DEPARTMENT OF HEALTH

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

# NOTICE OF TEMPORARY EXTENSION AND CONDITIONAL LICENSE

Electronically Delivered

July 13, 2026

Licensee
Jehu's Care Inc.
3141 Berwick Knoll North
Brooklyn Park, MN  55443

RE: Temporary Conditional License Number 422686
Health Facility Identification Number (HFID) 42176
Project Number(s) SL42176016

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on April 23, 2026, for the purpose of assessing compliance with state licensing statutes. Based on the survey results you were found not to be in substantial compliance with the laws pursuant to Minnesota Statutes, Chapter 144A.

As a result, pursuant to Minn. Stat. § 144A.473, Subd. 3(a), MDH is issuing a 90-day conditional temporary license due to expire on **October 11, 2026**.

**STATE CORRECTION ORDERS**
The enclosed State Form documents the state correction orders. The Department of Health documents state 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 . . ."

In accordance with Minn. Stat. § 144A.474 Subd. 11, MDH may assess fines and enforcement actions based on the level and scope of the violations; **however, no immediate fines are assessed for this survey at your agency**.

**DOCUMENTATION OF ACTION TO COMPLY**
Per Minn. Stat. § 144A.474, Subd. 8(c), the temporary licensee must document actions taken to comply with the correction orders and immediately correct any reissued orders outlined on the state form; however, plans of correction are not required to be submitted 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 business days of the correction order receipt date.

A state correction 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 under Minn. Stat. § 626.557.

To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

**CONDITIONAL LICENSE ISSUED:**

MDH will issue Jehu's Care Inc. a conditional temporary comprehensive home care license for 90 calendar days from the date of this notice. At an unannounced point in time, within the 90 calendar days, MDH will conduct a follow-up survey, as defined in Minn. Stat. § 144A.474, Subd. 2(e). Based on the results of the follow-up survey, MDH will determine if Jehu's Care Inc. is in substantial compliance.

The following conditions apply on the conditional temporary comprehensive license:

a. **No new substantiated maltreatment allegations:** If any new investigations begin in the conditional temporary license period, and the allegations are substantiated, MDH may pursue additional enforcement actions up to and including immediate temporary suspension and revocation of the license.

b. **No new admissions:** Jehu's Care Inc. will not admit any new clients under its conditional home care license until MDH removes the "no new admissions" condition. Jehu's Care Inc. must provide the Department:

   i. A list of the names and birthdates of any individuals Jehu's Care Inc. is currently in the process of admitting. These individuals will be able to continue the admittance process.

   ii. A list of all current clients including:
      1. Name and birthdate of each client

2. Current payment source for services
3. If Elderly Waiver, the name and contact information of the care coordinator/case manager
4. If the client is not able to make informed decisions, the name of their representative and how to contact the representative

**c. Consultant:** Jehu's Care Inc. will contract with an RN to provide consultation concerning all clients to whom Jehu's Care Inc. provides temporary licensed comprehensive home care services under the conditional license. The consultant must have access to all clients receiving services from Jehu's Care Inc.. The consultant will conduct initial and ongoing evaluations of the provider. Direct client observation may be required based on the consultant's judgement or at the discretion of MDH. The RN must not have any affiliation with Jehu's Care Inc. and MDH must review the RN's credentials and approve the selection. Jehu's Care Inc. is responsible for the expense of the contract with the RN. The main purpose of the consultant is to provide guidance to Jehu's Care Inc. in an effort to help Jehu's Care Inc. align their practices with the requirements of Minn. Stat. §§ 144A.43 – 144A.484 and to provide oral and written reports to MDH noting progress toward substantial compliance and/or concerns about observations. Jehu's Care Inc. will develop and implement policies, procedures, and processes specific to the offered services in accordance with the guidance provided by the consultant to ensure ongoing monitoring and substantial compliance with statutory requirements.

**d. Reports:** The RN consultant will provide MDH with regular reports at intervals specified by MDH. Reports will begin on a weekly basis until MDH notifies Jehu's Care Inc. and the RN consultant about a change. Each report will be electronically submitted to: **HRDConsultantReports.MDH@state.mn.us**. The content of the reports will include information such as:

i. Progress towards correction of orders;
ii. Observations of staff delivering home care services and the level of competency observed;
iii. Conversations with clients and family members about satisfaction with home care services;
iv. Conversations with staff about their level of knowledge about the tasks they perform, the people they serve and the health professionals who delegate to them;
v. Overall impressions about the quality of the home care services delivered;
vi. Overall impressions about the dignity with which the clients and their family members are treated;
vii. Concerns; and
viii. Any other information requested by the Department or considered important by the RN consultant(s).

e. **Monitoring visits:** MDH may make unannounced monitoring visits to assess the progress of Jehu's Care Inc. to correct the violations cited during the survey as well as to determine the overall practice of Jehu's Care Inc. in meeting the needs of the people it serves. In addition, the Office of Ombudsman for Long-Term Care (OOLTC) may also make unannounced monitoring visits to determine the level of satisfaction of those people who receive temporary licensed home care services. The OOLTC will share their findings with MDH.

f. **Follow-up survey:** At the time of the follow-up survey, MDH may pursue additional enforcement actions, up to and including immediate temporary suspension or revocation of the provisional license if MDH identifies any level 3, 4 or 5 violations or widespread care related violations.

g. **Corrective Action Plan:** Jehu's Care Inc. will develop and work within a corrective action plan (CAP). The CAP is a working document that includes at least the following information:
    i. A statement of the concern
    ii. A description of what will happen to correct the concern
    iii. A target date for when each correction will be complete
    iv. Who is responsible to make sure it happens
    v. Current status of correction work
    vi. Description of a plan to monitor and ensure ongoing substantial compliance for each corrected order

**RESULTS OF FOLLOW-UP EVALUATION DURING THE CONDITIONAL TEMPORARY LICENSE PERIOD:**
MDH will determine if Jehu's Care Inc. is in substantial compliance based on the results of the follow up survey. MDH will make this determination within the 90-day conditional license period. If MDH determines Jehu's Care Inc. is in substantial compliance on the follow up survey, MDH will remove the conditions from Jehu's Care Inc.'s temporary comprehensive home care license, and Jehu's Care Inc. will correct violations identified during the survey to come into substantial compliance. If MDH determines Jehu's Care Inc. is not in substantial compliance, MDH may take additional enforcement action against Jehu's Care Inc., including placement of additional conditions, issuing an extension to the conditional license, or employ any of the enforcement tools listed in Minn. Stat. § 144A.475 up to and including immediate temporary suspension and revocation.

**REQUEST FOR RECONSIDERATION:**
Pursuant to Minn. Stat. §144A.473, Subd. 3 (b)-(d), If the temporary licensee whose basic or comprehensive license has been denied or extended with conditions disagrees with the conclusions of the commissioner, then the temporary licensee may request a reconsideration no later than 15 calendar days after the temporary licensee receives notice of the action. **This is your only ability to request a reconsideration under this enforcement action.**

To submit a reconsideration request, please visit:
**https://forms.web.health.state.mn.us/form/HRDAppealsForm**

You are encouraged to retain this document for your records.  It is your responsibility to share the information contained in the letter and/or state form with your organization's Governing Body.

