on date of August 1, 2017, with g spinal stenosis and				
	visit, C2 was observed present. ULP-F state reminders to take numbers prescription creams needed, as C2's "state medications were continuous present the continu	at 12:45 p.m. during a home wed lying in bed with ULP-F ted he assisted C2 with nedications and he "applied" to C2's skin folds when kin breaks out bad." The lotrimazole 1% cream stop powder (antifungal), by C2.				
	C3 C3 had an admission with diagnoses included	on date of January 1, 2015, uding paraplegia.				
	visit, C3 was observ catheter bag hung o	at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G G stated he administered a				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 70 of 140

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	TH AVE SE	204		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	STER, MN 559	PROVIDER'S PLAN OF (CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
0 930	Continued From pa	nge 70	0 930			
	week or every othe	re medication) one time a r week to C3 to encourage which was verified by C3.				
	instructions for the	ds lacked specific written administration of the ocumentation of the client records.				
	ULP-F had a hire d	ate of September 8, 2011.				
	ULP-G had a hire of	date of June 16, 2017.				
	documented training	s records lacked evidence of ag in the proper methods to lications and demonstrated				
	(A)-A and registere licensee did not pro	at 2:11 p.m. administrator d nurse (RN)-B stated the ovide medication managemer ded medication reminders.	ıt			
	and C3's records la	at 10:15 a.m. RN-B verified Cacked the above. RN-B stated the ULP were providing the administration.				
	undated, indicated administer medicat the person is instru procedures to adm client; a RN specific the clients' records the medications an person demonstrat to completely follow	·				
	No further informat	ion was provided.				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 71 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		H21537		B. WING		04/2	29/2022
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	1032 15TI ROCHES	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
0 930	Continued From pa	ge 71		0 930			
	TIME PERIOD TO CORRECT- Seven (7) days.						
0 935 SS=D	5 144A.4792, Subd. 8 Documentation of Administration of Medication		0 935				
	Subd. 8.Documental medications. Each is comprehensive hor documented in the documentation must title of the person with medication. The domedication name, or administered, and radministered, and radministration. The reason why medical completed as present follow-up procedures the client's needs with the client's medical with the client's medical completed.	medication administed in the care provider standard in the signar of the	stered by aff must be ture and e include the me of ent the was not nt any ed to meet as not npliance				
	This MN Requirements: Based on observation review, the licenseed medication adminishome care provider client's record for tweed being administrecords reviewed.	on, interview and re failed to ensure ea tered by the compr staff was documen vo of two clients (C	ecord ach rehensive nted in the 2, C3) who				
	This practice resulted violation that did not safety but had the publication of the public terms of the pu	t harm a client's he potential to have ha fety, but was not lik	ealth or rmed a cely to				

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537		B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	-	1 AVE SE [ER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
0 935	Continued From pa	ge 72		0 935			
	limited number of climited number of s	olated scope (when one lients are affected or one taff are involved or the red only occasionally).					
	The findings include	e:					
		on date of August 1, 201 g spinal stenosis and	7 with				
	visit, C2 was observant was present. ULP-Freminders to take material prescription creams needed, as C2's "sk medications were compared to the	at 12:45 p.m. during a howed lying in bed with ULF stated he assisted C2 nedications and he "app" to C2's skin folds whe kin breaks out bad." The lotrimazole 1% cream stop powder (antifungal)	P-F with lied n				
	C3 C3 had an admission with diagnoses includes	on date of January 1, 20 uding paraplegia.	15,				
	visit, C3 was observed the catheter bag hung of was present. ULP-C suppository (laxative week or every other	at 3:30 p.m. during a horwed lying in bed with a Foot the bed frame and UlG stated he administered e medication) one time at week to C3 to encourally which was verified by C3	oley LP-G d a a ge				
	administration of the included the medical	s lacked documentation e above medications wh ation name, dosage, dat and method and route o	ich e and				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	29/2022
	PROVIDER OR SUPPLIER	F INC 1032 15TI		STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
0 935	On April 26, 2022, a (A)-A and registered licensee did not proservices, but provid On April 29, 2022, a and C3's records lashe was not aware above medication at The licensee's Medundated, indicated medication the personedication will initial No further information	at 2:11 p.m. administrator d nurse (RN)-B stated the evide medication management ded medication reminders. at 10:15 a.m. RN-B verified C2 cked the above. RN-B stated the ULP were providing the administration. ication Administration policy following administration of a son administering the all the medication sheet.	0 935			
0 965 SS=D	Subd. 13.Prescripti written or electronic defined in section 1 prescribed medicat home care provider This MN Requirements: Based on observation of two of two clients (Comedications, with reservations). This practice results	ons. There must be a current cally recorded prescription as 51.01, subdivision 16a, for all ions that the comprehensive is managing for the client. ent is not met as evidenced on, interview and record failed to ensure prescriptions f medications as required for C2, C3) who received	0 965			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 74 of 140

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		H21537	7	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TI ROCHES	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
0 965	Continued From paragraph safety but had the polient's health or sacause serious injurned was issued at an islimited number of situation has occur. The findings including deafness. On April 27, 2022, a visit, C2 was obserpresent. ULP-F stareminders to take in prescription creams needed, as C2's "simedications were cantifungal) and Ny was verified by C2. C3 C3 had an admission with diagnoses including was present. ULP-G suppository (laxative) week or every other bowel movement, we can a safety of the suppository (laxative) week or every other bowel movement, we can safety with diagnoses including was present. ULP-G suppository (laxative) week or every other bowel movement, we can safety was present.	potential to hately, but was y, impairment olated scope dients are affect aff are involved only occare: on date of Aug spinal stend at 12:45 p.m. wed lying in bated he assist nedications a sellotrimazole 1 stop powder on date of Januding paraple at 3:30 p.m. oved lying in boon the bed frag stated he are medication r week to C3	not likely to t, or death), and (when one or a ected or one or a ved or the isionally). gust 1, 2017 with osis and during a home ed with ULP-F ted C2 with and he "applied in folds when it bad." The % cream (antifungal) which egia. during a home ed with a Foley ame and ULP-G idministered a it o encourage	0 965			
	C2 and C3's record electronically record administered media	ded prescript					

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 75 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	H AVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 965	Continued From pa	ge 75	0 965			
	(A)-A and registered licensee did not proservices, but provide On April 29, 2022, and C3's records lashe was not aware above medication at The licensee's Medundated, indicated abeen prescribed by No further information.	ication Administration policy all medications must have a physician or dentist.				
01015 SS=F	Subd. 23.Loss or sphome care provider management must procedures for loss substances defined 6800.4220. These pwhen a spillage of a notation must be explaining the spilla notation must be signesponsible for the verification that any disposed of accordingulations. (b) The procedures comprehensive hor	pillage. (a) Comprehensive is providing medication develop and implement or spillage of all controlled in Minnesota Rules, part procedures must require that a controlled substance occurs, made in the client's record age and the actions taken. The gned by the person spillage and include contaminated substance was ing to state or federal	01015			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01015	Continued From pa	ge 76	01015			
	unaccounted for prescription drugs and take appropriate action required under state or federal regulations and document the investigation in required records.					
	by: Based on interview licensee failed to de	and record review the evelop and implement or spillage of all controlled lired.				
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).					
	The findings include	e:				
	visit, C2 was observersent. ULP-F state creams" to C2's skin "skin breaks out baclotrimazole 1% creams"	at 12:45 p.m. during a home wed lying in bed with ULP-F ted he "applied prescription in folds when needed, as C2's d." The medications included from (antifungal) and Nystop which was verified by C2.				
	visit, C3 was observ catheter bag hung of was present. ULP-C suppository (laxativ	at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G stated he administered a e medication) one time a r week to C3 to encourage				

6899

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY
				71. BOILDING.			
		H21537	•	B. WING		04/2	29/2022
NAME OF I	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAF	RE INC	1032 15TI ROCHES	·I AVE SE ΓER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		FICIENCIES EEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01015	Continued From pa	ige 77		01015			
	The licensee lacker procedures for loss substances defined 6800.4220 due to promanagement.	or spillage of I in Minnesota	f all controlled a Rules, part				
	On April 29, 2022, a (A)-A stated he had was provided.						
	No further informat	ion was provi	ded.				
	TIME PERIOD TO	CORRECT- S	Seven (7) days.				
01030 SS=F	144A.4793, Subd. 2	2 Policies and	l Procedures	01030			
33-1	Subd. 2.Policies and comprehensive hor treatment and thera must develop, impliciple up-to-date written to management policiple and process under the supervision registered nurse or professional consists standards and guident comprehensional consists and guident comprehensive horizonal consists and guident consists and	me care proving y management, and meter the earth ent or the estand procedures must be on and direction appropriate listent with currents.	der who provides nent services naintain nerapy dures. The e developed ion of a icensed health				
	(b) The written policaddress requesting prescriptions for treproviding the treatmof treatment or their communicating with therapy they are reevaluating the treatment or treatment or their communicating with the same communicat	and receiving eatments or the nent or therap rapy activities n clients abou ceiving, monit ment and the n the prescrib	g orders or nerapies, by, documenting , educating and at treatments or toring and erapy, and er.				
	This MN Requirem	ent is not me	t as evidenced				

6899

Minnesota Department of Health STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU		` ′	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	1032 15TI ROCHES	H AVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIE MUST BE PRECEDE SC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01030	Continued From particles by: Based on interview licensee failed to do maintain up-to-date management polici required. This practice result violation that did not safety but had the polici required. This practice result violation that did not safety but had the polici required in the polici required. This practice result violation that did not safety but had the policient's health or sacause serious injur was issued at a wide problems are pervertiallure that has affer a large portion or a large porti	and record reviewelop, implement written treatments and procedure are the complete and complete are procedured assisted complete and complete are complete assisted complete are complete are complete assisted complete assisted complete are complete assisted complete	ent and ent and therapy res as a violation (a health or harmed a t likely to r death), and (when he a systemic ential to affect a systemic ential to a syste	01030			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 79 of 140

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		H21537	B. WING		04/2	29/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01030	catheter site and chewhich was verified I C4 On April 28, 2022, a visit, C4 was observed Foley catheter bag walker and ULP-I wassisted C4 with pure (compression mater brace on left leg and to a leg bag, which the licensee lacked the rapy management which addressed the requesting and reformed treatments or the providing the treated documenting of the educating and contreatments or theral monitoring and even therapy; and communicating with the communication with the communication with the communicating with the communication	nanging catheter bag weekly by C3. At 7:30 a.m. during a home wed seated in a chair with a hung on the lower bar of a was present. ULP-I stated he litting on Tubigrips rial), putting on and removal of d changing Foley catheter bag was verified by C4. Id written treatment and ent policies and procedures e following: ceiving orders or prescriptions erapies; ment or therapy; eatment or therapy; eatment or therapy; eatment or therapy activities; municating with clients about py they are receiving; aluating the treatment and the the prescriber at 9:00 a.m., administrator in on further policies than what	01030			
01035 SS=E	Treatment/Therapy	Mgt Plan	01035			
		ed treatment or therapy For each client receiving				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H21537	B. WING		04/29/2022
NAME OF PROVIDER OR SUPPL	ER STREET AD	DRESS, CITY, S	STATE, ZIP CODE	
GLOBAL HOME HEALTH	ARE INC 1032 15TI	H AVE SE TER, MN 559	904	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTE
or therapy service care provider m service plan a wor therapy service client. The provimaintain a current therapy manage must contain at (1) a statement provided; (2) documentating to the tradministration; (3) identification will be delegated (4) procedures fappropriate licer problem arises we services; and (5) any client-sp documentation or received, verification therapy was administration of received, verification or received,	page 80 ordered or prescribed treatments les, the comprehensive home list prepare and include in the ritten statement of the treatment les that will be provided to the der must also develop and int individualized treatment and ment record for each client which least the following: of the type of services that will be on of specific client instructions leatments or therapy of treatment or therapy tasks that to unlicensed personnel; or notifying a registered nurse or sed health professional when a with treatments or therapy lecific requirements relating to of treatment and therapy lecific r	01035		

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 81 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE			
GLOBAL	HOME HEALTH CAR	E INC	H AVE SE TER, MN 559	2014			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
01035	plan to include all the four clients (C1, C3 or therapy manager.) This practice result violation that did no safety but had the policent's health or sa cause serious injury was issued at a path limited number of a limited number of situation has occur found to be pervasi. The findings include C1 c1 had an admissic 2021, with diagnose 2021, wi	ne required content for four of , C4, C6) receiving treatment ment, with records reviewed. ed in a level two violation (a t harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than a staff are involved, or the red repeatedly; but is not ve).					

