



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

March 4, 2026

Licensee
RN Homecare Services LLC
17990 Ixonia Avenue
Lakeville, MN 55044

RE: Project Number(s) SL38029017

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on February 5, 2026, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. Chapter 260E.

MDH concludes the licensee is in substantial compliance. State law requires the agency must take action to correct the state correction orders and document the actions taken to comply in the agency's records. The Department reserves the right to return to the agency at any time should the Department receive a complaint or deem it necessary to ensure the health, safety, and welfare of residents in your care.

STATE CORRECTION ORDERS

The enclosed State Form documents the state correction orders. MDH 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 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

In accordance with Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document actions taken to comply with the correction orders within the time period 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 MDH within 15 business days of the correction order receipt date.

To submit a reconsideration request, please visit:

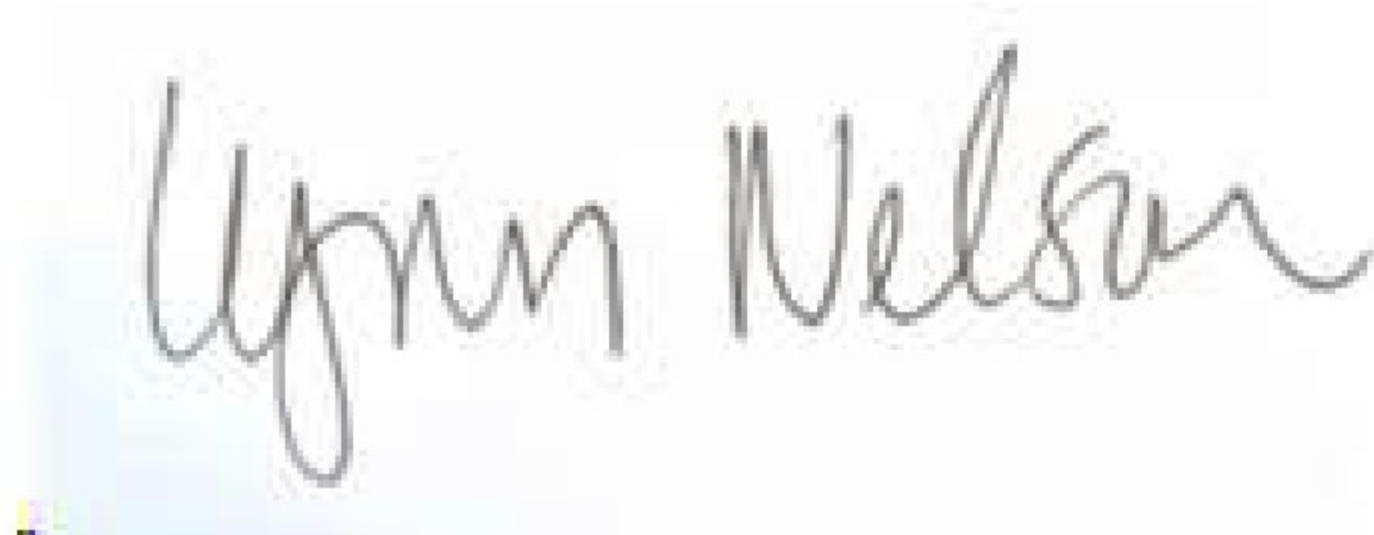
<https://forms.web.health.state.mn.us/form/HRDAppealsForm>

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **<https://forms.office.com/g/Bm5uQEPhVa>**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

A handwritten signature in blue ink that reads "Lynn Nelson". The signature is written in a cursive style and is positioned above a light blue rectangular background.