If you have any questions, please contact Casey DeVries directly at: 651-201-5917 or email at: casey.devries@state.mn.us.

Sincerely,

Rick Michals

Rick Michals, J.D.
**Interim Assistant Division Director**
**Minnesota Department of Health**
**Health Regulation Division**

JMD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 000 | Initial Comments<br><br>*****ATTENTION******<br><br>HOME CARE PROVIDER LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.<br><br>INITIAL COMMENTS:<br><br>SL42176016-0<br><br>On April 20, 2026, through April 23, 2026, the Minnesota Department of Health conducted an initial full survey at the above provider, and the following correction orders are issued. At the time of the survey, there was one client receiving services under the provider's temporary comprehensive license. | 0 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Home Care Providers. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the surveyors' findings is the Time Period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,"PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.<br><br>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL ISSUED PURSUANT TO 144A.474 SUBDIVISION 11 (b)(1)(2). | |
| 0 265 SS=F | 144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice | 0 265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 265 | Continued From page 1<br><br>receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure care and services were provided according to acceptable health care and medical or nursing standards for one of one client (C1) with bed rails.<br><br>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).<br><br>The findings include:<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's diagnoses included tracheostomy dependence, ventilator dependence, seizure disorder, and cerebral palsy with spastic quadriplegia.<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure (licensee held two previous comprehensive home care licenses). The service plan did not indicate services that would be provided. | 0 265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 265 | Continued From page 2<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the document was the "DAYCARE PLAN" for C1 and was to be completed by a private duty nurse (PDN) that was a registered nurse (RN) or licensed practical nurse (LPN) for up to 24 hours per day. The nurse was responsible for all of C1's medical needs in the school setting including school sites, field trips, transportation, and all other educational outings. In addition, the nurse was responsible for seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1. The document contained the following information related to C1:<br>- C1 would transition from their school program on April 26, 2026. C1 would then have the option to attend an accessibility job program under the care of one-on-one nurse care. No placement decision had been made. By May 1, 2026, C1 would be home bound 24/7, needing complex nursing care at home;<br>- two staff assist C1 with transfer because C1 was non ambulatory;<br>- the nurse would assess skin for tissue breakdown, reposition C1 in bed and wheelchair every two hours, and as needed; and<br>- C1 was provided paddy side rails on the bed for safety. C1's mother and staff had been educated on the importance of side rail use.<br><br>C1's Comprehensive Physical Assessment (SOC) dated January 2, 2026, indicated C1 had grab bars. | 0 265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 265 | Continued From page 3<br><br>C1's 90 Day Home Care Reassessment : Non-Skilled Care dated February 8, 2026, read, "SAFETY CONCERNS: Bed rails".<br><br>C1's record lacked the following required content related to bed rails:<br>-a bed rail assessment which included:<br>- the type of bed rail being assessed;<br>- the resident's preferences;<br>- the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person was at high risk for entrapment;<br>- whether the bed rail has the effect of being an improper restraint;<br>- the purpose and intention of the bed rail;<br>- if the bed rail was securely attached to the bed frame per manufacturer's recommendations; and<br>- measurements of the bed rail and documentation to show the bed rails were FDA compliant.<br>-risk vs benefit discussion.<br><br>On April 21, 2026, at 8:50 a.m., via text message, the surveyor received two photos of C1's bed, which showed bilateral full bed rails that created a crib like enclosure, the sides were able to be folded down to no longer have the bed rail in the upright position at the lower portion of the bed. The bed rails were padded on the interior side.<br><br>On April 22, 2026, at 3:32 p.m., RN-A stated they occasionally assisted C1's personal care attendant (PCA) prior to school at home, to get C1 out of bed because C1 was assisted by two with use of a mechanical lift for transfers.<br><br>On April 23, 2026, at 6:58 a.m., the surveyor received a text message from owner/registered | 0 265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 265 | Continued From page 4<br><br>nurse (O/RN)-B which indicated, "[RN-A] does not help with transfers with [C1's] out of bed to chair or anything else. She is checking her emergency bags."<br><br>On April 23, 2026, at 12:20 p.m., O/RN-B provided the surveyor with the following information related to C1's bed:<br>- serial number 33437; and<br>- sleep safe number 2 George's bed.<br><br>The FDA document titled A Guide to Bed Safety Bed Rails in Hospitals, Nursing Homes and Home Health Care: The Facts dated December 11, 2017, read, "When bed rails are used, perform an on-going assessment of the patient's physical and mental status, closely monitor high-risk patients." In addition, "Patients who have problems with memory, sleeping, incontinence, pain, uncontrolled body movement, or who get out of bed and walk unsafely without assistance, must be carefully assessed for the best ways to keep them from harm, such as falling. Assessment by the patient's health care team will help to determine how best to keep the patient safe."<br><br>The Minnesota Department of Health (MDH) website, Assisted Living Resources & Frequently-Asked Questions (FAQs) dated April 17, 2025, read, "To ensure an individual is an appropriate candidate for a bed rail, the licensee must assess the individual's cognitive and physical status as they pertain to the bed rail to determine the intended purpose for the bed rail and whether that person is at high risk for entrapment or falls. This may include assessment of the individual's incontinence needs, pain, uncontrolled body movement or ability to transfer in and out of bed without assistance. The | 0 265 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 265 | Continued From page 5<br><br>licensee must also consider whether the bed rail has the effect of being an improper restraint." Also, it included, "Best practice for documentation about a resident's bed rails includes, but is not limited to:<br>- Purpose and intention of the bed rail<br>- Measurements<br>- The resident's bed rail use/need assessment<br>- Risk vs. benefits discussion (individualized to each resident's risks)<br>- The resident's preferences<br>- Physical inspection of bed rail and mattress for areas of entrapment, stability, and correct installation<br>- Any necessary information related to interventions to mitigate safety risk or negotiated risk agreements".<br><br>The licensee's undated Use of Side Rails in the Home policy indicated side rails would not be used in the home setting except in situations where the assessment determined they are necessary for safety of the client. If the client or client's representative wanted side rails on the bed, the agency RN would educate the client/representative about the risks related to the side rails and would assess whether the side rails met FDA standard. A physician order would be obtained for the side rails if indicated.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 265 | | |