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H21537	B. WING 04		04/2	04/29/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	HAVE SE FER, MN 559	904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
01035	Continued From pa	ge 82	01035				
	on April 27, 2022, a visit, C3 was observed theter bag hung of was present. ULP-0 suppository (laxative week or every other bowel movement (f C3 with changing deatheter site and character which was verified by C3's Service Agree indicated provided stoileting, eating/means	at 3:30 p.m. during a home wed lying in bed with a Foley on the bed frame and ULP-G stated he administered a re medication) one time a reweek to C3 to encourage or bowel program), assisted ressing around suprapubic hanging catheter bag weekly,					
	indicated catheter be cleaned daily. Whe to the leg bag, clea Put vinegar water s and let soak for about empty. C3 was on day. C3's Service for suprape changes, administration (suppository) to endechanging Foley cather C4 C4 had an admission with diagnoses including the cleaned of the clean	an dated April 13, 2022, bag was to be emptied and in removing the overnight bag in the ends with alcohol wipe. Solution in the overnight bag but 10 minutes and then a bowel program every other Agreement lacked provision of ubic catheter site dressing					

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 83 of 140

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15T	H AVE SE TER, MN 559	04		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01035	visit, C4 was observed Foley catheter bag walker and ULP-I wassisted C4 with put (compression mater brace on left leg and to a leg bag, which C4's Service Agree indicated provided grooming, transferseating/meal prep, to laundry, other (doct care plan;" howeve within the same date C4's Client Care Plaindicated "has instructed "has instructed "has instructed "TED" howeve within the same date of the control of	wed seated in a chair with a hung on the lower bar of a was present. ULP-I stated he atting on Tubigrips rial), putting on and removal of d changing Foley catheter bag was verified by C4. ment dated July 7, 2021, services included dressing, s, bathing, mobility, bileting, light housekeeping, for visit) and "refer to client r, no care plan was provided	01035			

6899

Minnesota Department of Health
STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION		SURVEY PLETED
		H21537	B. WING		04/2	29/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	TH AVE SE STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01035	stretches." C1, C3, C4 and C6' individualized treatr plan to include the form of the provided; - documentation of relating to the treatr administration; - identification of trewill be delegated to - procedures for no appropriate license problem arises with services; and - any client-specific documentation of tree verification that all the tadministered as preferent ment or therap complications or additional complex of the complication of the complications or additional complex of the complex of	desistance with exercises and desistance with exercise that will be designed by the professional when a desire the exercise of the exe				
01040 SS=E	Treatments/Therap	у	01040			
	Subd. 4.Administra	tion of treatments and therapy	•			

NAME OF PROVIDER OR SUPPLIER March March		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER GLOBAL HOME HEALTH CARE INC				A. BUILDING:			
CADAL HOME HEALTH CARE INC 1032 15TH AVE SE ROCHESTER, MN 55904 10 10 10 10 10 10 10			H21537	B. WING		04/2	29/2022
XAI ID PROVIDERS PLAN OF CORRECTION (PREFIX TAGE) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) OF THE APPROPRIATE DATE OF CROSS-REFERENCE) OF THE APPROPRIATE DATE OF CROSS-REFERENCE OF THE APPROPRIATE DATE OF THE APPROPRIATE CONFIDENCE OF THE APPROPRIATE DATE OF THE APPROPRIATE DA	NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
(24) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) O1040 Continued From page 85 Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional authorized to assignemt. When administration of a treatment or therapy is represented uppersonnel, the home care provider must ensure that the registered nurse or authorized licensed health professional assigned to unlicensed personnel hability to competently follow the procedures; (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) had specified, in writing, specific instructions for each client and documented those instructions in the client's records and communicated with the unlicensed personnel about the individual needs of the client's records and communicated with the unlicensed personnel (ULP) about the individual needs of the client for four of four clients (C1, C3, C4, C6) who	GI ORAI	HOME HEALTH CAR	1032 15T	H AVE SE			
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) O1040 Continued From page 85 Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapies appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) had specified, in writing, specific instructions for each client and documented those instructions in the client's records and communicated with the unlicensed personnel (ULP) about the individual needs of the client for four of four clients (C1, C3, C4, C6) who	OLOBAL	TOME HEALTH GAI	ROCHES	STER, MN 559	904		
Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the home care provider must ensure that the registered nurse or authorized licensed health professional has: (1) instructed the unlicensed personnel in the proper methods with respect to each client and the unlicensed personnel has demonstrated the ability to competently follow the procedures; (2) specified, in writing, specific instructions for each client and documented those instructions in the client's record; and (3) communicated with the unlicensed personnel about the individual needs of the client. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) had specified, in writing, specific instructions for each client and documented those instructions in the client's records and communicated with the unlicensed personnel (ULP) about the individual needs of the client for four of four clients (C1, C3, C4, C6) who	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	N SHOULD BE E APPROPRIATE	COMPLETE
management; and had instructed the ULP in the proper methods to administer the treatment or therapy management, and the ULP had	01040	Ordered or prescrit must be administer other licensed heal perform the treatmed delegated or assign the licensed health appropriate practice assignment. When or therapy is delegated personnel, the home that the registered health professional (1) instructed the urproper methods with the unlicensed personal (2) specified, in write each client and documented the client's record; (3) communicated about the individual. This MN Requirements (1) by: Based on observation review, the licensed registered nurse (1) specific instructions documented those records and communicated those records	bed treatments or therapies red by a nurse, physician, or alth professional authorized to ent or therapy, or may be ned to unlicensed personnel by professional according to the estandards for delegation or administration of a treatment ated or assigned to unlicensed ne care provider must ensure nurse or authorized licensed I has: Inlicensed personnel in the th respect to each client and sonnel has demonstrated the tly follow the procedures; Iting, specific instructions for cumented those instructions in and with the unlicensed personnel all needs of the client. In the tild is not met as evidenced to ensure the RN) had specified, in writing, as for each client and instructions in the client's invitated with the unlicensed bout the individual needs of the cur clients (C1, C3, C4, C6) who atment or therapy had instructed the ULP in the administer the treatment or				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 86 of 140

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 1032 15TH AVE SE ROCHESTER, MIN 55994 SUMMARY STATEMENT OF DEFICIENCIES TAG CONTINUED (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety but had the potential to have harmed a client's health or safety but had the potential to have harmed a client's health or safety but had the potential to have harmed a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1 C1 had an admission date of September 22, 2021, with diagnoses including stroke. On April 27, 2022, at 11-45 am during a home visit, C1 was observed seated in a wheelchair and ULP-E was present. ULP-E stated C1 received physical therapsis. ULP-E stated Step laced a gait belt on C1 before C1 started the exercises per the physical therapsis. ULP-E stated Step laced a gait belt on C1 before C2 started the exercises be prevent falling, and assisted C1 with walking exercises to prevent falling, and assisted C1 with walking, grooming, transfers, bathing, mobility, light housekeeping, laundry and "refer to client care plan." C1's Client Care Plan dated October 27, 2021, indicated the same, C1's Service Agreement lacked the provision of services for exercises.		IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CAUSAL HOME HEALTH CARE INC 1032 15TH AVE SE ROCHESTER, MN 55904			H21537	B. WING		04/2	9/2022
GLOBAL HOME HEALTH CARE INC (XH) ID (XH) ID (PREFIX TAG GENCH DEFICIENCY MIST BE PRECEDED IN TILL (EACH DEFICIENCY) (THE PRECED IN THE APPROPRIATE (EACH DISTANCE OF THE MIST BE COME. (EACH DEFICIENCY) (THE PRECED IN THE APPROPRIATE (EACH DISTANCE OF THE MIST BE COME. (EACH DEFICIENCY) (THE PRECED IN THE APPROPRIATE (EACH DISTANCE OF THE MIST BE COME. (EACH DISTANCE OF THE MIST AND OTHER (EACH DISTANCE OF THE MIST AND OTHER (EACH DISTANCE OF	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG Centinued From page 86 procedures for three of four ULP (ULP-E, ULP-G and ULP-I) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety but had the potential to have harmed a client's health or safety but had the potential to have harmed a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1 C1 had an admission date of September 22, 2021, with diagnoses including stroke. On April 27, 2022, at 11.45 a.m. during a home visit, C1 was observed seated in a wheelchair and ULP-E was present. ULP-E stated C1 received physical therapy (PT) two times a week and C1 completed exercises per the physical therapist. ULP-E stated the exercises, monitored C1 during leg exercises to prevent falling, and assisted C1 with walking exercises. C1's Service Agreement dated October 27, 2021, indicated provided services included dressing, positioning, grooming, transfers, bathing, mobility, light housekeeping, laundry and "refer to client care plan." C1's Client Care Plan dated October 27, 2021, indicated the same. C1's Service Agreement lacked the provision of services for exercises.	GLOBAL	HOME HEALTH CAR	FINC	_	904		
procedures for three of four ULP (ULP-E, ULP-G and ULP-I) with records reviewed. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of slaff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1 C1 had an admission date of September 22, 2021, with diagnoses including stroke. On April 27, 2022, at 11:45 a.m. during a home visit, C1 was observed seated in a wheelchair and ULP-E was present. ULP-E stated C1 received physical therapy (PT) two times a week and C1 completed exercises per the physical therapist. ULP-E stated She placed a gait belt on C1 before C1 started the exercises, monitored C1 during leg exercises to prevent falling, and assisted C1 with walking exercises. C1's Service Agreement dated October 27, 2021, indicated provided services included dressing, positioning, grooming, transfers, bathing, mobility, light housekeeping, laundry and "refer to client care plan." C1's Client Care Plan dated October 27, 2021, indicated the same. C1's Service Agreement lacked the provision of services for exercises.	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
	01040	procedures for three and ULP-I) with recompleted experience of the procedure of the procedu	e of four ULP (ULP-E, ULP-G ords reviewed. ed in a level two violation (a tharm a client's health or obtential to have harmed a fety, but was not likely to y, impairment, or death), and tern scope (when more than a lients are affected, more than staff are involved, or the red repeatedly; but is not ve). e: on date of September 22, es including stroke. at 11:45 a.m. during a home yed seated in a wheelchair sent. ULP-E stated C1 lerapy (PT) two times a week exercises per the physical ated she placed a gait belt on ed the exercises, monitored C1 is to prevent falling, and alking exercises. ment dated October 27, 2021, services included dressing, ng, transfers, bathing, mobility, laundry and "refer to client lient Care Plan dated October the same. C1's Service	01040			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 87 of 140

