Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

October 13, 2025

Licensee
CustomCARE
7801 East Bush Lake Road, Suite 100
Bloomington, MN 55439

RE: Project Number SL40832016

Dear Licensee:

This is your **official notice** that you have been **granted your comprehensive home care license.** Your license effective and expiration dates remain the same as on your temporary license. Your updated status will be listed on the license certificate at renewal and **this letter serves as proof** in the meantime. If you have not received a letter from us with information regarding renewing your license within 45 days prior to your expiration date, please contact us at (651) 201-5273 or by email at: health.homecare@state.mn.us.

The Minnesota Department of Health (MDH) completed an initial survey on August 28, 2025, for the purpose of assessing compliance with state licensing statutes. At the time of the survey MDH noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A.

In addition, on August 28, 2025, evaluators of this Department's staff visited the above home and community based services (HCBS) provider and there were no correction orders issued. At the time of the evaluation, there were 733 active clients receiving services under the HCBS license.

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
Per 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 clients/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

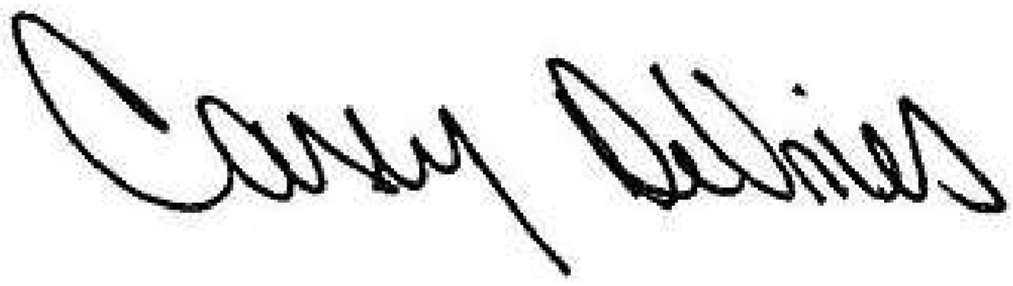
In accordance with Minn. Stat. § 144A.474, Subd. 12, you may challenge the correction order(s) issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by MDH within 15 business days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

Sincerely,



Casey DeVries, Supervisor
State Evaluation Team
Email: Casey.DeVries@state.mn.us
Telephone: 651-201-5917 Fax: 1-866-890-9290

CLN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40832	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTOMCARE	7801 EAST BUSH LAKE ROAD, SUITE 100 BLOOMINGTON, MN 55439

(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 *****ATTENTION****** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance. INITIAL COMMENTS: SL40832016-0 On August 25, 2025, through August 28, 2025, 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 were five clients receiving services under the provider's temporary Comprehensive Home Care 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. 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. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES. 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).	
0 860 SS=E	144A.4791, Subd. 8 Comprehensive Assessment and Monitoring	0 860		

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0 860	Continued From page 1 (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. (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. (c) Ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client and cannot exceed 90 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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure 90-day assessments were completed on time for two of three clients (C1, C3) This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the	0 860		

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0 860	Continued From page 2 situation has occurred repeatedly; but is not found to be pervasive). The findings include: C1 C1 Progress Visit/Review of Systems dated March 19, 2025. The next assessment was completed July 31, 2025, which was 93 days after the previous assessment, thus exceeding 90 calendar days. C3 C3 file included an assessment dated January 22, 2025. The next assessment was completed May 16, 2025, which was 114 days after the previous assessment, thus exceeding 90 calendar days. On August 26, 2025, at 9:32 a.m., registered nurse senior (RNS-C) stated they believed the responsible person for the client was required to be present during the 90-day assessment. RNS-C stated it was hard to coordinate with the responsible person to be available to meet the 90-day assessment. On August 28, 2025, at 9:38 a.m., RNS-C stated the progress visit documents were the 90-day assessments for clients. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 860		
0 870 SS=F	144A.4791, Subd. 9(f) Content of Service Plan (f) The service plan must include:	0 870		

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0 870	Continued From page 3 (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences; (2) the identification of the staff or categories of staff who will provide the services; (3) the schedule and methods of monitoring reviews or assessments of the client; (4) the schedule and methods of monitoring staff providing home care services; and (5) a contingency plan that includes: (i) the action to be taken by the home care provider and by the client or client's representative if the scheduled service cannot be provided; (ii) information and a method for a client or client's representative to contact the home care provider; (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 (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. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included all the required content for three of three clients (C1, C2, C3). 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	0 870		