| 0 415 SS=F | 144A.471, Subd. 1 License Required<br><br>A home care provider may not open, operate, manage, conduct, maintain, or advertise itself as | 0 415 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 415 | Continued From page 6<br><br>a home care provider or provide home care services in Minnesota without a temporary or current home care provider license issued by the commissioner of health.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain home care licensure while providing services to one of one client (C1).<br><br>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).<br><br>The findings include:<br><br>The licensee held previous temporary licenses from June 14, 2022, to June 12, 2023, and from December 13, 2023, to December 12, 2024. The licensee's current temporary license was effective October 31, 2025, to October 20, 2026.<br><br>During the survey April 20, 2026, through April 23, 2026, owner/registered nurse (O/RN)-B provided documents to the surveyor related to C1 that were dated for times the licensee had a break in licensure.<br><br>On April 23, 2026, at 6:58 a.m., the surveyor received a text message from O/RN-B which indicated C1 began receiving services on January 3, 2023. In addition, O/RN-B wrote "The 2024-2025 license was extended then | 0 415 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 415 | Continued From page 7<br>renewed/paid for".<br><br>On April 23, 2026, at 12:40 p.m., O/RN-B stated the home care agency continued to provide service to C1 at their school after the licensee's temporary license expired on December 13, 2024. O/RN-B stated the licensee had a contract with the school to provide services for payment. The surveyor requested to see the contract. O/RN-B stated they believed their previous temporary comprehensive license was extended not expired. O/RN-B stated they had been in contact with an employee from the Minnesota Department of Health (MDH) intermittently. O/RN-B stated they were told after their last license expired they would need to submit a new application however, the license would be extended, and they did not have to pay the licensure fee again. O/RN-B stated after they submitted the application they had not heard back from the MDH employee for a period of time. O/RN-B stated they misunderstood the next steps that needed to be completed for licensure and they believed they remained licensed. The surveyor explained the dates the licensee held a temporary license to O/RN-B and inquired if any services were provided between December 12, 2024, and October 31, 2025. O/RN-B stated yes. The surveyor did not receive the licensee's contract with the school prior to the conclusion of the survey.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 415 | | |
| 0 645 SS=F | 144A.475, Subd. 1 Conditions | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 8<br>(a) The commissioner may refuse to grant a temporary license, refuse to grant a license as a result of a change in ownership, refuse to renew a license, suspend or revoke a license, or impose a conditional license if the home care provider or owner or managerial official of the home care provider:<br>(1) is in violation of, or during the term of the license has violated, any of the requirements in sections 144A.471 to 144A.482;<br>(2) permits, aids, or abets the commission of any illegal act in the provision of home care;<br>(3) performs any act detrimental to the health, safety, and welfare of a client;<br>(4) obtains the license by fraud or misrepresentation;<br>(5) knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;<br>(6) denies representatives of the department access to any part of the home care provider's books, records, files, or employees;<br>(7) interferes with or impedes a representative of the department in contacting the home care provider's clients;<br>(8) interferes with or impedes a representative of the department in the enforcement of this chapter or has failed to fully cooperate with an inspection, survey, or investigation by the department;<br>(9) destroys or makes unavailable any records or other evidence relating to the home care provider's compliance with this chapter;<br>(10) refuses to initiate a background study under section 144.057 or 245A.04;<br>(11) fails to timely pay any fines assessed by the department;<br>(12) violates any local, city, or township ordinance relating to home care services; | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 9<br><br>(13) has repeated incidents of personnel performing services beyond their competency level; or<br>(14) has operated beyond the scope of the home care provider's license level.<br>(b) A violation by a contractor providing the home care services of the home care provider is a violation by the home care provider.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee impeded a representative of the Minnesota Department of Health (MDH) in the enforcement of this chapter and failed to fully cooperate with a full survey initiated on April 20, 2026. This had the potential to affect any current and/or future clients and staff.<br><br>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).<br><br>The findings include:<br><br>On April 20, 2026, at 11:02 a.m., via telephone, the surveyor left a message on the licensee's voicemail. The voicemail included the start time of the survey (12:00 p.m.) and requested a return call to the surveyor.<br><br>On April 20, 2026, at 11:07 a.m., the surveyor sent an entrance email to the licensee's email address on file with MDH. | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 10<br><br>On April 20, 2026, at 11:55 a.m., the surveyor arrived at the licensee's office location. The surveyor knocked and rang the doorbell. There was no answer.<br><br>The licensee's licensure application signed by owner/registered nurse (O/RN)-B on March 4, 2025, and provided to MDH, indicated the licensee's office hours were Monday through Friday, 9:00 a.m., to 5:00 p.m.<br><br>On April 20, 2026, at 11:59 a.m., the surveyor again reached out to the licensee via telephone. O/RN-B answered the telephone and stated they were at an appointment with a client. The surveyor inquired when the appointment would be complete or if the surveyor could meet O/RN-B at the appointment site. O/RN-B stated the appointment was over and they were returning to the area of the office. The surveyor inquired how long it would take to get back to the office. O/RN-B stated they first needed to take the client shopping to get supplies. The surveyor inquired if they could meet O/RN-B at the location they were going to. O/RN-B then stated the client was for a different home care agency where they were working, and the licensee's home care agency only had one client who was their son and he was at school. The surveyor told O/RN-B they would contact them again shortly.<br><br>On April 20, 2026, at 12:43 p.m., via telephone, the surveyor inquired when O/RN-B could return to the licensee's office. O/RN-B stated they would not be able to make it back to the office until after 3:15 p.m., and would be unable to have a conversation until after 4:00 p.m. O/RN-B stated they needed to complete services for the client of the other home care agency and then they | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 11<br><br>needed to attend a workman's compensation appointment before returning to the office. O/RN-B stated when they return to the office at 3:15 p.m., they would need to "settle" C1 from school (the office is within C1's home). O/RN-B stated they employed one other nurse however, they only assisted with C1's cares within the school. The surveyor stated they would send O/RN-B data requests and asked O/RN-B to email back the information by morning. O/RN-B stated they would after C1's personal care assistant (PCA) arrived.<br><br>On April 20, 2026, at 1:52 p.m., via email, the surveyor sent data requests for survey documents which included C1's record, registered nurse (RN)-A's employee record, and O/RN-B's employee record.<br><br>On April 20, 2026, at 3:02 p.m., via phone, O/RN-B stated RN-A only assisted C1 while they were at school and would not be available after school hours for an interview.<br><br>On April 20, 2026, at 3:04 p.m., via email, the surveyor requested multiple policies.<br><br>On April 21, 2026, at 6:15 a.m., the surveyor reviewed the emails that were sent by O/RN-B. The documents included Minnesota Adult Abuse Reporting Center (MAARC) reports, discharged roster, current resident roster, emergency plan, license for RN-A, and staff list.<br><br>On April 21, 2026, at 7:23 a.m., the surveyor sent an email and requested data that was previously requested however, not received. The surveyor also requested O/RN-B to verify they were unable to assist with the survey until after 3:00 p.m., due to their other job. | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 12<br><br>On April 21, 2026, at 8:26 a.m., the surveyor spoke to O/RN-B via phone. O/RN-B stated they were having technical difficulty with scanning and emailing the information requested by the surveyor. The surveyor inquired if they could meet O/RN-B at the office so the surveyor could scan the documents necessary to conduct the survey. O/RN-B stated they needed to go to their medical provider for high blood pressure and headache. O/RN-B stated they were up much of the night providing care to C1 and they only had a short amount of time to work on the data requested around midnight. O/RN-B stated there was nobody to assist them with obtaining the data requested. The surveyor inquired if O/RN/B planned to return to the office that day. O/RN-B stated, "I might be", however, they also planned to work on getting the surveyor permission to enter C1's school and they did not get any rest yesterday. The surveyor again offered to come scan the data from the office and then leave right after the scanning was complete. O/RN-B repeated that they had to be checked out for their medical issues, and stated some of C1's documents were at the school and could be collected by the surveyor there after the surveyor was allowed entry.