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
			7. BOILDING.			
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	STATE, ZIP CODE		
GLOBA	L HOME HEALTH CAF	SE INC	TH AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01040	C3 had an admission with diagnoses included in the ends with water solution in the clean the ends with water solution in the cabout 10 minute a bowel program of Agreement lacked suprapubic catheter bag with diagnoses included an admission with diagnoses included ends with catheter bag one time.	on date of January 1, 2015, luding paraplegia. at 3:30 p.m. during a home red lying in bed with a Foley on the bed frame. ULP-G ered a suppository (laxative ne a week or every other weel to bowel movement (for bowel C3 with changing dressing catheter site and changing ly, which was verified by C3. Tement dated April 13, 2022, services included dressing, real prep, positioning, bathing, transfers, light housekeeping to client care plan." Idan dated April 13, 2022, heter bag and clean daily. The eovernight bag to the leg bag in alcohol wipe. Put vinegar to evernight bag and let soak the es and then empty. C3 was on fevery other day. C3's Service provision of services for er site dressing changes, nedication (suppository) to novement and changing Foley				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 88 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	H21537		B. WING		04/2	9/2022	
	PROVIDER OR SUPPLIER	1032 15TH	H AVE SE	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01040	on Tubigrips (compand removal of brack Foley catheter bag verified by C4. C4's Service Agree indicated provided grooming, transfers eating/meal prep, to laundry, other (doctorare plan;" howeve within the same data C4's Client Care Plandicated "has instrexercises and stret needed;" dressing-indicated "TED" how "brace on left foot," knee when goes our urinary catheter "pr with changing from ensuring bags are of C4's Service Agree services for Tubigri C6 C6's had an admission with diagnoses included to C6's Service Agree indicated provided mobility, toileting, e housekeeping, laur plan." C6's Client Care Plandicated Care Plandi	pression material), putting on the concentrate on left leg and changing to a leg bag, which was services included dressing, so bathing, mobility, colleting, light housekeeping, tor visit) and "refer to client r, no care plan was provided the range. an dated September 27, 2021, services available to do ches; provide assistance and see (compression stocking), "assist with brace to R [right] at of the house," toileting-has a ovide assistance as needed bed bag to leg bag and cleaned on a regular basis." ment lacked provision of ps on both lower extremities. sion date of January 28, 2021, and dated June 3, 2021, services included transfers, atting/meal prep, light and "refer to client care and dated June 3, 2021,	01040	DEFICIENCY)			
	included "provide a stretches."	ssistance with exercises and					

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 89 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01040	Continued From pa	ge 89	01040			
	C1, C3, C4 and C6's records lacked specific written instructions for the administration of the treatment or therapy management services and documentation of the instructions in the client records.					
	ULP-E had a hire d	ate of November 3, 2021.				
	ULP-G had a hire date of June 16, 2017.					
	ULP-I had a hire da	ate of September 10, 2018.				
	ULP-E, ULP-G and ULP-I's records lacked evidence of documented training in the proper methods to administer the above treatment or therapy management services and demonstrated competency.					
	C1, C3, C4 and C6 RN-B stated she waduring leg exercises assisted C1 with washe was present in therapist was there	at 10:15 a.m. RN-B verified 's records lacked the above. as aware ULP-E monitored C1 s so he does not fall and alking exercise. RN-B stated C1's home when the PT. RN-B also stated she was were providing some of the				
	No further informati	ion was provided.				
	TIME PERIOD TO	CORRECT- Seven (7) days.				
01045 SS=E			01045			
	treatments and then therapy administered	ation of administration of rapies. Each treatment or ed by a comprehensive home be documented in the client's				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
			A. BUILDING.			
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01045	Continued From parecord. The docum signature and title of administered the trainclude the date and treatment or therapordered or prescrib document the reasonal any follow-up parecompareced to meet the client's. This MN Requiremby: Based on observative the licensee treatment or therapcomprehensive hor documented in the clients (C1, C3, C4 treatment or therapreviewed. This practice result violation that did no safety but had the parecompareced.	entation must include the of the person who eatment or therapy and must d time of administration. When pies are not administered as ed, the provider must on why it was not administered procedures that were provided	01045		OPRIATE	DATE
	was issued at a pat limited number of a limited number of	y, impairment, or death), and ttern scope (when more than a clients are affected, more than f staff are involved, or the red repeatedly; but is not ive).				
	The findings includ	e:				
	C1 C1 had an admission 2021, with diagnose	on date of September 22, es including stroke.				
	On April 27, 2022, a	at 11:45 a.m. during a home				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 91 of 140

PRINTED: 05/17/2022 FORM APPROVED

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1032 15TH AVE SE ROCHESTER, MN 55904 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B. WING O4/29/2022 STREET ADDRESS, CITY, STATE, ZIP CODE 1032 15TH AVE SE ROCHESTER, MN 55904 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DATE	STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	CIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER GLOBAL HOME HEALTH CARE INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X5) COMPLET PREFIX (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) (EACH DEFICIENCY) (X5) COMPLET CROSS-REFERENCED TO THE APPROPRIATE DATE				A. BOILDING.			
GLOBAL HOME HEALTH CARE INC 1032 15TH AVE SE ROCHESTER, MN 55904 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)			H21537	B. WING		04/2	9/2022
(X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ROCHESTER, MN 55904 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET DATE DEFICIENCY)	NAME OF PROVIDER OR SU	SUPPLIER		, ,	STATE, ZIP CODE		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)	GLOBAL HOME HEAL	LTH CAR	RE INC	_	904		
04045 0 15 15 04	PREFIX (EACH DE	EFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
visit, C1 was observed seated in a wheelchair. Unlicensed personnel (ULP)-E stated C1 received physical therapy (PT) two times a week and C1 completed exercises per the physical therapist. ULP-E stated she placed a gait belt on C1 before C1 started the exercises, monitored C1 during leg exercises to prevent falling, and assisted C1 with walking exercise. C1's Service Agreement dated October 27, 2021, indicated provided services included dressing, positioning, grooming, transfers, bathing, mobility, light housekeeping, laundry and "refer to client care plan." C1's Client Care Plan dated October 27, 2021, indicated the same. C1's Service Agreement lacked provision of services for exercises. C3 C3 had an admission date of January 1, 2015, with diagnoses including paraplegia. On April 27, 2022, at 3:30 p.m. during a home visit. C3 was observed lying in bed with a Foley catheter bag hung on the bed frame. ULP-G stated he administered C3 a suppository (laxative medication) one time a week or every other week to encourage bowel movement (for bowel program), assisted C3 with changing dressing around suprapubic catheter site and changing catheter bag weekly, which was verified by C3. C3's Service Agreement dated April 13, 2022, indicated provided services included dressing, tolleting, eating/meal prep, positioning, bathing, mobility, grooming, transfers, light housekeeping, laundry and "refer to client care plan." C3's Client Care Plan dated April 13, 2022,	visit, C1 was Unlicensed preceived phy and C1 com therapist. UL C1 before C during leg exassisted C1 C1's Service indicated propositioning, glight housek care plan." (27, 2021, inc. Agreement I exercises. C3 C3 had an a with diagnost on April 27, visit, C3 was catheter bag stated he ad medication) to encourage program), as around suprecatheter bag. C3's Service indicated protoileting, eat mobility, grolaundry and	as observed personal	ved seated in a wheelchair. hel (ULP)-E stated C1 herapy (PT) two times a week exercises per the physical ated she placed a gait belt on he the exercises, monitored C1 is to prevent falling, and halking exercise. ment dated October 27, 2021, hervices included dressing, high, transfers, bathing, mobility, halling laundry and "refer to client hient Care Plan dated October he same. C1's Service horovision of services for on date of January 1, 2015, huding paraplegia. hat 3:30 p.m. during a home haved lying in bed with a Foley hor the bed frame. ULP-G hered C3 a suppository (laxative he a week or every other week have movement (for bowel have a week or every other week have movement (for bowel have a week or every other week have a week or every other have a week or every ot	01045	DETICIENCY)		