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0 870	Continued From page 4 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1 C1 was admitted for home care services on March 25, 2024. C1 diagnoses included anoxic brain damage (damaged caused to the brain caused by lack of oxygen). C1's Care Plan dated July 31, 2025, indicated C1 received assistance with bathing, hair, skin, oral and nail care, dressing and undressing, medication administration, gastric tube (G-tube) feeding (a tube that is placed through the abdominal wall into the stomach for feeding), tracheostomy care (a surgical created opening in the trachea (the windpipe) that controls the breathing), transfers, positioning, light housekeeping, and shopping/errands/appointments. C1's service plan lacked the following required information: - the fees for services; - the identification of the staff or categories of staff who will provide the services; - the schedule and methods of monitoring reviews or assessments of the client and; - a contingency plan that includes: 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, and information and	0 870		

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0 870	Continued From page 5 a method for a client or client's representative to contact the home care provider. C2 C2 was admitted for home care services on March 25, 2024. C2's diagnoses included spina bifida (a birth defect where the spinal cord does not close completely during fetal development). C2's Working Care Plan dated December 27, 2024, indicated C2 received assistance with bathing, grooming, skin care, transfers, and light housekeeping. C2's service plan lacked the following required information: -the fees for services; - the identification of the staff or categories of staff who will provide the services; - the schedule and methods of monitoring reviews or assessments of the client and; - a contingency plan that includes: 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, and information and a method for a client or client's representative to contact the home care provider. C3 C3 was admitted for home care services on March 25, 2024. C3's diagnoses included muscular dystrophy (a genetic disorder that causes progressive muscle weakness and degeneration, fatty liver disease (a disease process where excessive fat collects in the liver), and spinal muscular dystrophy (a	0 870		

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0 870	Continued From page 6 genetic disorder that affects the nerves in the spinal cord). C3's Care Plan dated May 22, 2025, indicated C3 received assistance with bathing, grooming, medication administration, transfers, mobility, positioning, and light housekeeping. C3's service plan lacked the following required information: -the fees for services; - the identification of the staff or categories of staff who will provide the services; - the schedule and methods of monitoring reviews or assessments of the client and; - a contingency plan that includes: 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, and information and a method for a client or client's representative to contact the home care provider. On August 26, 2025, at 8:57 a.m., registered nurse senior (RNS)-C stated the process was to review the care plan each time an assessment was completed. RNS-C stated they were unaware of the required information that was to be included. On August 26, 2025, at 11:17 a.m., area manager (AM)-B stated they did not have a policy for service plans. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 870		

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0 920	Continued From page 7	0 920		
0 920 SS=D	144A.4792, Subd. 5 Individualized Medication Mgt Plan (a) For each client receiving medication management services, the comprehensive home care provider must prepare and include in the service plan a written statement of the medication management services that will be provided to the client. The provider must develop and maintain a current individualized medication management record for each client based on the client's assessment that must contain the following: (1) a statement describing the medication management services that will be provided; (2) a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; (3) documentation of specific client instructions relating to the administration of medications; (4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; (5) identification of medication management tasks that may be delegated to unlicensed personnel; (6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and (7) any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. (b) The medication management record must be current and updated when there are any	0 920		

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0 920	Continued From page 8 changes. (c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a current and individualized medication management plan was developed and maintained with all required content for one of two clients (C3). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C3 was admitted for home care services on March 25, 2024. C3's diagnoses included muscular dystrophy (a genetic disorder that causes progressive muscle weakness and degeneration, fatty liver disease (a disease process where excessive fat collects in the liver), and spinal muscular dystrophy (a genetic disorder that affects the nerves in the spinal cord). C3's Home Health Certification and Plan of Care indicated C3 received the following medications:	0 920		

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0 920	Continued From page 9 hydromorphone 2 milligrams (mg) every four hours as needed for pain, Tylenol 500 mg 1-2 tablets every six hours, aspirin 81 mg twice daily, hydroxyzine 25 mg 1-2 tablets every six hours as needed, ibuprofen 200 mg 1-2 tablets every six hours, calcium antacid 200mg 2 tablets three times daily, amlodipine 5 mg 1 tablet once daily, albuterol 90 micrograms (mcg) inhale 2 puffs every four hours as needed, albuterol nebulizer 2.5/3 milliliters (ml) every four hours as needed, azelastine 0.1 percent (%) install 2 sprays into each nostril (nose) twice daily, guaifenesin 600 mg extended release 1 tablet once daily, montelukast 10 mg 1 tablet once daily, testosterone 1 % 50 mg apply to shoulders, clotrimazole 1% cream, nystatin powder apply to skin twice daily, bisacodyl 10 mg 1 rectal suppository as needed for constipation, polyethylene glycol 17 grams (gm) powder mixed into 4-8 ounces of water, methocarbamol 500 1-2 tablets every six hours as needed, cetirizine 10 mg tablet once daily, and Excedrin 250 mg 1 tablet every 4 hours as needed. C3's Care Plan dated May 22, 2025, indicated C3 received assistance with medication administration. C3's record lacked a medication management plan to include the following required content: - statement describing the medication management services that will be provided; - a description of storage of medications based on the client's needs and preferences, risk of diversion, and consistent with the manufacturer's directions; - documentation of specific client instructions relating to the administration of medications; - identification of persons responsible for	0 920		