<br><br>On April 21, 2026, at 12:18 p.m., the surveyor called O/RN-B after visiting C1's school. O/RN-B stated they had just finished their medical appointment, and they were advised to go to the emergency room. O/RN-B stated they would not be able to make it to the office until after 4:00 p.m., and they were still having technical issues sending data to the surveyor. The surveyor told O/RN-B that they could provide the documents via email, or the surveyor could go to the office as long as there was someone there to let them in, | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 13<br>even if O/RN-B could not be present.<br><br>On April 21, 2026, at 1:05 p.m., via email, the surveyor reiterated their previous document request. In addition, the surveyor provided O/RN-B with a deadline to provide documents by 10:00 a.m., the following day.<br><br>On April 21, 2026, at 3:02 p.m., via phone, O/RN-B stated the surveyor would need to come to the office around 8:00 a.m., because they needed to celebrate C1's birthday at school on April 22, 2026. The surveyor made an appointment with O/RN-B to collect documents at 8:00 a.m., on April 22, 2026.<br><br>On April 22, 2026, at 7:42 a.m., the surveyor arrived at the licensee's office and observed C1 being transported onto a bus with the assistance of RN-A. The surveyor was shown to the kitchen table by C1's PCA (who was not affiliated with the licensee's agency). The surveyor began scanning the documents that were available. At 7:48 a.m., O/RN-B greeted the surveyor and answered questions related to C1's service plan and then made herself unavailable so she could take a shower.<br><br>On April 22, 2026, at 8:46 a.m., the surveyor requested C1's medication setup record. O/RN-B stated they were still having technical issues. Because O/RN-B appeared rushed, the surveyor inquired how much time they could have in the licensee's office to scan documents. O/RN-B stated, "you said it would take about 30 minutes to scan but I don't think you can scan that fast, so I will wait until you are done scanning."<br><br>On April 22, 2026, at 8:53 a.m., the surveyor inquired when they could come back for an | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 14<br><br>interview since O/RN-B stated they had to leave for C1's school. O/RN-B inquired how long the interview would take. The surveyor stated anywhere between one and a half hours to three hours. O/RN-B did not respond. The surveyor again asked when they could either return for an interview or conduct an interview by phone in the next 24-hours. O/RN-B did not answer the surveyor's question and stated C1 had an appointment the following day at 9:00 a.m., that they had to take them to.<br><br>On April 22, 2026, at 10:05 a.m., the surveyor exited the licensee's office and told O/RN-B they would contact them later in the day for an interview. O/RN-B stated they may be too tired or busy. The surveyor told O/RN-B they would still attempt to call.<br><br>On April 22, 2026, at 3:03 p.m., via email, O/RN-B stated they had gathered the remaining documents that were not provided to the surveyor. There were no documents attached to the email. O/RN-B wrote that some of the documents were located at the school and some were located in the office.<br><br>On April 22, 2026, at 3:07 p.m., via email, O/RN-B stated they received their login information to provide the surveyor information related to background studies. They would send the surveyor the roster. There were no documents attached to the email.<br><br>On April 22, 2026, at 3:10 p.m., the surveyor called O/RN-B to conduct an interview. O/RN-B did not answer the phone, and the surveyor left a message related to conducting an interview and receiving the remaining documents. | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 15<br><br>On April 22, 2026, at 3:18 p.m., via email, the surveyor requested O/RN-B pick a time for an interview on April 23, 2026. The surveyor indicated the interview would take between one and a half hours and three hours.<br><br>On April 22, 2026, at 3:28 p.m., the surveyor received a text message from O/RN-B related to tuberculosis screening. O/RN-B did not return the telephone call from the surveyor.<br><br>On April 23, 2026, at 6:07 a.m., the surveyor reviewed emails sent when the surveyor was not working. O/RN-B sent two emails, one at 4:03 p.m., and one 4:54 p.m., on April 22, 2026. One of the emails indicated for the surveyor to be at the licensee's office that day at 8:00 a.m., and the other to be at the office between 12:00 p.m., and 1:00 p.m. O/RN-B wrote, "please be advised that there may be interruptions as I will be providing care for him [C1] during our meeting." The surveyor sent an email to clarify which time O/RN-B would be available.<br><br>On April 23, 2026, at 6:24 a.m., via email, O/RN-B confirmed they would be available between 12:00 p.m., and 1:00 p.m.<br><br>On April 23, 2026, at 1:06 p.m., the surveyor asked questions about O/RN-B's availability during the survey. O/RN-B stated on Monday they had to take a client to St. Paul. Tuesday, they had health issues and did not get enough rest. Wednesday, they needed to be at C1's school for their graduation, and Thursday morning they had to take C1 to a medical appointment. O/RN-B stated they did not have anyone available to assist them.<br><br>No further information was provided. | 0 645 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 645 | Continued From page 16<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 645 | | |
| 0 810 SS=F | 144A.479, Subd. 6(b) Individual Abuse Prevention Plan<br><br>(b) Each home care provider must develop and implement an individual abuse prevention plan for each vulnerable minor or adult for whom home care services are provided by a home care provider. The plan shall contain an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults or minors; the person's risk of abusing other vulnerable adults or minors; and statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review the licensee failed to develop and implement an individual abuse prevention plan (IAPP) for one of one client (C1).<br><br>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). | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 810 | Continued From page 17<br><br>The findings include:<br><br>The licensee held previous temporary licenses from June 14, 2022, to June 12, 2023, and from December 13, 2023, to December 12, 2024. The licensee's current temporary license was effective October 31, 2025, to October 20, 2026.<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's diagnoses included tracheostomy dependence, ventilator dependence, seizure disorder, and cerebral palsy with spastic quadriplegia.<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure. The service plan did not indicate services that would be provided.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the nurse was responsible for seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>C1's Abuse Prevention Plan: Vulnerability and Safety Assessment completed on April 28, 2025, indicated C1 was at risk of abuse from others and was not at risk to abuse others. The document lacked statements of specific measures to be taken to minimize the risk of abuse to C1. The document was created during a break in | 0 810 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 810 | Continued From page 18<br>licensure.<br><br>C1's record lacked an IAPP from the current licensee.<br><br>On April 23, 2026, at approximately 12:40 p.m., owner/registered nurse (O/RN)-B stated they believed their previous temporary comprehensive license was extended, not expired, therefore the IAPP remained applicable. O/RN-B stated C1's care was a continuation of service, and they completed an IAPP yearly. O/RN-B stated C1's IAPP was due next on April 25, 2026, and they did not know they needed to complete a new IAPP with the new licensure.<br><br>The licensee's undated Abuse Prevention Plan policy indicated that all clients admitted to the licensee would be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The licensee would develop a statement of specific measures that would be taken to minimize the risk of abuse to that person and other vulnerable adults.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 810 | | |