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 92 of 140

	NT OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			
		H2153	37	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAI	HOME HEALTH CAR	RE INC	1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		EFICIENCIES ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01045	Continued From parcleaned daily. Whe to the leg bag, clear Put vinegar water is and let soak for about empty. C3 was on day. C3's Service of catheter site dressis medication (supposite movement and chartime a week. C4 C4 had an admission with diagnoses included "As an admission with diagnoses included "Teb" on Tubigrips (compand removal of brain Foley catheter bag walker. ULP-I state on Tubigrips (compand removal of brain Foley catheter bag verified by C4. C4's Service Agree indicated provided grooming, transfers eating/meal prep, to laundry, other (doctor plan;" howeve within the same dain cated "Teb" howeve when goes on urinary catheter "provided "provided "Teb" howeve when goes on urinary catheter "provided "provided "Teb" howeve when goes on urinary catheter "provided "provided "Teb" howeve when goes on urinary catheter "provided "provided "provided "Teb" howeve when goes on urinary catheter "provided "provided "provided "provided "provided "Teb" howeve when goes on urinary catheter "provided "	n removing in the ends we colution in the ends we colution in the cout 10 minute a bowel property of the end o	with alcohol wipe. e overnight bag les and then gram every other acked suprapubic administration of courage bowel catheter bag one actober 9, 2017, le sclerosis. during a home n a chair with a lower bar of a led C4 with putting lerial), putting on g and changing which, was July 7, 2021, luded dressing, lobility, housekeeping, "refer to client an was provided ptember 27, 2021, able to do le assistance as listance and lesion stocking), brace to R [right] lese," toileting-has a	01045			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 93 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15T	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01045	with changing from ensuring bags are of C4's Service Agree services for Tubigri C6 C6's had an admiss with diagnoses included provided a mobility, toileting, enhousekeeping, laun plan." C6's Client Care Plaincluded "provide astretches." C1, C3, C4 and C6'documentation of the management service administered the tredate and time of administered the tredate and time of administered C1, lacked the above.	bed bag to leg bag and cleaned on a regular basis." ment lacked provision of ps on both lower extremities. Sion date of January 28, 2021, uding cerebral palsy. ment dated June 3, 2021, services included transfers, ating/meal prep, light dry and "refer to client care an dated June 3, 2021, ssistance with exercises and as records lacked the treatment or therapy ces which included the of the person who eatment or therapy, and the ministration. at 10:15 a.m. registered nurse C3, C4 and C6's records RN-B stated she was not e providing some of the above	01045	DEFICIENCY)		
01050 SS=E	144A.4793, Subd. 6	CORRECT- Seven (7) days. Treatment and Therapy	01050			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	TH AVE SE STER, MN 559	10.4		
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CO	ORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETE DATE
01050	O Continued From page 94		01050			
	must be an up-to-d- recorded order from all treatments and t contain the name o the treatment or the frequency, duration needed to administ Treatment and ther at least every 12 mg					
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure prescriptions for administration of treatments or therapy as required for four of four clients (C1, C3, C4, C6) who were receiving treatment or therapy management, with records reviewed.		5			
	This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), 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 to be pervasive).					
	The findings include	e:				
	C1 C1 had an admission 2021, with diagnose	on date of September 22, es including stroke.				
		at 11:45 a.m. during a home ved seated in a wheelchair.				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 95 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		H21537		B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	S	TREET ADD	RESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	032 15TH	_	20.4		
0(1) 15	CLIMMA DV CTA		OCHESI	ER, MN 559	PROVIDER'S PLAN OF C	ODDECTION	(2/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
01050	Continued From page 95			01050			
	received physical the and C1 completed therapist. ULP-E st. C1 before C1 started	nel (ULP)-E stated C1 nerapy (PT) two times a exercises per the physi ated she placed a gait t ed the exercises, monite is to prevent falls, and a ercises.	cal celt on ored C1				
	indicated provided positioning, groomi light housekeeping care plan." C1's CI 27, 2021, indicated	ment dated October 27 services including dressing, transfers, bathing, ralaundry and "refer to client Care Plan dated Othe same. C1's Service the provision of service	sing, mobility, lient ctober				
	C3 C3 had an admission with diagnoses incl	on date of January 1, 20 uding paraplegia.	015,				
	visit, C3 was obser- catheter bag hung of stated he administed medication) one time to C3 to encourage program), assisted around suprapubic	at 3:30 p.m. during a hoved lying in bed with a fonthe bed frame. ULPered a suppository (laxable a week or every other bowel movement (for bowel movement) dress catheter site and changly, which was verified by	Foley G ative er week bowel sing ging				
	indicated provided toileting, eating/me	ment dated April 13, 20 services included dress al prep, positioning, bat transfers, light housek o client care plan."	sing, :hing,				
	included catheter b	an dated April 13, 2022 ag to be emptied and c ng the overnight bag to	leaned				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 96 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBA	L HOME HEALTH CAR	E INC 1032 15TH ROCHEST	I AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01050	bag, clean the ends vinegar water soluti soak for about 10 n program every other Agreement lacked pure suprapubic catheter administration of mencourage bowel matheter bag one time. C4 C4 had an admission with diagnoses inclusively catheter bag walker. ULP-I state on Tubigrips (compand removal of brace on Tubigrips (compand remo	s with alcohol wipe. Put on in the overnight bag and let ninutes and then empty. Bowel or day. C3's Service provision of services for a site dressing changes, edication (suppository) to novement and changing Foleyme a week. On date of October 9, 2017, adding multiple sclerosis. At 7:30 a.m. during a home wed seated in a chair with a hung on the lower bar of a domain had be assisted C4 with putting ression material), putting on the lower bar of a domain had be a sisted C4 with putting ression material), putting on the lower bar of a domain had be a sisted C4 with putting ression material), putting on the lower bar of a domain had be a sisted C4 with putting ression material), putting on the lower bar of a domain had been been been been been been been bee	01050			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 97 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		H21537	B. WING		04/	29/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	TH AVE SE STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
01050	Continued From pa	ge 97	01050			
	C4's Service Agree	cleaned on a regular basis." ment lacked the provision of ps on both lower extremities.				
		sion date of January 28, 2021, uding cerebral palsy.				
	indicated provided s mobility, toileting, ea	ment dated June 3, 2021, services included transfers, ating/meal prep, light dry and "refer to client care				
	C6's Client Care Plan dated June 3, 2021, included "provide assistance with exercises and stretches."					
		's records lacked written or ded prescriptions for the above nent or therapies.				
	(RN)-B verified C1, lacked the above.	at 10:15 a.m. registered nurse C3, C4 and C6's records RN-B stated she was not e providing some of the above				
	No further informati	ion was provided.				
	TIME PERIOD TO	CORRECT- Seven (7) days.				
01080 SS=E	144A.4794, Subd. 3	3 Contents of Client Record	01080			
		f client record. Contents of a e the following for each client:				
		nation, including the client's , address, and telephone				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 98 of 140

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	HAVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01080	an emergency contrepresentative, if are (3) names, address the client's health a and other home care (4) health informaticallergies, and when medications, treatm documentation, and records; (5) client's advance (6) the home care passessments and so (7) all records of coclient's home care so (8) documentation of client's status and at the needs of the client professional; (9) documentation of and actions taken in client including reposupervisor or health (10) documentation of the client including reposupervisor or health (10) documentation of the client including reposupervisor or health (10) documentation of the client including reposupervisor or health (10) documentation of the client including reposupervisor or health (10) documentation (10)	ess, and telephone number of act, family members, client's by, or others as identified; ses, and telephone numbers of and medical service providers by the providers, if known; and, including medical history, the provider is managing anents or therapies that require dother relevant health directives, if any; arovider's current and previous dervice plans; and munications pertinent to the services; and significant changes in the actions taken in response to the anent including reporting to the sor or health care.	01080	DEFICIENCY)		
	(11) documentation	that the client has received				

	IT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA CATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		H2153	7	B. WING		04/2	29/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01080	and reviewed the h (12) documentation provided the staten limitations of service subdivision 3; (13) documentation resolution; (14) discharge sum termination notice a when applicable; and (15) other document chapter and relevant status. This MN Requirem by: Based on interview licensee failed to end (C1, C2, C3, C4, Cd) required content with twicense that did not safety but had the public client's health or saccause serious injurning was issued at a path limited number of a limited number of a limited number of situation has occur found to be pervasion.	ome care bil In that the clie In that the clie In ent of disclo In of complain In mary, includ In and related of Int to the clier In and record in Insure six of si Insure six	ent has been obsure on etion 144A.4791, ats received and ing service locumentation, ared under this of the services or et as evidenced review the exist clients' records ontained the eviewed. It wo violation (a ent's health or ave harmed a so not likely to oft, or death), and when more than a fected, more than a fected, more than a fected, or the	01080			
	C1 C1's record lacked	documented	I information for				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 100 of 140

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
			7. BOILDING.			
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	5TH AVE SE ESTER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01080	emergency contact documentation servidentified in the servident and telephor member's name ar would provide back address of the contamember. C1's Service Agree included provided splan." C1's Client C2021, indicated "had cream to be applied feet elevated to kee C1's Service Agree reminders. C1's Time and Actilicensee's staff data April 10, 2022, lack were provided. C2 C2's record lacked provided as identificated "needs medicated "nee	is person, family member and vices were provided as vice plan. In emergency contact person the number and a family and telephone number who kup care, but lacked the tact person and family Interpretation of the provided the tact person and family Interpretation of the provided to daily. Needs to have his perpensure off of his heels." Interpretation by the ped March 14, 2022, through the documentation the service of the provided to daily. The provided to daily the pressure off of his heels." Interpretation of the provided to documentation by the provided to documentation the service of the provided to documentation the service of the provided to documentation the service of the provided to daily after the date service of the provided to documentation the service of the provided to daily after the date service of the provided to the	1, es e	DEFICIENCY)		
	visit, C2 was obser he assisted C2 with	at 12:45 p.m. during a home ved lying in bed. ULP-F state n reminders to take n was verified by C2. C2 state				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 101 of 140

	NT OF DEFICIENCIES OF CORRECTION		R/SUPPLIER/CLIA ATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	,	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAF	RE INC	1032 15TI ROCHES	H AVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01080	the ULP also remin sugar four times a captal C2's Time and Actilicensee's staff date April 24, 2022, lack services were provened C3 C3's record lacked health and medical C3's record listed to the captal ca	ded her to che day. vity documented March 14, ed daily documented service provious me name and n, but lacked documented persons, oth service provious were provices were provice plan. In emergency is the names a he primary phase numbers. ment dated J services inclus, bathing, mobileting, light I tor visit) and 'r, no care plate range.	tation by the 2022, through imentation the information for der. telephone the address. information for ers as identified, der, and ovided as contact person's out lacked the nd address of the hysician, but uly 7, 2021, ided dressing, obility, housekeeping, trefer to client n was provided	01080			
	C4's Client Care Pl indicated assist wit eating/meal prep, to housekeeping and	h dressing, gi ransfers, toile	rooming, bathing,				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 102 of 140

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	RE INC	H AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES OF THE AP	ULD BE	(X5) COMPLETE DATE
01080	Continued From pa	nge 102	01080			
	licensee's staff date April 24, 2022, lack	vity documentation by the ed March 29, 2022, through ed evidence of consistent services were provided.				
	emergency contact	documented information for persons and documentation ided as identified in the service				
		n emergency contact person's ne numbers, but lacked the				
	C5's Service Agreement Plan dated January 21, 2021, indicated provided services included grooming, light housekeeping, laundry and "refer to client care plan;" however, no care plan was provided within the same date range.					
	needs assistance v and creams to area bathing: limited ass help washing back, laundry and housel	ed June 15, 2021, indicated with grooming: applying lotions as not able to reach and sistance with bathing, needs legs, feet-especially ankles, keeping. C5's Service provision of service for				
		at 4:12 p.m. C5 stated the ULF pplying lotion, shower, laundry weekly.				
	licensee's staff date identified light hous being documented	ails documentation by the ed April 5, 12, 26, 2022, sekeeping and laundry were only. C5's record lacked entation for the services of				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 103 of 140