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0 920	Continued From page 10 monitoring medication supplies and ensuring that medication refills are ordered on a timely basis; - identification of medication management tasks that may be delegated to unlicensed personnel; - procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services, and; - any client-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions. On August 26, 2025, at 9:19 a.m., registered nurse senior (RNS)-C stated they were responsible for the medication management for clients. RNS-C stated they did not have that information for C3 and was unsure why that information was not completed. On August 26, 2025, at 11:17 a.m., area manager (AM)-B stated they did not have a policy for medication management plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 920		
01030 SS=F	144A.4793, Subd. 2 Policies and Procedures (a) A comprehensive home care provider who provides treatment and therapy management services must develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures. The policies and procedures must be developed	01030		

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01030	Continued From page 11 under the supervision and direction of a registered nurse or appropriate licensed health professional consistent with current practice standards and guidelines. (b) The written policies and procedures must address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting of treatment or therapy activities, educating and communicating with clients about treatments or therapy they are receiving, monitoring and evaluating the treatment and therapy, and communicating with the prescriber. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop, implement, and maintain up-to-date written treatment or therapy management policies and procedures as required. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1 was admitted for home care services on March 25, 2024. C1's Care Plan dated July 31, 2025, indicated C1 received assistance with gastric tube (G-tube)	01030		

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01030	Continued From page 12 feeding (a tube that is placed through the abdominal wall into the stomach for feeding), tracheostomy care (a surgical created opening in the trachea (the windpipe). The licensee lacked written policies and procedures for treatment or therapy management to address requesting and receiving orders or prescriptions for treatments or therapies, providing the treatment or therapy, documenting of treatment or therapy activities, educating and communicating with clients about treatments or therapy they are receiving, monitoring and evaluating the treatment and therapy, and communicating with the prescriber. On August 28, 2025, at 9:37 a.m., registered nurse senior (RNS)-C stated they do not have policies related to treatments or therapies. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01030		
01035 SS=F	144A.4793, Subd. 3 Individualized Treatment/Therapy Mgt Plan For each client receiving management of ordered or prescribed treatments or therapy services, the comprehensive home care provider must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the client. The provider must also develop and maintain a current individualized treatment and therapy management record for each client which must contain at least the following: (1) a statement of the type of services that will be	01035		

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	H40832	A. BUILDING: _____ B. WING _____	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUSTOMCARE	7801 EAST BUSH LAKE ROAD, SUITE 100 BLOOMINGTON, MN 55439

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01035	Continued From page 13 provided; (2) documentation of specific client instructions relating to the treatments or therapy administration; (3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel; (4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and (5) any client-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to develop and maintain a complete individualized treatment and therapy management plan for one of one client (C1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include:	01035		

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01035	Continued From page 14 C1 was admitted for home care services on March 25, 2024. C1 diagnoses included anoxic brain damage (damaged caused to the brain caused by lack of oxygen). C1's Care Plan dated July 31, 2025, indicated C1 received assistance with gastric tube (G-tube) feeding (a tube that is placed through the abdominal wall into the stomach for feeding), tracheostomy care (a surgical created opening in the trachea (the windpipe). C1's entire file lacked the following required content: - any client-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. On August 28, 2025, at 9:37 a.m., registered nurse senior (RNS)-C stated they were unaware of the required content for the treatment management plan and did not have a policy for treatment management plans. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01035		
01045 SS=D	144A.4793, Subd. 5 Documentation of Treatment/Therapy Each treatment or therapy administered by a comprehensive home care provider must be	01045		

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01045	Continued From page 15 documented in the client's record. The documentation must include the signature and title of the person who administered the treatment or therapy and must include the date and time of administration. When treatment or therapies are not administered as ordered or prescribed, the provider must document the reason why it was not administered and any follow-up procedures that were provided to meet the client's needs. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure treatments were documented in the client record for one of one client (C1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved or the situation has occurred only occasionally). The findings include: C1 was admitted for home care services on March 25, 2024. C1 diagnoses included anoxic brain damage (damaged caused to the brain caused by lack of oxygen). C1's Care Plan dated July 31, 2025, indicated C1 received assistance with bathing, hair, skin, oral,	01045		

