DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 12, 2025

Licensee
Allpro Staffnet LLC
2355 Highway 36 West Suite 421
Roseville, MN 55113

RE: Project Number(s) SL40730016

Dear Licensee:

On November 6, 2025, the Minnesota Department of Health (MDH) completed a follow-up survey of your agency to determine correction of orders found on the survey completed on June 18, 2025. The follow-up survey determined your agency had not corrected all of the state licensing orders issued pursuant to the June 18, 2025 survey.

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.

In accordance with Minn. Stat. § 144A.474, Subd. 11, state licensing orders issued pursuant to the last survey, completed on June 19, 2025, found not corrected at the time of the November 6, 2025, follow-up survey and/or subject to penalty assessment are as follows:

0815-Employee Records-144a.479, Subd. 7
0865-Service Plan, Implementation & Revisions-144a.4791, Subd. 9(a-E)
0870-Content Of Service Plan-144a.4791, Subd. 9(f)
1110-Unlicensed Personnel - Basic-144a.4795, Subd. 3(a)
1180-Orientation To Client-144a.4796, Subd. 4
1245-Tb Infection Control-144a.4798, Subd. 1

The details of the violations noted at the time of this follow-up survey completed on November 6, 2025 (listed above), are on the attached State Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags.

Also, at the time of this follow-up survey completed on November 6, 2025, we identified the following violation(s):

0560-Correction Orders-144a.474, Subd. 8 - $500.00

The details of the violation(s) noted at the time of this follow-up survey are delineated on the attached State Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction.

The total amount you are assessed is $500.00. You will be invoiced approximately 30 days after receipt of this notice, subject to appeal.

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 outlined on the state form; however, plans of correction are not required to be submitted for approval.

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

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

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

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

REQUESTING A HEARING
Alternatively, in accordance with Minn. Stat. § 144A.474, Subd. 11 (g), a home care provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144A.475, subd 4 and Subd. 7, a request for a hearing must be in writing and received by MDH within 15 calendar days of the correction order receipt date. The request must contain a brief and plain statement describing each matter or issue contested and any new information you believe constitutes a defense or mitigating factor.

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

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both. If you wish to contest tags without fines in a reconsideration and tags with the fines at a hearing, please submit two separate appeals forms at the website listed above.

We urge you to review these orders carefully. If you have questions, please contact Jodi Johnson at 507-344-2730.