NAME OF PROVIDER OR SUPPLIER GLOBAL HOME HEALTH CARE INC (C4) ID PREFIX TAG OCHESTER, MN 55904 CONTINUED FOR THE MISSING SUMMARY STATEMENT OF DEFICIENCY MISSING PRECIDED BY FULL TAG C6'S record lacked documented information for emergency contact persons, others as identified, health and medical service provider and documentation services were provided as identified in the service plan. C6'S record listed an emergency contact person's name and telephone numbers, but lacked the address, and listed the names of the social worker and the primary physician, but lacked the addresses and telephone numbers. C6'S Service Agreement dated June 3, 2021, indicated provided services included transfers, mobility, toileting, eating/meal prep, light housekeeping, laundry and "refer to client care plan." C6'S Client Care Plan dated June 3, 2021, indicated provided assistance with getting on and off the toilet as well as on and		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
GLOBAL HOME HEALTH CARE INC SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (CACH DEFICIENCY) PREFIX TAG O1080 Continued From page 103 O1080 assisting with grooming and bathing.			H21537	B. WING		04/2	9/2022
GLOBAL HOME HEALTH CARE INC (A4) ID PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 01080 Continued From page 103 assisting with grooming and bathing. C6 C6's record lacked documented information for emergency contact persons, others as identified, health and medical service provider and documentation services were provided as identified in the service plan. C6's record listed an emergency contact person's name and telephone numbers, but lacked the addresses and telephone numbers. C6's Service Agreement dated June 3, 2021, indicated provided services included transfers, mobility, tolieting, eating/meal prep, light housekeeping, laundry and "refer to client care plan." C6's Client Care Plan dated June 3, 2021, indicated dressing-she is unable to tie her shoes; eating/meal prep-provide assistance with meal prep; transfers-requires some assistance with meal prep; transfers-requires some assistance with getting on and off the toilet as well as on and	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) 01080 Continued From page 103 assisting with grooming and bathing. C6 C6's record lacked documented information for emergency contact persons, others as identified, health and medical service provider and documentation services were provided as identified in the service plan. C6's record listed an emergency contact person's name and telephone numbers, but lacked the address, and listed the names of the social worker and the primary physician, but lacked the addresses and telephone numbers. C6's Service Agreement dated June 3, 2021, indicated provided services included transfers, mobility, toileting, eating/meal prep, light housekeeping, laundry and "refer to client care plan." C6's Client Care Plan dated June 3, 2021, indicated dressing-she is unable to the her shoes; eating/meal prep-provide assistance with meal prep; transfers-requires some assistance getting into wheelchair from bed and needs assistance with getting on and off the toilet as well as on and	GLOBAL	HOME HEALTH CAR	RE INC		904		
assisting with grooming and bathing. C6 C6's record lacked documented information for emergency contact persons, others as identified, health and medical service provider and documentation services were provided as identified in the service plan. C6's record listed an emergency contact person's name and telephone numbers, but lacked the address, and listed the names of the social worker and the primary physician, but lacked the addresses and telephone numbers. C6's Service Agreement dated June 3, 2021, indicated provided services included transfers, mobility, toileting, eating/meal prep, light housekeeping, laundry and "refer to client care plan." C6's Client Care Plan dated June 3, 2021, indicated dressing-she is unable to the her shoes; eating/meal prep-provide assistance with meal prep; transfers-requires some assistance getting into wheelchair from bed and needs assistance with getting on and off the toilet as well as on and	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	COMPLETE
off the shower chair; mobility-can walk very short distances with crutches and the assistance of another person; toileting-needs assistance to transfer from wheelchair onto the toilet; assistance with housekeeping and laundry. C6's Time and Activity documentation by the licensee's staff dated April 4, 2022, through April 24, 2022, identified light housekeeping and laundry were being documented only. C6's record lacked documentation for the services of assisting with dressing, transfers, mobility and eating/meal prep.	01080	assisting with groom C6 C6's record lacked emergency contact health and medical documentation servidentified in the service Agree indicated provided service Agree indicated provided service Agree indicated provided service and the prinary for the service Agree indicated dressing-eating/meal preppiprep; transfers-requinto wheelchair from with getting on and off the shower chair distances with crutof another person; toil transfer from wheel assistance with hour C6's Time and Activitiensee's staff date 24, 2022, identified laundry were being lacked documentat assisting with dressisting with dressisting with dressisting services.	documented information for persons, others as identified, service provider and vices were provided as vice plan. In emergency contact person's in enumbers, but lacked the the names of the social mary physician, but lacked the phone numbers. In emergency contact person's in enumbers, but lacked the the names of the social mary physician, but lacked the phone numbers. In emergency contact person's in enumbers, but lacked the phone numbers, but lacked the phone numbers. In emergency contact person's in enumbers, but lacked the the names of the social mary physician, but lacked the phone numbers. In emergency contact person's in enumbers, but lacked the the names of the services included transfers, ating/meal prep, light added assistance with meal but lacked assistance with meal but lacked and needs assistance getting in bed and needs assistance of the toilet as well as on and represent the toilet as well as on and represent the toilet; as and the assistance to lichair onto the toilet; as ekeeping and laundry. In emergency contact person's identified as well as contact person and the sassistance of letting-needs assistance to lichair onto the toilet; as ekeeping and laundry. In emergency contact person's identified as well as contact person as identified as well as on and represent person and the assistance of letting-needs assistance to lichair onto the toilet; as ekeeping and laundry. In emergency contact person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as well as on and represent person as identified as	01080			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 104 of 140

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUF		` ′	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TI ROCHES	TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEN Y MUST BE PRECEDED SC IDENTIFYING INFO	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01080	Continued From pa	nge 104		01080			
	On April 29, 2022, a (A)-A and registere C2, C3, C4, C5 and above required con	d nurse (RN)-B von 1 C6's records lace lace lace lace lace lace lace lace	erified C1, ked the				
	No further informat	ion was provided.					
	TIME PERIOD FOR (21) days	R CORRECTION	: Twenty-one				
01145 SS=F	144A.4795, Subd. T Evals All Staff	7(b) Training/Com	npetency	01145			
	(b) Training and co unlicensed personr						
	(1) documentation provided;	requirements for	all services				
	(2) reports of chang the supervisor desi provider;						
	(3) basic infection of pathogens;	control, including	blood-borne				
	(4) maintenance of environment;	a clean and safe					
	(5) appropriate and hygiene and groom		in personal				
	(i) hair care and ba	thing;					
	(ii) care of teeth, gu devices;	ıms, and oral pro	sthetic				
	(iii) care and use of	f hearing aids: an	d				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
			A. BUILDING.			
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	RE INC	H AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01145	Continued From pa	age 105	01145			
	(6) training on the p working with the eld falls;	ssisting with toileting; prevention of falls for providers derly or individuals at risk of				
	(7) standby assistance techniques and how to perform them;					
	(8) medication, exer reminders;	ercise, and treatment				
	(9) basic nutrition, rand assistance with	meal preparation, food safety, n eating;				
	(10) preparation of licensed health pro	modified diets as ordered by a fessional;				
	(11) communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family;					
	(12) awareness of	confidentiality and privacy;				
		appropriate boundaries clients and the client's family;				
	(14) procedures to emergency situatio	utilize in handling various ns; and				
		commonly used health ent and assistive devices.				
	by: Based on observat review the licensee	ent is not met as evidenced ion, interview and record failed to ensure training and ations as required prior to				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 106 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
	H21537		B. WING		04/	29/2022
NAME OF PROVIDER OR SUPPL	ER	STREET AD		STATE, ZIP CODE		
GLOBAL HOME HEALTH	CARE INC		TER, MN 559	904		
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCI NCY MUST BE PRECEDED B IR LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
This practice reviolation that did safety but had the client's health of cause serious in was issued at a problems are perfailure that has a large portion of the findings incompleted exerous the completed exerous the completed exerous the completed exerous the cause serious in was issued at a problems are perfailure that has a large portion of the findings incompleted exerous the completed exerous the completed exerous the cause of the cause o	care for four of four un- E, ULP-F, ULP-G, ULF d. sulted in a level two vio not harm a client's here ne potential to have han safety, but was not like jury, impairment, or de widespread scope (where vivasive or represent a affected or has potential r all of the clients).	lation (a alth or med a ely to eath), and en systemic al to affect 2021. a home elchair received a and C1 herapist. C1 before 1 during leg 1 with d she is, is, ited "date d s s signed orm had ation under listed"	01145			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
	PROVIDER OR SUPPLIER	1032 15Ti		STATE, ZIP CODE		
GLOBAI	HOME HEALTH CAR	RE INC	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01145	-safety/falls team -medication remind -skin care -bathing -dressing -grooming -nail/foot cares -oral/denture care -gait belt -toileting -urinal -bed pan -gloving -mobility aids -feeding -homemaking -meal preparation -communication log However, the check written procedure a competency evalua topics. ULP-E record lacke competency evalua topics. ULP-E record lacke competency evalua topics. ULP-F record lacke competency evalua topics. ULP-F record lacke competency evalua - hair care - care and use of he - stand by assistance perform them ULP-F ULP-F had a hire d On April 27, 2022, a visit, C2 was observ present. ULP-F sta dressing, showers, medications, transf	klist lacked evidence of a and indication of pass or fail for ations of the above "skills" ed evidence of documented ation for the following topics: earing aids ce techniques and how to ate of September 8, 2011. at 12:45 p.m. during a home ved lying in bed with ULP-F ted he assisted C2 with	01145			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 108 of 140

	NT OF DEFICIENCIES OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
				7 55.2515.			
		H215	37	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC	1032 15TI	_			
			ROCHES	TER, MN 55	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	MUST BE PRE	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01145	Continued From pa	ge 108		01145			
	verified by C2. ULP prescription creams needed, as C2's "sl were clotrimazole 1 Nystop powder (and C2. C2 stated the Ucheck her blood su	F further si to C2's sk kin breaks o cream (a tifungal), wh JLP also rer gar four tim	cin folds when but bad," which antifungal) and hich was verified by minded her to es a day.				
	ULP-F's Competen performed" was No "supervising RN" the RN. The form was had "skills" listed wunder "comments" listed on the form wabove.	vember 5, 2 ere was no signed by U ith minimal for each ski	2011, and for signature of an LP-F. The form steps/information II. The "skills"				
	However, the check written procedure a competency evalua signature of an RN	nd indicatio tions of the	n of pass or fail for				
	ULP-F-s Annual Ed 7, 2021, and was s The subjects listed limited to, the follow-infection control te -OSHA and infection fall prevention -dining, nutrition, ar -cultural competencemergency preparetrauma informed comply health informulation (HIPAA) -professional bound housekeeping, lau -mobility-exercise -personal cares -activities for older sisted to the subject t	igned by RN for training ving: chniques n control and food safe by edness are mation and daries ndry and be	I-B and ULP-F. included, but not ety				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH ROCHEST	I AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01145	Continued From pa	ge 109	01145			
	training for the follor-documentation req provided; -reports of changes supervisor designat-maintenance of a cestandby assistance perform them; -medication, exercise-preparation of modicensed health profecommunication skill dignity of the client client and the client	in the client's condition to the ted by the home care provider; clean and safe environment; te techniques and how to se, and treatment reminders; diffied diets as ordered by a fessional; alls that include preserving the and showing respect for the 's preferences, and family; monly used health technology				
	competency evalual -appropriate and sa hygiene and groom (i) hair care and bat (ii) care of teeth, gu devices; (iii) care and use of (iv) dressing and assistance perform them ULP-G ULP-G had a hire d On April 27, 2022, a visit, C3 was observed the catheter bag hung of present. ULP-G sta suppository (laxativ	thing; ms, and oral prosthetic				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 110 of 140

	NT OF DEFICIENCIES I OF CORRECTION		DER/SUPPLIER/CLIA ICATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		H215	37	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	·	
GLOBAI	- HOME HEALTH CAR	RE INC	1032 15TH ROCHES	HAVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	MUST BE PR	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
01145	bowel movement, a transfers using Hoy showers, cleaning I repositioning, cook changing dressing site and changing of was verified by C3. catheter leg bag. ULP-G's Competer performed" was Se signed by a previou The form had "skills steps/information uskill. The "skills" list as mentioned aboved the written procedure a competency evaluation to competency evaluation to competency evaluation to care and use of hestand by assistant perform them ULP-I ULP-I had a hire day visit, C4 was obserfoley catheter bag walker with ULP-I passisted C4 with purposition of the case	assisted C3 ver or ceiling iving space ing meals a around sup catheter bac C3 stated acy Test For ptember 28 usly employe is listed with nder "comr ted on the fe e. clist lacked and indication itions of the determined and indication ition for the caring aids are technique at 7:30 a.m. ved seated hung on the oresent. ULI utting on Tu uting), putting nanging Fol	g lift, grooming, a, laundry, and cutting up food, rapubic catheter g weekly, which he no longer used a rm indicated "date 8, 2017, and was ed RN and ULP-G. h minimal ments" for each orm were the same evidence of a on of pass or fail for above "skills" ce of documented following topics: es and how to ember 10, 2018. during a home in a chair with a elower bar of a P-I stated he bigrips g on and removal of ey catheter bag to	01145			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 111 of 140