| 0 835 SS=C | 144A.4791, Subd. 3 Statement of Home Care Services<br><br>Prior to the date that services are first provided to the client, a home care provider must provide to the client or the client's representative a written statement which identifies if the provider has a basic or comprehensive home care license, the | 0 835 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 835 | Continued From page 19<br><br>services the provider is authorized to provide, and which services the provider cannot provide under the scope of the provider's license. The home care provider shall obtain written acknowledgment from the clients that the provider has provided the statement or must document why the provider could not obtain the acknowledgment.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to ensure the licensee's Statement of Home Care Services was provided to the client or client representative prior to initiation of services for one of one client (C1).<br><br>This practice resulted in a level one violation (a violation that will cause only 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 potential to affect a large portion or all of the clients).<br><br>The findings include:<br><br>The licensee held previous temporary licenses from June 14, 2022, to June 12, 2023, and from December 13, 2023, to December 12, 2024. The licensee's current temporary license was effective October 31, 2025, to October 20, 2026.<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure. The service plan did not indicate services that would be provided. | 0 835 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 835 | Continued From page 20<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the nurse was responsible for seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>C1's record included a document titled Statement of Home Care Services: Comprehensive Home Care Provider signed April 28, 2025. The document was created during a break in licensure.<br><br>C1's record lacked a Statement of Home Care Services provided by the current licensee.<br><br>On April 23, 2026, at 12:40 p.m., owner/registered nurse (O/RN)-B stated believed their previous temporary comprehensive license was extended not expired, therefore the Statement of Home Care Services remained applicable.<br><br>On April 23, 2026, at 1:08 p.m., O/RN-B stated they filled out the Statement of Home Care Services: Comprehensive Home Care Provider to show what services were provided to C1. O/RN-B stated the document listed above was updated when there was a change to C1's services or annually. The surveyor explained to O/RN-B what the document's intended purpose was. O/RN-B stated they did not understand how the form was to be used, and they did not provide C1 with the Statement of Home Care Services when the licensee received their new temporary license | 0 835 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 835 | Continued From page 21<br>because they believed it was a continuation of service.<br><br>The licensee's undated Scope of Services Statement policy indicated the licensee would determine the type and scope of services that they would provide as a comprehensive home care provider. The information would be communicated to all clients and/or their representative. In addition, the Scope of Service Statement would be signed by the client or the client's representative, and a copy would be maintained in the client record.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 835 | | |
| 0 860 SS=F | 144A.4791, Subd. 8 Comprehensive Assessment and Monitoring<br><br>(a) When the services being provided are comprehensive home care services, an individualized initial assessment must be conducted in person by a registered nurse. When the services are provided by other licensed health professionals, the assessment must be conducted by the appropriate health professional. This initial assessment must be completed within five days after the date that home care services are first provided.<br>(b) Client monitoring and reassessment must be conducted in the client's home no more than 14 days after the date that home care services are first provided.<br>(c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 | 0 860 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 860 | Continued From page 22<br><br>days from the last date of the assessment. The monitoring and reassessment may be conducted at the client's residence or through the utilization of telecommunication methods based on practice standards that meet the individual client's needs.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to complete an initial assessment within five days after the date that home care services were first performed for one of one client (C1).<br><br>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).<br><br>The findings include:<br><br>The licensee held previous temporary licenses from June 14, 2022, to June 12, 2023, and from December 13, 2023, to December 12, 2024. The licensee's current temporary license was effective October 31, 2025, to October 20, 2026.<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's diagnoses included tracheostomy dependence, ventilator dependence, seizure disorder, and cerebral palsy with spastic quadriplegia. | 0 860 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 860 | Continued From page 23<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure. The service plan did not indicate services that would be provided.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the nurse was responsible seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>C1's record included nursing assessments dated February 15, 2025, April 28, 2025, May 13, 2025, July 6, 2025, July 25, 2025, August 12, 2025, and October 4, 2025, completed during a break in licensure. In addition, C1's record included nursing assessments completed on November 10, 2025, January 2, 2026, February 8, 2026, and April 1, 2026, during the licensee's current licensure. C1's record lacked an initial assessment completed within five days after starting comprehensive services.<br><br>On April 23, 2026, at 12:40 p.m., the surveyor inquired once the licensee received their new temporary license on October 31, 2025, when was the first day C1 received services. Owner/registered nurse (O/RN)-B stated on October 31, 2025, they received services at the school however there was no discontinuation of services for C1, and the licensee's home care agency continued to provide service to C1 at their school after the licensee's temporary license expired on December 13, 2024. | 0 860 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 860 | Continued From page 24<br><br>On April 23, 2026, at 12:55 p.m., O/RN-B stated they did not complete an assessment after the licensee received their new temporary comprehensive license. O/RN-B stated the assessment "was not based on the license it was based on the continuation of service" for C1. O/RN-B stated they continued the comprehensive schedule of initial, 14-day, 90-day, and with change of condition for C1's assessments.<br><br>The licensee's undated Comprehensive Client Assessment policy indicated the initial client assessment would be completed within five days after the initiation of services.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 860 | | |
| 0 865 SS=F | 144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions<br><br>(a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan.<br>(b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.<br>(c) The home care provider must implement and | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 25<br><br>provide all services required by the current service plan.<br>(d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.<br>(e) Staff providing home care services must be informed of the current written service plan.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to finalize a current written service plan no later than 14 days after the date that home care services were first provided.<br><br>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).<br><br>The findings include:<br><br>The licensee held previous temporary licenses from June 14, 2022, to June 12, 2023, and from December 13, 2023, to December 12, 2024. The licensee's current temporary license was effective October 31, 2025, to October 20, 2026.<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's diagnoses included tracheostomy dependence, ventilator dependence, seizure disorder, and cerebral palsy with spastic | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 26<br>quadriplegia.<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure. The service plan did not indicate services that would be provided.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the nurse was responsible seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>On April 21, 2026, at 12:07 p.m., the surveyor observed registered nurse (RN)-A administer a medication via feeding tube. RN-A stated it was C1's Keppra for seizures.<br><br>On April 23, 2026, at 12:40 p.m., owner/registered nurse (O/RN)-B stated believed their previous temporary comprehensive license was extended not expired.<br><br>On April 23, 2026, at 1:08 p.m., O/RN-B stated they did not initiate a new service plan with the effective date of their temporary license in October 2025. O/RN-B stated they believed it was a continuation of service, and they did not know they needed to complete a new service plan.<br><br>The licensee's undated Service Plan policy indicated a service plan shall be developed with all clients no later than 14 days after the start of services. | 0 865 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 865 | Continued From page 27<br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 865 | | |