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

Sincerely,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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: SL40730016-1 On November 6, 2025, surveyors of this Department's staff conducted a revisit at the above provider to follow-up on orders issued pursuant to a survey completed on June 18, 2025. At the time of the survey, there were seven clients that were receiving basic services. As a result of the revisit, the following orders were reissued: 0815, 0865, 0870, 1110, 1180, 1245.	{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 USED PURSUANT TO 144A.474 SUBD. 11 (b) (1) (2).	
0 560 SS=F	144A.474, Subd. 8 Correction Orders Subd. 8.Correction orders. (a) A correction order	0 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 560	Continued From page 1 may be issued whenever the commissioner finds upon survey or during a complaint investigation that a home care provider, a managerial official, or an employee of the provider is not in compliance with sections 144A.43 to 144A.482. The correction order shall cite the specific statute and document areas of noncompliance and the time allowed for correction. (b) The commissioner shall mail copies of any correction order to the last known address of the home care provider, or electronically scan the correction order and e-mail it to the last known home care provider e-mail address, within 30 calendar days after the survey exit date. A copy of each correction order and copies of any documentation supplied to the commissioner shall be kept on file by the home care provider, and public documents shall be made available for viewing by any person upon request. Copies may be kept electronically. (c) By the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction order in future surveys, upon a complaint investigation, and as otherwise needed. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to have sufficient documentation with actions taken to comply with the correction orders for a survey completed on June 18, 2025, and a revisit survey completed on November 6, 2025.	0 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 560	Continued From page 2 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: During the revisit entrance conference on November 6, 2025, at 1:30 p.m., regional operations manager (ROM)-F reported steps had been taken to correct the orders which had been identified from the previous survey completed on June 18, 2025. ROM-F reported that she felt the orders had been corrected and/or were in the process of correction. Care coordinator (CC)-A stated the plan of correction was documented on November 6, 2025 (the day of survey). During the revisit survey on November 6, 2025, a review of the licensee's policies and procedures, client records, and employee records lacked evidence to indicate the licensee had attempted to correct the following orders issued on September 24, 2025: 0815 and 1245. No further information was provided. TIME PERIOD FOR CORRECTION: Seven (7) days	0 560		
{0 815} SS=D	144A.479, Subd. 7 Employee Records Subd. 7.Employee records. The home care provider must maintain current records of each	{0 815}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{0 815}	Continued From page 3 paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations; (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years.	{0 815}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{0 815}	Continued From page 4 This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure employee records included the required content for one of one employee (unlicensed personnel (ULP)-F). 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: ULP-F had a hire date of September 30, 2025, to provide direct home care services to the licensee's clients. ULP-F's employee record lacked evidence of a job description including qualifications, responsibilities, and identification of staff providing supervision. On November 6, 2025, at 2:16 p.m., regional operations manager (ROM)-F stated ULP-F's employee record did not include a job description, and it was missed with onboarding. The plan of correction document dated November 6, 2025 (the day survey started), indicated the licensee shall ensure that employee files are complete with signed job descriptions, and onboarding.	{0 815}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{0 815}	Continued From page 5 The licensee's Employee Records policy, undated, indicated the licensee maintains a personnel file on each employee. The personnel's file includes such information as the employee's job application, resume, records of training, annual evaluations, competency verifications, signed job description, reference checks, verification on credentials, records of TB screening, Hepatitis B, decline/acceptance form, bloodborne pathogen training. No further information was provided.	{0 815}		
{0 865} SS=D	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan	{0 865}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 865}	Continued From page 6 must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was finalized no later than 14 days after the date services began for one of one client (C4). 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: C4 began receiving basic home care services on September 8, 2025. C4's care plan/service plan signed on September 26, 2025, indicated C4's services included assistance with laundry, linen, bedmaking, housekeeping, shopping, meal prep/cooking, bathing, grooming, and dressing. C4's record lacked evidence to indicate the client was provided with a written service plan that was finalized no later than 14 days after the date services were provided. C4's service plan was	{0 865}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 865}	Continued From page 7 signed 18 days after the date services were provided. On November 6, 2025, at 2:26 p.m., care coordinator (CC)-A stated the licensee did not complete the service plan on time and should have completed it no later that 14 days after services were provided. The plan of correction document dated November 6, 2025 (the day survey started), indicated the licensee's coordinator shall ensure that completed and finalized service plans are in the clients file within 14 days of care being initiated. No further information was provided.	{0 865}		