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
H21537	B. WING		04/2	9/2022
NAME OF PROVIDER OR SUPPLIER STREET AD 1032 15T		STATE, ZIP CODE		
GLOBAL HOME HEALTH CARE INC	TER, MN 559	904		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
was verified by C4. C4 stated she was not using the brace to her right knee anymore. ULP-I's Competency Test Form indicated "date performed" was September 10, 2018, and was signed by a previously employed RN and ULP-G. The form had "skills" listed with minimal steps/information under "comments" for each skill. The "skills" listed on the form were the same as mentioned above. However, the checklist lacked evidence of a written procedure and indication of pass or fail for competency evaluations of the above "skills" topics. ULP-I's record lacked evidence of documented competency evaluation for the following topics: -hair care -care and use of hearing aids -stand by assistance techniques and how to perform them On April 29, 2022, at 10:15 a.m. RN-B verified ULP-E, ULP-F, ULP-G and ULP-I's records lacked the above. RN-B stated she was not completing competency evaluations for any ULP for hair care and care and use of hearing aids. RN-B stated she did complete competency evaluations for the ULP for stand by assistance techniques and how to perform them. RN-B confirmed competency evaluations for stand by assistance techniques and how to perform them was not documented for the ULP. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	01145			

Minnesota Department of Health STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TI	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
01150	Continued From page 112		01150			
01150 SS=F	144A.4795, Subd. 7(c) Training/Competency Evals Comp Staff		01150			
	competency evalua	ragraph (b), training and tion for unlicensed personnel ensive home care services				
	(1) observation, rep client status;	orting, and documenting of				
	changes in body fur	e of body functioning and nctioning, injuries, or other that must be reported to nel;				
	(3) reading and recording temperature, pulse, and respirations of the client;					
	(4) recognizing physical, emotional, cognitive, and developmental needs of the client;					
	(5) safe transfer ted	chniques and ambulation;				
	(6) range of motion	ing and positioning; and				
	(7) administering m required.	edications or treatments as				
	by: Based on observati review, the licenses competency evalua providing direct car personnel (ULP-E, records reviewed.	ent is not met as evidenced on, interview and record e failed to ensure training and tions as required prior to e for four of four unlicensed ULP-F, ULP-G, ULP-I) with ed in a level two violation (a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		H2153	37	B. WING		04/:	29/2022
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GLOBAL	HOME HEALTH CAR	E INC	1032 15TH ROCHES	HAVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC) REGULATORY OR L	MUST BE PRE	ECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01150	Continued From particles violation that did not safety but had the policient's health or sacause serious injury was issued at a wide problems are pervarially that has affer a large portion or all the findings included ULP-E ULP-E had a hire down a large portion or all the findings included ULP-E ULP-E had a hire down a large portion or all the findings included ULP-E had a hire down a large portion or all the findings included ULP-E had a hire down a large portion or all the findings included ULP-E stated a hire down a large of motion (Polymer Large of Motion (Poly	t harm a clipotential to he fety, but way, impairme lespread so sive or reproted or has I of the clier etc. ate of Nove at 11:45 a.m. wed seated to ULP-E state of Nove is per the phelaced a gair cises, moninate falls and a ULP-E furthedication registered number 3, 2 gistered number 3, 2 gistered number information skills" listed er	nave harmed a s not likely to nt, or death), and ope (when esent a systemic potential to affect nts). mber 3, 2021. In during a home in a wheelchair ated C1 received as a week and C1 nysical therapist. It belt on C1 before tored C1 during legassisted C1 with er stated she minders, transfers, dry. In indicated "date 2021, and rese]" was signed had "skills" listed under "comments"	01150			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 114 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	0/2022
NAME OF	PROVIDER OR SUPPLIER		ADDRESS, CITY, S	STATE ZID CODE	04/2	9/2022
		1032 1	TH AVE SE	STATE, ZIF CODE		
GLOBAL	. HOME HEALTH CAR	RE INC ROCHI	STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01150	Continued From pa	age 114	01150			
	-catheter care -mobility aids					
	However, the checklist lacked evidence of a written procedure and indication of pass or fail for competency evaluations of the above "skills" topics.		or			
	competency evalua	ked evidence of documented ation for the following topics: ding temperature, pulse, and client;				
	ULP-F ULP-F had a hire d	late of September 8, 2011.				
	On April 27, 2022, at 12:45 p.m. during a home visit, C2 was observed lying in bed with ULP-F present. ULP-F stated he assisted C2 with dressing, showers, reminders to take medications, transfers, toileting, peri cares, housekeeping, meals and laundry, which was verified by C2. ULP-F further stated he "applied prescription creams" to C2's skin folds when needed, as C2's "skin breaks out bad." The medications were clotrimazole 1% cream (antifungal) and Nystop powder (antifungal), which was verified by C2. C2 stated the ULP also reminded her to check her blood sugar four times a day.					
	performed" was No "supervising RN" th RN. The form was had "skills" listed w under "comments"	ncy Test Form indicated "date ovember 5, 2011, and for nere was no signature of an signed by ULP-F. The form rith minimal steps/information for each skill. The "skills" vere the same as mentioned				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	9/2022
	PROVIDER OR SUPPLIER	F INC 1032 15TH	AVE SE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01150	Continued From page 115		01150			
	written procedure a competency evaluating signature of an RN. ULP-F-s Annual Ed 7, 2021, and was signature.	ucation 2021 was dated July gned by RN-B and ULP-F. for training included the erving and reporting and ambulation safe transfers notion				
	ULP-F's record lacked evidence of documented training for the following topics: -reading and recording temperature, pulse, and respirations of the client; -administering medications (all routes) ULP-F's record lacked evidence of documented competency evaluation for the following topics: -reading and recording temperature, pulse, and respirations of the client; -safe transfer techniques and ambulation; -range of motioning and positioning; -administering medications (all routes)					
	ULP-G ULP-G had a hire date of September 16, 2017. On April 27, 2022, at 3:30 p.m. during a home visit, C3 was observed lying in bed with a Foley catheter bag hung on the bed frame with ULP-G present. ULP-G stated he administered a suppository (laxative medication) one time a week or every other week to C3 to encourage					

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 116 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREE	ADDRESS, CITY,	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	5TH AVE SE ESTER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
01150	bowel movement, a transfers using Hoy showers, cleaning I repositioning, cooki changing dressing a site and changing of was verified by C3. catheter leg bag. ULP-G's Competent performed" was Sesigned by a previou The form had "skills steps/information uskill. The "skills" list as mentioned above However, the check written procedure a competency evaluated topics. ULP-G's Annual Ed 18, 2022, and was and ULP-G. The suincluded the followinging process documenting, obsermobility-exercise armobility-iffting and mobility-range of memobility-positioning ULP-G's record lactoring and record respirations of the correspirations of the correspira	issisted C3 with dressing, for or ceiling lift, grooming, iving space, laundry, ing meals and cutting up for around suprapubic catheter atheter bag weekly, which C3 stated he no longer use acy Test Form indicated "dat ptember 28, 2017, and was asly employed RN, and ULP is listed with minimal inder "comments" for each and indication of pass or fail tions of the above "skills" ucation 2021 was dated Applications of the a	d a e G. me for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC	TH AVE SE STER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01150	Continued From pa	ge 117	01150			
	competency evalua					
	ULP-I had a hire date of September 10, 2018. On April 28, 2022, at 7:30 a.m. during a home visit, C4 was observed seated in a chair with a Foley catheter bag hung on the lower bar of a walker with ULP-I present. ULP-I stated he assisted C4 with putting on Tubigrips (compression material), putting on and removal of brace on left leg, changing Foley catheter bag to a leg bag dressing, showers and cooking, which was verified by C4. C4 stated she was not using the brace to her right knee anymore. ULP-I's Competency Test Form indicated "date performed" was September 10, 2018, and was signed by a previously employed RN, and ULP-G. The form had "skills" listed with minimal steps/information under "comments" for each skill. The "skills" listed on the form were the same as mentioned above.					
			f			
	written procedure a	clist lacked evidence of a nd indication of pass or fail for tions of the above "skills"				
	23, 2021, and was a employed RN of the subjects listed for transging process	cation 2021 was dated July signed by a previously elicensee and ULP-I. The raining included the following:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/:	29/2022
	PROVIDER OR SUPPLIER HOME HEALTH CAR	F INC 1032 15T	DRESS, CITY, S H AVE SE TER, MN 55	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
01150	-mobility-exercise a -mobility-lifting and -mobility-range of m -mobility-positioning ULP-I's record lack training for the follo -reading and record respirations of the of ULP-I's record lack competency evalua -reading and record respirations of the of -ambulation On April 29, 2022, a ULP-E, ULP-F, ULF lacked the above. F competency evalua and recording temp respirations of the of confirmed compete for stand by assistat perform them was r she completed com the ULP as mention The licensee's Med undated, indicated a administer medicati the person is instru- procedures to admi client; a RN specific the clients' records the medications and	nd ambulation safe transfers notion ded evidence of documented wing topics: ling temperature, pulse, and client; ed evidence of documented tion for the following topics: ling temperature, pulse, and client; at 10:15 a.m. RN-B verified P-G and ULP-I's records RN-B stated she did complete tions for the ULP for reading erature, pulse, and client, and ambulation. RN-B ncy evaluations for the ULP nce techniques and how to not documented. RN-B stated apetency evaluations only for ned above. ication Administration policy a home health aide may sons if prior to administration ceted by a RN in the nister the medications to the es in writing and documents in the procedures to administer d prior to administration the es to a RN the person's ability of the procedure.	01150			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TH	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01150	Continued From page 119		01150			
	TIME PERIOD FOR CORRECTION: Twenty-One (21) days					
01155 SS=D	144A.4795, Subd. 7	7(d) RN/LHP Responsibilities	01155			
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) had documented instructions for a delegated task in the client's record and ensured prior to the delegation one of one unlicensed personnel (ULP-G) was trained in the proper methods and and was able to demonstrate the ability to follow the procedures for one of one resident (C3) with record reviewed. This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a					

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TH ROCHEST	1 AVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01155	Continued From pa	ge 120	01155			
	cause serious injury was issued at an is limited number of re a limited number of	safety, but was not likely to y, impairment, or death), and olated scope (when one or a esidents are affected or one or staff are involved or the red only occasionally).				
	The findings include	e:				
	indicated provided stoileting, eating/mea	ment dated April 13, 2022, services included dressing, al prep, positioning, bathing, transfers, light housekeeping, o client care plan."				
	indicated needs total	an dated April 13, 2022, al assist with transfers using lift) or lift system (ceiling).				
	visit, C3 was obserwas present. ULP-0 utilizing a Hoyer or	at 3:30 p.m. during a home ved lying in bed and ULP-G 3 stated he transferred C3 ceiling lift. A Hoyer lift and above C3's bed and tub area) '3's home.				
	of the Hoyer lift and instructions for use	instructions for the utilization I ceiling lift system, including of the sling (assistive device s by use of electrical or				
	ULP-G had a hire d	ate of September 16, 2017.				
	performed" was Se signed by a previou The form had "skills steps/information u	ncy Test Form indicated "date ptember 28, 2017, and was isly employed RN and ULP-G. is" listed with minimal inder "comments" for each ted on the form included:				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 121 of 140