Lynn Nelson, Regional Operations Supervisor
Health Regulation Division
Email: Lynn.nelson@state.mn.us
Telephone: 651-201-4392 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H38029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER RN HOMECARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17990 IXONIA AVENUE LAKEVILLE, MN 55044		
(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 HOME CARE PROVIDER LICENSING CORRECTION ORDER(S) In accordance with Minnesota Statutes, section 144A.43 to 144A.482, these correction order(s) are issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL38029017 On February 3rd through February 5, 2026, a surveyor of The Minnesota Department of Health, visited the above provider and the following correction orders are issued. At the time of the survey, there were three (3) clients receiving services under the Comprehensive license.	0 000			
01190 SS=D	144A.4796, Subd. 6 Required Annual Training (a) All staff that perform direct home care services must complete at least eight hours of annual training for each 12 months of employment. The training may be obtained from the home care provider or another source and must include topics relevant to the provision of home care services. The annual training must include: (1) training on reporting of maltreatment of minors under chapter 260E and maltreatment of vulnerable adults under section 626.557,	01190			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H38029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER RN HOMECARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17990 IXONIA AVENUE LAKEVILLE, MN 55044		
(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
01190	Continued From page 1 whichever is applicable to the services provided; (2) review of the home care bill of rights in section 144A.44; (3) review of infection control techniques used in the home and implementation of infection control standards including a review of hand-washing techniques; the need for and use of protective gloves, gowns, and masks; appropriate disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades; disinfecting reusable equipment; disinfecting environmental surfaces; and reporting of communicable diseases; and (4) review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures. (b) In addition to the topics listed in paragraph (a), annual training may also contain training on providing services to clients with hearing loss. Any training on hearing loss provided under this subdivision must be high quality and research-based, may include online training, and must include training on one or more of the following topics: (1) an explanation of age-related hearing loss and how it manifests itself, its prevalence, and challenges it poses to communication; (2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or (3) information about strategies and technology that may enhance communication and involvement, including communication strategies, assistive listening devices, hearing aids, visual and tactile alerting devices, communication access in real time, and closed captions.	01190			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H38029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER RN HOMECARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17990 IXONIA AVENUE LAKEVILLE, MN 55044		
(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
01190	Continued From page 2 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure two of five employees, Registered Nurse (RN)-D and RN-E, had received annual training in the required topics and performance reviews since hire. 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 harm a client's health or safety) and was issued at an isolated scope when a limited number of staff are involved. Findings include: During record review, RN-D had hire date of 12/26/2023. RN-D's employee record lacked indication any required annual training or annual performance evaluations were completed. During record review, RN-E had hire date of 4/5/2024. RN-E's employee record lacked indication any required annual training or annual performance evaluations were completed. During interview with facility owner (RN)-B on 2/4/26 at 11:59 a.m., RN-B verified she was the only person to hire all staff and was responsible for all orientation and training. RN-B stated challenges in keeping staff "more than six months". In addition, RN-D and RN-E were the only staff (of 6 RNs) that worked for agency for more than 6 months. RN-B verified she did not provide annual training and performance evaluations for RN-D and RN-E. Undated facility policy titled Annual Training Requirements identified, "All staff that provide	01190			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H38029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER RN HOMECARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17990 IXONIA AVENUE LAKEVILLE, MN 55044			
(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
01190	Continued From page 3 direct home care services must complete at least eight (8) hours of annual training for each 12 months of employment" including specified areas of required training. TIMEPERIOD FOR CORRECTION: Twenty-One (21) days	01190			
01245 SS=D	144A.4798, Subd. 1 TB Infection Control (a) A home care provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current 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. (b) The home care provider must maintain written evidence of compliance with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure TB (tuberculosis) symptom screening was documented and completed for two of five employees, Registered Nurse (RN)-D and RN-E reviewed for TB screening and testing. According to the Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on Centers for Disease	01245			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H38029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER RN HOMECARE SERVICES LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 17990 IXONIA AVENUE LAKEVILLE, MN 55044			
(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 4 Control (CDC) guidelines, indicated a TB infection control program should include symptom screening (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated within 90 days before hire. In addition, baseline TB screening should be documented in the employee's record. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). Findings include: During record review, RN-D was hired 12/26/2023. Employee file lacked completed TB symptom screening form. During record review, RN-E was hired 4/5/2024. Employee file lacked completed TB symptom screening form. During interview with facility owner (RN)-B on 2/4/26 at 11:59 a.m., RN-B verified she was the only person to hire all staff and was responsible for all orientation and training. RN-B verified RN-D and RN-E failed to have completed TB symptom screening forms. RN-B stated she had had difficulty in having staff fill out the form prior to sending them to a clinic for the TB blood tests, medical evaluation (if appropriate), or chest x-ray. RN-B stated she understood importance of obtaining a signed and completed symptom screening form in addition to the results of the TB	01245			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: H38029	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/05/2026
NAME OF PROVIDER OR SUPPLIER RN HOMECARE SERVICES LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 17990 IXONIA AVENUE LAKEVILLE, MN 55044		
(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 5 tests at hire and having that information in each employee file. Undated facility policy titled Tuberculosis Screening identified, "For all employees or contract personnel providing direct client care, there shall be evidence of baseline TB screening". TIME PERIOD FOR CORRECTION: twenty one (21) days	01245			