| 0 870 SS=F | 144A.4791, Subd. 9(f) Content of Service Plan<br><br>(f) The service plan must include:<br>(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;<br>(2) the identification of the staff or categories of staff who will provide the services;<br>(3) the schedule and methods of monitoring reviews or assessments of the client;<br>(4) the schedule and methods of monitoring staff providing home care services; and<br>(5) a contingency plan that includes:<br>(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;<br>(ii) information and a method for a client or client's representative to contact the home care provider;<br>(iii) names and contact information of persons the client wishes to have notified in an emergency or if there is a significant adverse change in the client's condition; and<br>(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.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the | 0 870 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 870 | Continued From page 28<br><br>licensee failed to ensure the service plan included all required content for one of one client (C1).<br><br>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).<br><br>The findings include:<br><br>The licensee held previous temporary licenses from June 14, 2022, to June 12, 2023, and from December 13, 2023, to December 12, 2024. The licensee's current temporary license was effective October 31, 2025, to October 20, 2026.<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's diagnoses included tracheostomy dependence, ventilator dependence, seizure disorder, and cerebral palsy with spastic quadriplegia.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the nurse was responsible seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1. | 0 870 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 870 | Continued From page 29<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure. The service plan lacked the following required content:<br>- a description of the home care services to be provided including the frequency of each service according to the client's current assessment;<br>- identification of the staff or categories of staff who would provide the services;<br>- method of monitoring reviews or assessment of the client; and<br>- method of monitoring staff providing home care services.<br><br>On April 23, 2026, at 1:08 p.m., owner/registered nurse (O/RN)-B stated they filled out the Statement of Home Care Services: Comprehensive Home Care Provider to show what services were provided to C1. The surveyor explained to O/RN-B what the intended purpose of Statement of Home Care Service was for. O/RN-B stated they misunderstood how that form was to be used. In addition, O/RN-B stated the licensee purchased the service plan template and they did not know they needed to add additional information to the template.<br><br>The licensee's undated Service Plan policy indicated the service plan would include:<br>- a description of the home care services to be provided;<br>- the staff or categories of staff that would provide the services;<br>- the type and frequency of visits/services proposed to be furnished according to the client's current review/assessment and client preferences;<br>- the fees for services;<br>- the schedule and methods of monitoring reviews or assessments of client; | 0 870 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 870 | Continued From page 30<br>- the frequency of sessions of supervision of staff and type of personnel who would supervise staff; and<br>- a contingency plan when services when services cannot be provided.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 870 | | |
| 0 940 SS=F | 144A.4792, Subd. 9 Documentation of Medication Setup<br><br>Documentation of dates of medication setup, name of medication, quantity of dose, times to be administered, route of administration, and name of person completing medication setup must be done at the time of setup.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to document all medication setups for one of one client (C1).<br><br>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).<br><br>The findings include:<br><br>C1 began receiving comprehensive home care | 0 940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 940 | Continued From page 31<br>services on October 31, 2025.<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure (licensee held two previous comprehensive home care licenses). The service plan did not indicate services that would be provided.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the nurse was responsible seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>C1 received home care services in a school setting. C1's care included medication administration that was provided by registered nurse (RN)-A.<br><br>C1's medication administration record (MAR) dated April 2026, indicated RN-A administered the following medications on April 1, 6, 7, 13, 14, 15, and 20, 2026:<br>- carbidopa-levodopa 10 milligrams (mg)/ 100 mg dissolve 4 tablets in 20 milters (ml) of water and divide into 10 doses of 2 ml. Give 2 ml via gtube (feeding tube) at 2:00 p.m.;<br>- methemine 1 gram at 8:00 a.m. take with vitamin C; and<br>- levetiracetam 600 mg at 12:00 p.m.<br><br>On April 21, 2026, at 10:21 a.m., the surveyor observed a plastic bag with two empty syringes and two syringes that contained a liquid | 0 940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 940 | Continued From page 32<br>medication in C1's backpack at school.<br><br>On April 21, 2026, at 10:40 a.m., RN-A stated C1's mother (owner/registered nurse (O/RN)-B) set up the medications and then put medications into the school backpack to be administered at the school by RN-A.<br><br>On April 21, 2026, at 12:07 p.m., the surveyor observed RN-A administer a medication via feeding tube. RN-A stated it was C1's Keppra for seizures.<br><br>On April 22, 2026, at 8:46 a.m., O/RN-B confirmed they set up C1's medication for RN-A to administer at school. The surveyor requested C1's medication setup record. O/RN-B stated they used an app (software program) to record the medication set up and the app was currently not working. O/RN-B stated if the app worked, they could then print out the form and provide it to the surveyor.<br><br>On April 22, 2026, at 1:46 p.m., via email, the surveyor again requested C1's medication setup record.<br><br>On April 22, at 3:19 p.m., via email, the surveyor sent an additional request for C1's mediation setup record.<br><br>On April 23, 2026, at 12:59 p.m., O/RN-B stated they were only able to obtain one of the medication setup documents for the surveyor. O/RN-B stated they would check the application again to see if they would be able to provide more documents.<br><br>On April 23, 2026, at 1:17 p.m., O/RN-B again stated they would look for the medication setup | 0 940 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 940 | Continued From page 33<br>record and send it to the surveyor.<br><br>On April 23, 2026, at 2:11 p.m., via text message, O/RN-B sent the surveyor three images of one document titled Medication Setup Record. The document was dated April 1, 2026, and included the medication set up of the three medications listed above. The document indicated on April 1, 2026, the above medications were provided to RN-A at 7:27 a.m.<br><br>The surveyor did not receive a medication setup record for the three medications listed above for the dates of April 6, 7, 13, 14, 15, and 20, 2026, by 4:00 p.m., on the day the survey concluded.<br><br>The licensee's undated Medication Set Up Policy indicated a nurse would clearly document what nursing tasks were performed, what was assessed, and the findings found when completed medication setup.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 940 | | |
| 0 950 SS=F | 144A.4792, Subd. 10(b) Medication Mgt for Clients - Unplanned<br><br>(2) for unplanned time away, when the pharmacy is not able to provide the medications, a licensed nurse or unlicensed personnel shall give the client or client's representative medications in amounts and dosages needed for the length of the anticipated absence, not to exceed seven calendar days;<br>(3) the client or client's representative must be provided written information on medications, | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 950 | Continued From page 34<br>including any special instructions for administering or handling the medications, including controlled substances;<br>(4) the medications must be placed in a medication container or containers appropriate to the provider's medication system and must be labeled with the client's name and the dates and times that the medications are scheduled; and<br>(5) the client or client's representative must be provided in writing the home care provider's name and information on how to contact the home care provider.