



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

Electronically Delivered

March 31, 2025

Licensee  
AJ Home Health Care Inc  
2106 Pembina Lane  
Shakopee, MN 55379

RE: Project Number SL40492016

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](mailto:health.homecare@state.mn.us).

The Minnesota Department of Health (MDH) completed an initial survey on March 5, 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 March 5, 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 no active clients receiving services under the HCBS license.

The Department of Health 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**

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.

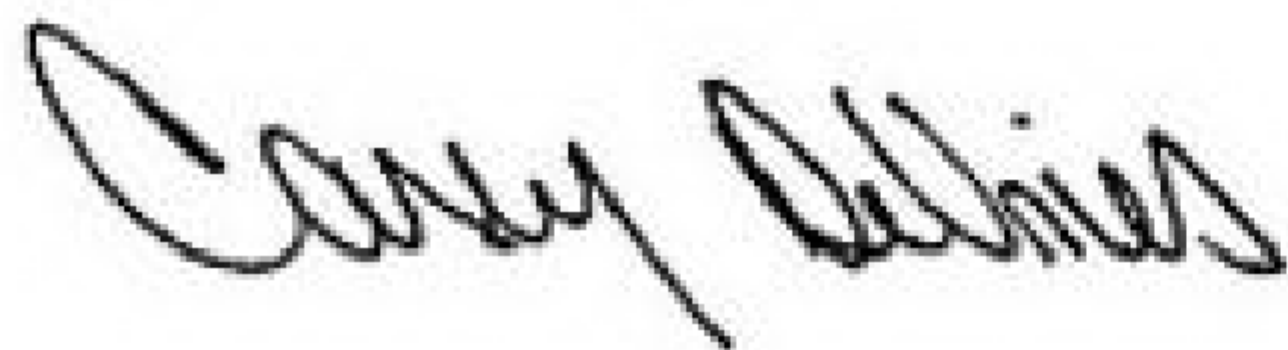
To submit a reconsideration request, please visit:

**<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](mailto: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](mailto:Casey.DeVries@state.mn.us)  
Telephone: 651-201-5917 Fax: 1-866-890-9290

HHH

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>H40492</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |  | (X3) DATE SURVEY COMPLETED<br><br><b>03/05/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AJ HOME HEALTH CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2106 PEMBINA LANE<br/>SHAKOPEE, MN 55379</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |  | (X5)<br>COMPLETE<br>DATE                            |
| 0 000                                                              | <p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>HOME CARE PROVIDER LICENSING<br/>CORRECTION ORDER</p> <p>In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey.</p> <p>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.</p> <p>INITIAL COMMENTS:</p> <p>SL40492016-0</p> <p>On March 3, 2025, through March 5, 2025, a surveyor of this Department's staff, visited the above temporary comprehensive home care licensed provider and the following correction orders were issued. At the time of the survey, there was one active client who received services under the temporary comprehensive license.</p> | 0 000                                                                   | <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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).</p> |  |                                                     |
| 0 810<br>SS=F                                                      | 144A.479, Subd. 6(b) Individual Abuse Prevention Plan                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 810                                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |  |                                                     |

Minnesota Department of Health

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

TITLE

(X6) DATE

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>AJ HOME HEALTH CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2106 PEMBINA LANE<br/>SHAKOPEE, MN 55379</b>                                 |  |                                                     |
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| 0 810                                                              | <p>Continued From page 1</p> <p>(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.</p> <p>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 (C2).</p> <p>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).</p> <p>The findings include:</p> <p>C1's diagnoses included other asthma, disruptive mood dysregulation disorder, generalized anxiety disorder, attention deficit hyperactivity disorder, major depressive order, and post-traumatic stress disorder.</p> | 0 810                                                                   |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| 0 810                                                              | <p>Continued From page 2</p> <p>C1's IAPP dated January 18, 2025, indicated C1 had had the following vulnerability: history of attempted suicide or thoughts of suicide, and need for physical help in an emergency.</p> <p>C1's IAPP failed to contain an individualized review or assessment of C1's susceptibility to abuse by another individual, including other vulnerable adults or minors; C1'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 C1 and other vulnerable adults or minors.</p> <p>On March 4, 2025, at 9:30 a.m., registered nurse (RN)-A stated they were not aware of the requirement to include the missing individualized assessment in C1's IAPP.</p> <p>The licensee's undated Abuse Prevention Plan policy indicated all clients admitted to the agency will be assessed for their susceptibility to abuse by other individuals, including other vulnerable adults and their risk of abusing other vulnerable adults. The agency will develop a statement of the specific measures that will be taken to minimize the risk of abuse to that person and other vulnerable adults. This includes self-abuse.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 0 810                                                                   |                                                                                                                          |  |                                                     |
| 0 860<br>SS=F                                                      | <p>144A.4791, Subd. 8 Comprehensive Assessment and Monitoring</p> <p>(a) When the services being provided are</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 0 860                                                                   |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| 0 860                                                              | <p>Continued From page 3</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure a registered nurse (RN) completed an initial assessment within five days after the date that home care services were first provided for one of one client (C2).</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> | 0 860                                                                                    |                                                                                                                          |  |                                                     |