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	H AVE SE TER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
01155	-Hoyer Lift (position safety at all times, or However, the check written procedure a competency evaluated ULP-G's record lacked demonstration for the and ceiling lift system. On April 29, 2022, a C3's record lacked of the Hoyer lift and confirmed ULP-G's training and competency lift and ceiling. The licensee's Tranundated, indicated mechanical lift transneeding a mechanical No further information.	client in sling, monitor for do not rush) klist lacked evidence of a and indication of pass or fail for tion for Hoyer Lift. ked training and skills he delegated task of Hoyer lift em. at 10:15 a.m. RN-B confirmed instructions for the utilization I ceiling lift system. RN-B record lacked evidence of tency for utilization of the g lift system with C3. asfer/Lift Assistance policy only employees trained in the sfer will be assigned to clients cal lift transfer.	01155			
01170 SS=D	,	2 Content of Orientation a) The orientation must contain	01170			
	(1) an overview of s 144A.4798;(2) introduction and policies and proced					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H21537	B. WING		04/29/2022	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE	•	
GI OBAI	. HOME HEALTH CAR	SE INC	TH AVE SE			
	Г	ROCHE	STER, MN 55			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (COMMITTEE OF THE APPROPRIATE OF		ΓE
01170	O Continued From page 122		01170			
	person;					
	(3) handling of emergencies and use of emergency services;					
		n and reporting of the nors or vulnerable adults 5.556 and 626.557;				
	(5) home care bill c 144A.44;	of rights under section				
	(6) handling of clients' complaints, reporting of complaints, and where to report complaints including information on the Office of Health Facility Complaints and the Common Entry Point;		;			
	(7) consumer advocacy services of the Office of Ombudsman for Long-Term Care, Office of Ombudsman for Mental Health and Developmental Disabilities, Managed Care Ombudsman at the Department of Human Services, county managed care advocates, or other relevant advocacy services; and					
		pes of home care services the roviding and the provider's	:			
	orientation may als services to clients v on hearing loss pro must be high qualit include online train	e topics listed in paragraph (a to contain training on providing with hearing loss. Any training ovided under this subdivision by and research-based, may ing, and must include training the following topics:	j			
		of age-related hearing loss ts itself, its prevalence, and				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. I`´	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				3:		
		H21537	B. WING		04/2	29/2022
NAME OF	PROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	32 15TH AVE SE CHESTER, MN 5	5904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
01170	Continued From pa	ige 123	01170			
	challenges it poses	to communication;				
	(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or		,			
	that may enhance of involvement, include assistive listening of and tactile alerting of	ut strategies and technolocommunication and ing communication strate levices, hearing aids, visudevices, communication, and closed captions.	egies,			
	This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure one of four unlicensed personnel (ULP-F) received orientation to home care licensing requirements and regulations prior to providing home care services for clients with records reviewed.		our			
	violation that did no safety but had the p client's health or sa cause serious injury was issued at an is limited number of c limited number of s	ed in a level two violation of harm a client's health of potential to have harmed fety, but was not likely to y, impairment, or death), olated scope (when one delients are affected or one taff are involved or the red only occasionally).	and or a			
	The findings include	e:				
	ULP-F was hired or	n September 8, 2011.				
	visit, C2 was observ	at 12:45 p.m. during a ho ved lying in bed and ULP = stated he assisted C2 v	-F			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 124 of 140

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/:	29/2022
	PROVIDER OR SUPPLIER - HOME HEALTH CAR	F INC 1032 15TI	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01170	dressing, showers, medications, transfe housekeeping, mea verified by C2. ULP prescription creams needed, as C2's "shedications were contifungal) and Nywhich was verified by C2 stated they her home in person ULP-F record lacker following: -handling of clients' complaints, and whincluding information Facility Complaints -consumer advocated Ombudsman for Medicate Developmental Discombudsman at the Services, county monother relevant advorteview of the types employee will be prescope of licensure On April 29, 2022, and No further informations information in the prescope of licensure on the prescope of licensure of the	reminders to take ers, toileting, peri cares, als and laundry, which was -F further stated he "applied s" to C2's skin folds when kin breaks out bad." The lotrimazole 1% cream stop powder (antifungal), by C2. C2 stated the ULP also eck her blood sugar four times to last time a nurse came to to was back in 2019. Indeed evidence or training for the complaints, reporting of ere to report complaints on on the Office of Health and the Common Entry Point; by services of the Office of ental Health and abilities, Managed Care Department of Human anaged care advocates, or cacy services; and of home care services the oviding and the provider's at 10:15 a.m. RN-B verified bove training as required.	01170			

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	TH AVE SE STER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01185	Continued From pa	age 125	01185			
01185 SS=E	144A.4796, Subd. Training Required	5 Alzheimer's/Dementia	01185			
	disease and related providers that providers that providers that providers that providers that providers are related staff and supervisor must receive training explanation of Alzhdisorders, effective problem-solve whe challenging behavior	equired relating to Alzheimer's didisorders. For home care ide services for persons with ted disorders, all direct care in working with those clients ing that includes a current eimer's disease and related approaches to use to in working with a client's ors, and how to communicate ve Alzheimer's or related				
	This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure training for training as required for Alzheimer's disease and related disorders for three of four unlicensed personnel (ULP-F, ULP-G, ULP-I) with records reviewed.					
	violation that did no safety but had the p client's health or sa cause serious injur was issued at a pat limited number of a limited number of	ted in a level two violation (a but harm a client's health or potential to have harmed a afety, but was not likely to y, impairment, or death), and ttern scope (when more than a clients are affected, more than f staff are involved, or the red repeatedly; but is not ive).				
	The findings includ	e:				
		at 2:11 p.m. administrator ensee provided services to				

6899

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPL IDENTIFICATION N		, ,	E CONSTRUCTION		SURVEY PLETED
		H21537		B. WING		04/2	29/2022
NAME OF F	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	, , ,	
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15TI	_	004		
0(4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENC		TER, MN 55		CORRECTION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORN	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
01185	Continued From pa	ge 126		01185			
	clients with dement	ia.					
	ULP-F ULP-F had a hire date of September 8, 2011.						
	ULP-F's record lacked documented evidence of training for Alzheimer's disease and related disorders for the following topics: - explanation of Alzheimer's disease and related disorders; - assistance with activities of daily living; - problem solving with challenging behaviors; and - communication skills						
	ULP-G ULP-G had a hire d	late of June 16, 201	17.				
	ULP-G's record lac training for Alzheim disorders for the fol assistance with ac	er's disease and re llowing topics:	lated				
	ULP-I ULP-I had a hire da	ate of September 10), 2018.				
	ULP-I's record lack training for Alzheim disorders for the fol - assistance with ac	er's disease and re llowing topics:	lated				
	On April 29, 2022, a ULP-F, ULP-G and training relating to A related disorders.	ULP-I lacked the a	bove				
	No further informat	ion was provided.					
	TIME PERIOD FOR (21) days	R CORRECTION:	Twenty one				

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Minnesota Department of Health

	ıt of periorNoiro		(VO) MUUTIDI	E CONSTRUCTION	(VO) DATE	OLIDVEV		
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	LETED		
,	0. 0020	.5	A. BUILDING:					
		H21537	B. WING		04/2	9/2022		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DDRESS, CITY, STATE, ZIP CODE					
		1032 15Th						
GLOBAL	. HOME HEALTH CAR	E INC	TER, MN 559	904				
	OUR MAN DV OTA		-		×			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE		
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		DATE		
				DEFICIENCY)				
01225	Continued From pa	ge 127	01225					
01220	Continued From pa	gc 121	01220					
01225	144A.4797, Subd. 3	Supervision of Staff - Comp	01225					
SS=E		·						
	Subd. 3.Supervision	n of staff providing delegated						
	nursing or therapy h	nome care tasks. (a) Staff who						
		nursing or therapy home care						
		rvised by an appropriate						
		fessional or a registered nurse						
		he services are being						
		at the work is being						
		ently and to identify problems						
		ed to the staff person's ability						
		s. Supervision of staff						
	performing medicat							
		be provided by a registered						
		e licensed health professional						
		bservation of the staff						
		nedication or treatment and the						
	interaction with the	client.						
	(b) The direct super	ruisian of staff parforming						
		rvision of staff performing ust be provided within 30 days						
		nich the individual begins						
		ne care provider and first						
		tasks for clients and						
		ed based on performance. This						
		oplies to staff who have not						
		ed tasks for one year or longer.						
	porronnou dorogano	a tache ici cine year er icingen						
	This MN Requireme	ent is not met as evidenced						
	by:							
		on, interview and record						
		e failed to ensure supervision						
		elegated nursing tasks was						
		egistered nurse (RN) or						
		professional within 30 days						
		pegan working and first						
		tasks, and included direct						
		eraction with a client for four of						
	four unlicensed per	sonnel (III P-F III P-F						

6899

STATEMENT OF DEFICIENT AND PLAN OF CORRECTION			ER/SUPPLIER/CLIA CATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		H2153	37	B. WING		04/2	29/2022
NAME OF PROVIDER OR	SUPPLIER				STATE, ZIP CODE	·	
GLOBAL HOME HEA	LTH CAF	RE INC	1032 15TH ROCHES	HAVE SE FER, MN 559	904		
PREFIX (EACH [DEFICIENC'		EFICIENCIES CEDED BY FULL G INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
This practiviolation the safety but client's head cause sering was issued limited nursituation here found to be the safety but the safety but the safety but the safety but the safety between the safety but the safety	P-I) with ce result at did no had the path or sa ous injured at a paraber of cumber of as occur e pervas gs included a hire of the company of	ed in a level of harm a clie potential to harm a clie potential tern scope (elients are affected repeated ive). e: late of Novel late of September of Septem	two violation (a ent's health or have harmed a s not likely to nt, or death), and (when more than a fected, more than volved, or the dly; but is not mber 3, 2021. during a home n a wheelchair stated C1 was two times a week ne physical aced a gait belt on ises, monitored C1 falling and ises. ULP-E further nsfers. ember 8, 2011. during a home bed and ULP-Fassisted C2 with cription creams" to is C2's "skin"	01225			

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 129 of 140

Minnesota Department of Health						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	HOME HEALTH CAR	E INC 1032 15TI ROCHES	HAVE SE FER, MN 55	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
01225	Continued From pa	ge 129	01225			
	On April 27, 2022, a visit, C3 was observed the bag hung of was present. ULP-C suppository (laxative week or every other movement, assisted Hoyer or ceiling lift, suprapubic catheter bag weekly, which was observed to a leg bag, which weekly was observed to a leg bag, which weekly weekly was observed to a leg bag, which weekly weekly weekly, which weekly, which weekly weekly, which weekly, which weekly, which weekly, which weekly weekly, which weekly, which weekly weekly, which we we weekly, which	atte of September 10, 2018. at 7:30 a.m. during a home wed seated in a chair with a hung on the lower bar of a was present. ULP-I stated he atting on Tubigrips rial), putting on and removal of d changing Foley catheter bag was verified by C4.				
		at 10:15 a.m. RN-B verified P-G and ULP-I's records on was provided.				