<br>(b) For unplanned time away when the licensed nurse is not available, the registered nurse may delegate this task to unlicensed personnel if:<br>(1) the registered nurse has trained the unlicensed staff and determined the unlicensed staff is competent to follow the procedures for giving medications to clients; and<br>(2) the registered nurse has developed written procedures for the unlicensed personnel, including any special instructions or procedures regarding controlled substances that are prescribed for the client. The procedures must address:<br>(i) the type of container or containers to be used for the medications appropriate to the provider's medication system;<br>(ii) how the container or containers must be labeled;<br>(iii) the written information about the medications to be given to the client or client's representative;<br>(iv) how the unlicensed staff must document in the client's record that medications have been given to the client or the client's representative, including documenting the date the medications were given to the client or the client's representative and who received the medications, the person who gave the medications to the | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 950 | Continued From page 35<br><br>client, the number of medications that were given to the client, and other required information;<br>(v) how the registered nurse shall be notified that medications have been given to the client or client's representative and whether the registered nurse needs to be contacted before the medications are given to the client or the client's representative;<br>(vi) a review by the registered nurse of the completion of this task to verify that this task was completed accurately by the unlicensed personnel; and<br>(vii) how the unlicensed staff must document in the client's record any unused medications that are returned to the provider, including the name of each medication and the doses of each returned medication.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to label medications that were sent with one of one client (C1) for planned time away from home.<br><br>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).<br><br>The findings include:<br><br>C1 began receiving comprehensive home care services on October 31, 2025. | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 950 | Continued From page 36<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure (licensee held two previous comprehensive home care licenses). The service plan did not indicate services that would be provided.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the document was the "DAYCARE PLAN" for C1 and was to be completed by a private duty nurse (PDN) that was a registered nurse (RN) or licensed practical nurse (LPN) for up to 24 hours per day. The nurse was responsible for all of C1's medical needs in the school setting including school sites, field trips, transportation, and all other educational outings. In addition, the nurse was responsible for seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>On April 21, 2026, at 10:21 a.m., the surveyor was at C1's school and observed a plastic bag with two empty syringes and two syringes that contained a liquid medication in C1's backpack. The surveyor observed that the bag and syringes were not labeled with C1's name or a date and time the medications were scheduled to be administered.<br><br>On April 21, 2026, at 10:40 a.m., RN-A stated C1's mother (owner/registered nurse (O/RN)-B) set up the medications and then put medications into the school backpack to be administered at | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 950 | Continued From page 37<br><br>school. In addition, the licensee did not follow the nursing standard of practice that a nurse cannot administer a medication that was preset by another nurse.<br><br>On April 21, 2026, at 12:07 p.m., the surveyor observed RN-A administer a medication via feeding tube. RN-A stated it was C1's Keppra for seizures. At 12:12 p.m., the surveyor inquired how RN-A knew what medication was being administered. RN-A stated the blue medication was for 2:00 p.m. administration, and the one they just administered was the noon medication. RN-A also described what the other two empty syringes contained prior to administration and then stated they knew what to administer by the color of the solution.<br><br>On April 22, 2026, at 9:11 a.m., O/RN-B stated they completed medication set ups for C1's medications. O/RN-B showed the surveyor a medication refrigerator located in C1's home (also the licensee's office). The refrigerator contained multiple baskets. The surveyor observed some baskets labeled with the name of the drug and the times to be administered and other baskets were labeled with the drug name, how many milters (ml) the syringe contained, and the time the medication was supposed to be administered. On the outside of medication refrigerator there were multiple sticky labels with times. O/RN-B stated normally they would grab the medication needed during school hour, grab a time label off of the front of the refrigerator, place the label onto the syringe, place the syringes into a plastic bag, and place them into the backpack to go with C1 to school. O/RN-B stated they forgot to label C1's medications with the times prior to sending them with C1 to school. | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 950 | Continued From page 38<br><br>The licensee's undated Medications for A Client Who Will Be Away from Home When Medications Are Scheduled policy indicated the RN or licensed practical nurse (LPN) would place medications in a properly labeled container (s) to go with the client when there was a planned absence away from home. The containers used for the medications were to be labeled with the client's name and the dates and times the medications were scheduled.<br><br>Ostendorf, P.A.P.A.G.P.P.A.S.A.H.W. R. (2025). Fundamentals of Nursing (12th ed.). Elsevier Health Sciences (US). https://bookshelf.vitalsource.com/books/9780443245336 Section 31. Medication Administration, page 643, Standards indicated, "To prevent medication errors, follow the seven rights of medication administration consistently every time you administer medications. Many medication errors can be linked in some way to an inconsistency in adhering to these seven rights:<br>1. The right medication<br>2. The right dose<br>3. The right patient<br>4. The right route<br>5. The right time<br>6. The right documentation<br>7. The right indication".<br><br>Page 644, Right Medication indicated, "Once you determine that information on a patient's MAR is accurate, use it to prepare and administer medications. When preparing medications from bottles or containers, compare the label of the medication container with the MAR 3 times: (1) before removing the container from the drawer or shelf, (2) as the amount of medication ordered is removed from the container, and (3) at the patient's bedside before administering the | 0 950 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 950 | Continued From page 39<br><br>medication to the patient. Never prepare medications from unmarked containers or containers with illegible labels (TJC, 2024a). With unit-dose prepackaged medications, check the label with the MAR when taking medications out of the medication dispensing system. Finally, verify all medications at the patient's bedside with the patient's MAR and use at least two identifiers before giving the patient any medications (TJC, 2024a)".<br><br>In addition, page 644 read, "Because the nurse who administers the medication is responsible for any errors related to it, nurses administer only the medication they prepare. You cannot delegate preparation of medication to another person and then administer the medication to the patient."<br><br>The licensee's undated Medications for A Client Who Will Be Away from Home When Medications Are Scheduled policy indicated the RN or licensed practical nurse (LPN) would place medications in a properly labeled container (s) to go with the client when there was a planned absence away from home. The containers used for the medications were to be labeled with the client's name and the dates and times the medications were scheduled.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 950 | | |
| 0 995 SS=F | 144A.4792, Subd. 19 Storage of Medications<br><br>A comprehensive home care provider providing storage of medications outside of the client's private living space must store all prescription | 0 995 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 995 | Continued From page 40<br><br>medications in securely locked and substantially constructed compartments according to the manufacturer's directions and permit only authorized personnel to have access.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview, and record review, the licensee failed to ensure medications were securely locked and permitted only authorized personnel to have access for one of one client (C1).<br><br>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).<br><br>The findings include:<br><br>C1 began receiving comprehensive home care services on October 31, 2025.<br><br>C1's record included a Service Plan dated April 28, 2025. The document was created during a break in licensure (licensee held two previous comprehensive home care licenses). The service plan did not indicate services that would be provided.<br><br>C1's Department of Health and Human Services document titled Home Health Certification and Plan of Care signed February 9, 2026, indicated the document was the "DAYCARE PLAN" for C1 and was to be completed by a private duty nurse | 0 995 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 995 | Continued From page 41<br><br>(PDN) that was a registered nurse (RN) or licensed practical nurse (LPN) for up to 24 hours per day. The nurse was responsible for all of C1's medical needs in the school setting including school sites, field trips, transportation, and all other educational outings. In addition, the nurse was responsible for seizure management, tracheostomy cares when needed (PRN), oxygen administration PRN, assistance with oral feeding, tube feeding, repositioning, condom catheter care, medication administration, brace management, pain management, and psychosocial needs of C1.