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| 0 860                                                              | <p>Continued From page 4</p> <p>C2 was admitted to the licensee on October 5, 2024, to receive comprehensive home care services.</p> <p>C2's Service Plan dated October 5, 2024, indicated C2 received the following home care services: medication management services - ordering, injection every other week, and client education.</p> <p>C1's record included an initial assessment completed on October 14, 2024, which was eight days after initiation of home care services.</p> <p>On March 4, 2025, at 10:10 a.m., registered nurse (RN)-A stated they had completed the initial assessment on paper, then on October 14, 2024, transferred the assessment information to Rtask (documentation software). However, when the surveyor requested for the paper assessment the licensee was not able to provide it.</p> <p>The licensee's undated Comprehensive Home Care Resource Manual policy indicated nurses shall conduct assessments, monitoring, and reassessments consistent with Comprehensive Home Care requirements and the individualized needs of each home care client. The policy also indicated initial individualized assessment would be completed within five days after the date home care services are first provided.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 0 860                                                                   |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| 01190                                                              | Continued From page 5                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 01190                                                                                    |                                                                                                                          |  |                                                        |
| 01190<br>SS=F                                                      | <b>144A.4796, Subd. 6 Required Annual Training</b><br><br>(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:<br>(1) training on reporting of maltreatment of minors under chapter 260E and maltreatment of vulnerable adults under section 626.557, whichever is applicable to the services provided;<br>(2) review of the home care bill of rights in section 144A.44;<br>(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<br>(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.<br>(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:<br>(1) an explanation of age-related hearing loss | 01190                                                                                    |                                                                                                                          |  |                                                        |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>H40492</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                    |  | (X3) DATE SURVEY COMPLETED<br><br><b>03/05/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AJ HOME HEALTH CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2106 PEMBINA LANE<br/>SHAKOPEE, MN 55379</b>                                 |  |                                                     |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  | (X5)<br>COMPLETE<br>DATE                            |
| 01190                                                              | <p>Continued From page 6</p> <p>and how it manifests itself, its prevalence, and challenges it poses to communication;<br/>(2) health impacts related to untreated age-related hearing loss, such as increased incidence of dementia, falls, hospitalizations, isolation, and depression; or<br/>(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.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the licensee failed to ensure employee received at least eight hours of annual training for each 12 months of employment to include all the required topics for one of one employee (registered nurse (RN)-A).</p> <p>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).</p> <p>The findings include:</p> <p>RN-A started employment with the licensee on February 2, 2024, to provide direct home care services.</p> <p>RN-A's employee record lacked the required eight hours of annual training within 12 months of</p> | 01190                                                                   |                                                                                                                          |  |                                                     |

Minnesota Department of Health

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>H40492</b>               | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                      |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>03/05/2025</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>AJ HOME HEALTH CARE INC</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2106 PEMBINA LANE<br/>SHAKOPEE, MN 55379</b> |                                                                                                                                                                                                                                                                            |  |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                           | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                   |  | (X5)<br>COMPLETE<br>DATE                               |
| 01190                                                              | <p>Continued From page 7</p> <p>employment in the following topics:</p> <ul style="list-style-type: none"><li>- training on reporting of maltreatment of minors and/or adults;</li><li>- review of the home care bill of rights in section 144A.44;</li><li>- review of infection control techniques used in the home; and</li><li>- review of the provider's policies and procedures relating to the provision of home care services and how to implement those policies and procedures.</li></ul> <p>On March 4, 2025, at 12:00 p.m., RN-A stated they had not received the required annual training as they did not know when it was due. RN-A also stated they were the only employee currently working for the licensee.</p> <p>The licensee's undated Required Annual Staff Training policy indicated all staff that perform direct home care services will complete a minimum of eight (8) hours of annual training for each 12 months of employment. The policy also included all the missing topics above.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days</p> | 01190                                                                                    |                                                                                                                                                                                                                                                                            |  |                                                        |
| 0 000                                                              | <p>Integrated License (HCBS) Initial Comments</p> <p>INITIAL COMMENTS:<br/>SL40492016-0</p> <p>On March 3, 2025, through March 5, 2025, a surveyor of this Department's staff, visited the above provider. At the time of the survey, registered nurse (RN)-A stated there were no</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | 0 000                                                                                    | <p>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</p> |  |                                                        |

Minnesota Department of Health

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| NAME OF PROVIDER OR SUPPLIER<br><br><b>AJ HOME HEALTH CARE INC</b> |                                                                                                                                                  |                                                                         | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>2106 PEMBINA LANE<br/>SHAKOPEE, MN 55379</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |  |                                                     |
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| 0 000                                                              | Continued From page 8<br><br>clients receiving services under the Integrated<br>license; Home and Community Based Service<br>(HCBS) Designation. | 0 000                                                                   | <p>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.</p> <p>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.</p> <p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</p> <p>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)</p> |  |                                                     |