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01045	Continued From page 16 and nail care, dressing and undressing, medication administration, gastric tube (G-tube) feeding (a tube that is placed through the abdominal wall into the stomach for feeding), tracheostomy care (a surgical created opening in the trachea (the windpipe) that controls the breathing), transfers, positioning, light housekeeping, and shopping/errands/appointments. C1's Care Plan dated July 31, 2025, indicated staff were to perform G-tube cares that included cleaning with peroxide (an aseptic solution) twice daily, administer 250 milliliters (ml) of Complete (a dietary supplement), 150 ml of water with 3 ounces of baby food three times daily, weekends give an additional 500 ml of Complete and give an additional 300 ml on Saturday and Sunday. The Care Plan also indicated staff were to perform tracheostomy care which included cleaning with peroxide twice daily, use ties (used to connect the breathing tube to the appliance on the patient), dressing change at the opening, and suctioning (removing excessive secretions). C1's record lacked documentation that treatments were administered by staff. On August 28, 2025, at 9:37 a.m., registered nurse senior (RNS)-C stated they were unaware staff were required to document any treatments performed. RNS-C further stated they do not have a policy related to treatment documentation. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01045		

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01050	Continued From page 17	01050		
01050 SS=F	144A.4793, Subd. 6 Treatment and Therapy Orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a prescriber order was obtained for treatments for one of one client (C1). This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients). The findings include: C1 was admitted for home care services on March 25, 2024. C1 diagnoses included anoxic brain damage (damaged caused to the brain caused by lack of oxygen). C1's Care Plan dated July 31, 2025, indicated C1	01050		

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01050	Continued From page 18 received assistance with gastric tube (G-tube) feeding (a tube that is placed through the abdominal wall into the stomach for feeding), tracheostomy care (a surgical created opening in the trachea (the windpipe). C1's Care Plan dated July 31, 2025, indicated staff were to perform G-tube cares that included cleaning with peroxide (an aseptic solution) twice daily, administer 250 milliliters (ml) of Complete (a dietary supplement), 150 ml of water with 3 ounces of baby food three times daily, weekends give an additional 500 ml of Complete and give an additional 300 ml on Saturday and Sunday. The Care Plan also indicated staff were to perform tracheostomy care that included cleaning with peroxide twice daily, use ties (used to connect the breathing tube to the appliance on the patient), dressing change at the opening, and suctioning (removing excessive secretions). C1's record lacked signed prescriber orders for the tracheostomy care and G-tube feeding. On August 28, 2025, at 9:25 a.m., registered nurse senior (RNS)-C stated they were unaware they were required to have signed orders for treatments. RNS-C stated they trained staff to follow the Care Plan for treatments. The licensee's Orders policy dated August 2023, indicated licensee would have signed orders from a prescriber. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	01050		

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01245	Continued From page 19	01245		
01245 SS=F	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 the provider established and maintained a tuberculosis (TB) prevention program, based on the most current guidelines issued by the Centers for Disease Control and Prevention (CDC) to include an updated facility TB risk assessment. Additionally, the licensee failed to include TB symptom evaluation, and baseline TB screening for one of three employees (registered nurse (RN)-D). 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	01245		

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01245	Continued From page 20 a large portion or all of the clients). The findings include: MISSING FACILITY TB RISK ASSESSMENT On August 26, 2025, at 10:50 a.m., the surveyor requested the facility TB risk assessment. Area manager (AM)-B stated they did not complete a TB facility risk assessment and was unaware of the requirement. MISSING TB SCREENING RN-D was hired on April 29, 2024, to provide supervision and direct care services. RN-D's record lacked a TB history and symptom screen at hire and a TB test (TB blood test or a TB skin test). On August 25, 2025, at 2:55 p.m., human resources manager (HRM)-G stated the TB screening was completed upon hire. HRM-G was not able to produce the TB screening for RN-D. HRM-G stated they were unsure why the screening was missing. On August 27, 2025, at 8:58 a.m., registered nurse senior (RNS)-C stated they do not have a TB screening or TB facility risk worksheet policy. The Minnesota Department of Health Tuberculosis Prevention and Control Program dated July 2013 recommended a TB screening was required for all healthcare workers, which consisted of assessment for current symptoms of active TB disease, assessing TB history, testing for the presence of infection Mycobacterium tuberculosis by administered either a two-step tuberculosis skin test (TST), or single interferon	01245		

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01245	Continued From page 21 gamma release assay (a blood test to determine if a person has been infected with TB). The Center for Disease Control Clinical Testing Guidance for Tuberculosis: Health Care Personnel dated May 17, 2019, recommended all United States health care personnel should have a completed a TB risk assessment, symptom evaluation, TB testing for tuberculosis, with additional working for TB disease with a positive test results or symptoms compatible with TB disease. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01245		
0 000	Integrated License (HCBS) Initial Comments SL40832016-0 On August 25, 2025, through August 28, 2025, a surveyor of this Department's staff visited the above provider. At the time of the survey, there were 733 clients that were receiving services under the Integrated licensure; Home and Community Based Service Designation. As a result of the survey, the licensee was determined to be in compliance with 144A.484 Integrated Licensure; Home and Community Based Service Designation.	0 000		