<br><br>C1's Medication Management Services - Addendum to Service Plan signed April 4, 2026, indicated C1 required medication administration daily by the RN or LPN. In addition, the document read, "Storage of Medications Yes", the frequency of the medication storage was daily, and the responsible person responsible for medication storage was the RN or LPN. The individualized medication management plan did address that medications would be stored, however, did not address where the medication would be stored or if the medications would be secured.<br><br>On April 21, 2026, at 10:21 a.m., while making observations in C1's school, the surveyor observed RN-A walk away after they removed a hand split from C1. RN-A was out of the line of site from C1 for approximately two minutes, during which time, the surveyor observed multiple ambulatory people around the area of C1 in the special education school. When RN-A returned to C1, the surveyor inquired where C1's medications were located. RN-A pulled a bag with two empty syringes and two syringes that contained liquid medication from an unlocked and unsecured tan colored backpack located on the back of C1's | 0 995 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 995 | Continued From page 42<br><br>wheelchair. RN-A stated when they left C1, they were returning C1's splint back to the classroom.<br><br>On April 21, 2026, at 10:40 a.m., RN-A stated if they needed to leave the line of sight of C1 a teacher would watch C1. The surveyor inquired who would watch the medication while they were away from C1 to ensure no one had access. RN-A stated the medications were in the backpack and no one went through the backpack. RN-A agreed there were other students nearby C1 in the school. RN-A then stated the teachers were watching C1 when they were not near C1. The surveyor inquired if they believed there was a possibility another student or person could have accessed C1's medications. RN-A stated nobody would. The surveyor inquired why the medications were not secured in the school. RN-A stated C1's mother (owner/registered nurse (O/RN)-B) set up the medication and then put them into the school backpack. RN-A stated they did not have a lock to secure the medication at the school.<br><br>On April 21, 2026, at 10:44 a.m., school employee (SE)-C stated from what they knew, all medications should be locked in the school nursing office, and they were unaware C1 had medications at school. SE-C stated if they saw another student going into another student's backpack they would try to intervene.<br><br>On April 21, 2026, at 10:52 a.m., SE-D stated they believed medications should be stored in the nursing office and personal items kept in a locker. SE-D stated if RN-A left C1's line of site there was normally another employee near C1. SE-D stated they did not know C1 had medications in their backpack. | 0 995 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 0 995 | Continued From page 43<br><br>On April 21, 2026, at 10:52 a.m., school nurse (SN)-E stated they were not under the impression C1 received any medications while they were at school. In addition, the school nurse did not do anything for C1 while at school.<br><br>Although C1 had other people near them when RN-A was out of sight, the school workers listed above did not have awareness of the medications nor was it their responsibility to ensure the medication remained secure.<br><br>On April 22, 2026, at 9:20 a.m., O/RN-B stated C1's backpack did not have a lock on it to keep medications secured. O/RN-B stated they used to use a lunch box to hold the medication and then stick that into the bag however, the lunch box was not secured either.<br><br>The licensee's undated Medication Storage policy indicated if a client required assistance with medications an individualized plan would be developed that included storage of medication. The RN would identify in the individualized medication management plan where the client's medication would be stored or secured, any temperature controls needed, and who would have access to the medications.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 0 995 | | |
| 01245 SS=F | 144A.4798, Subd. 1 TB Infection Control<br><br>(a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current | 01245 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 01245 | Continued From page 44<br><br>tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in the CDC's Morbidity and Mortality Weekly Report. This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, and volunteers. The commissioner shall provide technical assistance regarding implementation of the guidelines.<br>(b) The home care provider must maintain written evidence of compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced by:<br>Based on interview and record review, the licensee failed to maintain a tuberculosis (TB) prevention and control program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC), which included an accurate two-step tuberculin skin test (TST) or other evidence of TB screening such as a blood test for one of two employees (registered nurse (RN)-A) and failed to conduct a health history symptom screen for one of two employees (owner/registered nurse (O/RN)-B).<br><br>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).<br><br>The findings include:<br><br>The licensee held a temporary home care license | 01245 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 01245 | Continued From page 45<br>effective October 31, 2025.<br><br>The licensee's Facility Risk Assessment Worksheet for Health Care Settings Licensed by MDH* (Minnesota Department of Health) dated June 30, 2025. The document was created during a break in licensure (licensee held two previous comprehensive home care licenses) and indicated the licensee's TB risk level was medium.<br><br>RN-A<br>RN-A was hired to the licensee under the previous temporary license on March 28, 2023, and began providing comprehensive services for the licensee on October 31, 2025.<br><br>RN-A's personnel record included a baseline TB screening tool for Healthcare Workers (HCWs) completed on March 28, 2023. In addition, RN-A's personnel record included a TST first step administered on March 28, 2026, and a second step TST completed April 1, 2026, four days after the first step TST. RN-A's record lacked a second step TST completed one to three weeks after the first step TST.<br><br>O/RN-B<br>O/RN-B was hired to the licensee under the previous temporary license on April 20, 2020, and began providing comprehensive services for the licensee on October 31, 2025.<br><br>O/RN-B's personnel record included a chest Xray which indicated O/RN-B had previously had a positive QuantiFERON TB gold test and O/RN-B was negative for TB. O/RN-B employee record lacked a TB health history symptom screen.<br><br>On April 23, 2026, at 12:59 p.m., O/RN-B stated | 01245 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 01245 | Continued From page 46<br><br>they did not know the timing of how a TST was supposed to be conducted. O/RN-B stated TB testing was completed at the employee's doctor's office and then brought to the licensee. O/RN-B stated the symptom evaluation was completed in the doctor's office prior to their TB blood test however, they did not have a record that it was conducted.<br><br>The CDC's Clinical Testing Guidance for Tuberculosis Health Care Personnel dated December 15, 2023, indicated TB screening included a baseline individual TB risk assessment, TB symptom evaluation, and a TB test.<br><br>The CDC's Testing for Tuberculosis : Skin Test dated January 31, 2025, indicated if the first TB skin Test result was negative, a second TB skin test should be completed one to three weeks later.<br><br>The licensee's undated Tuberculosis Screening policy indicated each employee having direct contact with clients must have documents of baseline health screening prior to providing care to clients. The evidence in a personnel record of baseline TB screening consisted of two components:<br>- assessing for current symptoms of active TB; and<br>- testing for the presence of infection by administering a TST or a TB blood Test.<br>In addition, the second step TST should be administered one to three weeks after the first step TST if the result was negative.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one | 01245 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | H42176 | A. BUILDING: _____ B. WING _____ | 04/23/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JEHU'S CARE INC | 3141 BERWICK KNOLL N BROOKLYN PARK, MN 55443 |

| (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 |
|---|---|---|---|---|
| 01245 | Continued From page 47<br>(21) days | 01245 | | |