TIME PERIOD FOR CORRECTION: Twenty-one

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPI		l ` ′	E CONSTRUCTION		SURVEY PLETED
AND FLAN	OF CONNECTION	IDENTIFICATION	NOMBER.	A. BUILDING:		COIVII	LLILD
		H21537		B. WING		04/:	29/2022
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	1032 15T	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01225	Continued From pa	nge 130		01225			
	(21) days						
01245 SS=F				01245			
	5 144A.4798, Subd. 1 TB Infection Control						
	the licensee emplo This practice result		•				

6899

	NT OF DEFICIENCIES I OF CORRECTION		ER/SUPPLIER/CLIA CATION NUMBER:	` ′	E CONSTRUCTION		SURVEY PLETED
		H2153	37	B. WING		04/	29/2022
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GLOBAL	HOME HEALTH CAR	RE INC	1032 15TH ROCHES	HAVE SE FER, MN 559	904		
(X4) ID PREFIX TAG	SUMMARY STA (EACH DEFICIENC' REGULATORY OR L		CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
01245	Continued From particular violation that did not safety but had the policent's health or sacause serious injurned was issued at a wide problems are pervariallure that has affer a large portion or a serious included. The findings included the	ot harm a clie cotential to h fety, but was y, impairmer despread sco sive or repre cted or has il of the clien e: MENT cility TB Risk ith Care Set Department of licensee's R n office were d not list eac ding services es of active on for "3. Is a conducted on eated LTBI [by CDC." ate of Nover ed evidence ed. ate of Septe tep tuberculi 2011, with no 1. ULP-F lace	ave harmed a so not likely to not, or death), and ope (when esent a systemic potential to affect outs). Assessment tings Licensed by of Health), cochester office to both completed the county the so in to determine TB and did not an annual all health care clatent TB infection] The symptom The symptom The symptom The symptom The symptom The symptom The symptom	01245			

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Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION		DATE SURVEY COMPLETED	
		H21537	B. WING		04/0	9/2022	
NAME OF I	PROVIDER OR SUPPLIER		1	STATE, ZIP CODE	04/2	.9/2022	
	. HOME HEALTH CAR	1032 15T	H AVE SE	577 T. 2, 211 GGDL			
GLOBAL	. HOWE HEALTH CAN	ROCHES	TER, MN 55	904			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUNDERSON THE APPROPRIES OF	JLD BE	(X5) COMPLETE DATE	
01245	Continued From pa	ige 132	01245				
	plan for the proceding recognition, isolation residents with suspit therefore, none of the received training or the Minnesota Deguidelines "Regulation Minnesota Health 2013, and based on TB risk assessmentand then for low-rischould be updated may begin working TB symptom scree TB disease) and a first step) dated wit second TST may be starts working with have written TB information in the starts working with the starts with suspice to the starts working with the starts with suspice to the starts with st	d a written TB infection control ures to address early on and referral for handling ected or confirmed active TB; the licensee's employees had in their role in the procedure. Deartment of Health (MDH) tions for Tuberculosis Control in Care Settings' dated July in CDC guidelines, indicated a at should be completed initially its settings the risk assessment every other year; an employee with patients after a negative in (i.e., no symptoms of active negative IGRA or TST (i.e., hin 90 days before hire. The e performed after the HCW patients; each agency should ection control procedures that gnition, isolation and referral;					
	Care Worker and S indicated all health have TB screening included baseline s personal care atten should receive sym baseline testing upon	erculosis Screening of Health Screening Tool undated, care settings were required to program at a minimum which creening at the time of hire. All dants/home health aids uptom screening upon hire and on hire using two step TST or d assay for M. tuberculosis) to th M. tuberculosis.					
	No further informat						
	TIME PERIOD FOR	R CORRECTION: Seven (7)					

6899

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		H21537	B. WING		04/2	9/2022
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	RE INC	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
01245	Continued From pa	nge 133	01245			
	days					
01252 SS=F	144A.4798, Subd. 3	3 Infection Control Program	01252			
35-1	provider must establinfection control pro	ontrol program. A home care blish and maintain an effective ogram that complies with re, medical, and nursing tion control.				
	This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to establish and maintain an effective infection control program that complies with accepted heath care, medical and nursing standards for infection control related to current recommendations for COVID-19.					
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva	ed in a level two violation (a of harm a client's health or cotential to have harmed a afety, but was not likely to y, impairment, or death), and despread scope (when asive or represent a systemic ected or has potential to affect II of the clients).				
	The findings include	e:				
	visit, C4 was obser Foley catheter bag walker and unlicens	AL MASK at 7:30 a.m. during a home ved seated in a chair with a hung on the lower bar of a sed personnel (ULP)-I was not wearing a facial mask.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAR	E INC 1032 15TI ROCHES	H AVE SE TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01252			01252			
	employees for COV chills, cough, shortr breathing, fatigue, r headache, new loss	E SCREENING to screen clients and /ID-19 symptoms (fever or ness of breath or difficulty muscle or body aches, s of taste or smell, sore throat, r nose, nausea or vomiting,				
	C1, C2, C3, C4, C5 and C6's records lacked evidence of documented daily screening (or when being provided services) of COVID-19 symptoms and temperature.					
	ULP-E, ULP-F, ULP-G and ULP-I's records lacked evidence of documented daily screening of COVID-19 symptoms and temperature before start of shift.					
	On April 29, 2022, at 10:15 a.m. administrator (A)-A and registered nurse (RN)-B stated ULP-I was supposed to be wearing a facial mask when in C4's home. A-A and RN-B stated, "No" clients were not being screened. A-A stated employees were to call the office if they had symptoms before their shift. A-A stated employees were not documenting for screening of symptoms or temperature before start of shift.					
	Personal Protective Control Grids dated grid for healthcare where transmission facemask were reconsubstantial and high facemask and eye	partment of Health COVID-19 Equipment (PPE) and Source April 7, 2022, included a PPE workers. In communities levels are low and moderate, commended and with transmission levels, protection are recommended residents/clients without med COVID-19.				

6899

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
GLOBAL	. HOME HEALTH CAF	RE INC	HAVE SE	204		
040.15	CLIMMA DV CT		TER, MN 559		FION	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
01252	Continued From pa	age 135	01252			
	(CDC) webpage titl updated February 2 with COVID-19 have symptoms reported to severe illness. S days after exposure have mild to severe symptoms may have Cough, Shortness Fatigue, Muscle or loss of taste or sme runny nose, Nause list does not include will continue to updabout COVID-19. Ohave severe under heart or lung diseat higher risk for dever	sease Control and Prevention led "Symptoms of COVID-19" 22, 2021, indicated "People ve had a wide range of dranging from mild symptoms symptoms may appear 2-14 et o the virus. Anyone can esymptoms. People with these ve COVID-19: Fever or chills, of breath or difficulty breathing, body aches, Headache, New ell, Sore throat, Congestion or a or vomiting, Diarrhea, This e all possible symptoms. CDC late this list as we learn more older adults and people who lying medical conditions like se or diabetes seem to be at eloping more serious				
	(CDC) Interim Infect Recommendations During the Coronal (COVID-19) Pande 2021, indicated sou distancing are recohealth care settings should wear source they could encount also indicates all he home health care, identify anyone entitleir vaccination strollowing so that the 1) a positive viral te symptoms of COVI for quarantine or experience.	sease Control and Prevention ction Prevention and Control of for Healthcare Personnel virus Disease 2019 emic, dated September 10, curce control and physical emmended for everyone in any so, and health care personnel experience control in all areas where the patients. The document ealth care facilities, including should establish a system to earing the facility, regardless of atus, who has any of the ey can be properly managed: est for SARS-CoV-2, 2) ID-19, or 3) who meets criteria exclusion from work. This repersonnel and visitors.				

Minnesota Department of Health

STATE FORM 6899 31V011 If continuation sheet 136 of 140

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		` '	LETED
		H21537	B. WING		04/2	9/2022
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GI OBAI	. HOME HEALTH CAR	1032 15TH	_			
OLODAL	TOME HEALTH SAN	ROCHEST	TER, MN 559	904		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFINED TO THE	D BE	(X5) COMPLETE DATE
01252	Continued From pa	ge 136	01252			
	Confirmed Cases a (Coronavirus) unda would make except exposures to respir identify staff and pe and epidemiologica adhere to Federal a recommendations. are required to wea any offices, building staff are required to covering when provany business relate	All persons, staff and visitors in face coverings upon entering gs and work site locations. All o wear facemask and/or face viding services or conducting ed task.				
02015 SS=D	who has reason to is being or has been knowledge that a vua physical injury whexplained shall immed to the common entroulnerable adult soladmitted to a facility required to report so	eport. (a) A mandated reporter believe that a vulnerable adult n maltreated, or who has ulnerable adult has sustained lich is not reasonably nediately report the information ry point. If an individual is a lely because the individual is y, a mandated reporter is not uspected maltreatment of the rred prior to admission,	02015			
	another facility and	as admitted to the facility from the reporter has reason to				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	9/2022
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY,	STATE, ZIP CODE	•	
GLOBAL HOME HEALTH CARE INC 1032 15TH AVE SE ROCHESTER, MN 55904						
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE	
02015	Continued From pa	nge 137	02015			
	previous facility; or					
	(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, paragraph (a), clause (4).					
	(b) A person not required to report under the provisions of this section may voluntarily report as described above.					
	known or suspected knows or has reason	section requires a report of d maltreatment, if the reporter on to know that a report has common entry point.				
	(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.					
	reason to believe the 626.5572, subdivision (5), occurred must subdivision. If the rebelieves that an invinvestigative agence determine that the according to the crisubdivision 17, para reporter or facility nentry point or direct agency information meets the criteria usubdivision 17, para lead investigative a	porter who knows or has nat an error under section ion 17, paragraph (c), clause make a report under this eporter or a facility, at any time restigation by a lead by will determine or should reported error was not neglect iteria under section 626.5572, agraph (c), clause (5), the may provide to the common thy to the lead investigative explaining how the event ander section 626.5572, agraph (c), clause (5). The igency shall consider this making an initial disposition of bdivision 9c.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H21537	B. WING		04/2	29/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1032 15TH AVE SE ROCHESTER, MN 55904							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
02015	This MN Requirements: by: Based on interview licensee failed to im Minnesota Adult Ab (MAARC) suspecte exploitation for one reviewed. This practice results violation that did no safety but had the polient's health or saccause serious injury was issued at an isolimited number of colimited number of colimited number of situation has occurred. The findings included incident dated Febrindicated C9's familiation the office with a semployee (unlicensing had security camerareview of the	and record review, the imediately report to the use Reporting Center d maltreatment of financial of one client (C9) with record and in a level two violation (and tharm a client's health or potential to have harmed and fety, but was not likely to and the compartment, or death), and collected scope (when one or a staff are involved or the red only occasionally). The compartment is decomparated and reported area involved and reported area installed	02015				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
		H21537	B. WING		04/2	9/2022		
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
GLOBAL HOME HEALTH CARE INC 1032 15TH AVE SE								
(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		
02015	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		02015					

6899