{0 870} SS=D	144A.4791, Subd. 9(f) Content of Service Plan (f) The service plan must include: (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences; (2) the identification 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	{0 870}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 870}	Continued From page 8 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 one of one client (C4). 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: C4 C4 began receiving Basic home care services on September 8, 2025.	{0 870}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 870}	Continued From page 9 C4's care plan/service plan signed on September 26, 2025, indicated C4's services included assistance with laundry, linen, bedmaking, housekeeping, shopping, meal prep/cooking, bathing, grooming, and dressing. C4's service plan lacked the following required content: -frequency of each service, according to the client's current review or assessment and client preferences; -the schedule and methods of monitoring reviews or assessments of the client; -the schedule and methods of monitoring staff providing home care services; and -a contingency plan that includes: 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 - 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. On November 6, 2025, at 2:51 p.m., regional operations manager (ROM)-F stated the service plan did not include the above required content. The plan of correction document dated November 6, 2025 (the same day survey started), indicated the licensee has updated the service plan to include missing documentation. The licensee's coordinator and operations team shall ensure that the corrected service plan is utilized for each client and signed. The licensee's Service Plan Contents policy, undated, indicated the service plan must include the following: The service plan must include the	{0 870}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{0 870}	Continued From page 10 following: -type of service(s) and care to be rendered. -frequency and duration of services -restrictions -identification of staff or categories of staff -schedule and methods of monitoring reviews or assessments -schedule and methods of monitoring staff -safety measures and goals -alternate staffing measures include: -action to be taken -licensee's contact information -emergency Contact -circumstances in which emergency medical services are NOT to be contacted No further information was provided.	{0 870}		
{01110} SS=D	144A.4795, Subd. 3(a) Unlicensed Personnel - Basic Subd. 3.Unlicensed personnel. (a) Unlicensed personnel providing basic home care services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the home care provider and the topics listed in subdivision 7, paragraph (b); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and in the topics listed in subdivision 7, paragraph (b); and successfully demonstrated competency of topics in subdivision 7, paragraph (b), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel providing home care	{01110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{01110}	Continued From page 11 services for a basic home care provider may not perform delegated nursing or therapy tasks. (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive home care provider must: (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. (c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks in subdivision 4 and any other training or competency requirements within the licensed health professional scope of practice relating to delegation or assignment of tasks to unlicensed personnel. This MN Requirement is not met as evidenced by: Based on interview and record review the licensee failed to ensure one of one unlicensed	{01110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{01110}	Continued From page 12 personnel (ULP-E) successfully completed training, competency evaluation, and demonstrated competency on the tasks the ULP-E would perform. 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: ULP-E was hired on September 30, 2025, to provide basic home care services for the licensee's clients. ULP-E's employee record lacked evidence ULP-E had demonstrated competency by satisfactorily completing a written or oral test on all of the tasks to be performed and successfully demonstrated competency by a practical skills test. On November 6, 2025, at 2:53 p.m., regional operations manager (ROM)-F stated ULP-E's employee file lacked all of the required training and competency evaluation and demonstrated competency on all tasks. The plan of correction document dated November 6, 2025 (same day survey started), indicated the licensee's administrative team in collaboration with operations support and coordinators shall ensure that all unlicensed staff has been assigned and completed required in services, trainings, and competency evaluations.	{01110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{01110}	Continued From page 13 Documentation of such shall be maintained the personnel files of the individual. The licensee's Unlicensed Personnel - Basic Training policy, undated, indicated unlicensed personnel providing basic home care services must have successfully completed training and competency evaluation by the home care provider. Unlicensed personnel shall have training and competency evaluations for the following: -documentation requirements for all services provided; -reports of changes in the client's condition to the supervisor designated by the agency; -basic infection control, including blood-borne pathogens maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; -training on prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminder; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between	{01110}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{01110}	Continued From page 14 staff and clients and the client's family; -procedures to utilize in handling various emergency situations; and -awareness of commonly used health technology equipment and assistive devices. No further information was provided.	{01110}		
{01180} SS=D	144A.4796, Subd. 4 Orientation to Client Subd. 4.Orientation to client. Staff providing home care services must be oriented specifically to each individual client and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the employee record included evidence of orientation to the client for one of one employee (unlicensed personnel (ULP)-E). 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:	{01180}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
{01180}	Continued From page 15 ULP-E was hired on September 30, 2025, to provide basic care services for the licensee's clients. ULP-E's employee record lacked documentation of orientation to each client and services provided. On November 6, 2025, at 2:57 p.m., care coordinator (CC)-A stated ULP-E's employee record lacked documentation of orientation to each client and services provided. CC-A stated this is done verbally, and there is no documentation of this. The plan of correction document dated November 6, 2025, indicated the licensee's coordinator shall ensure that the personnel providing care for the client has to be oriented to the care and needs specified in the service plan. Documentation of such orientation shall be maintained in the personnel file. The licensee's Orientation to Client policy, undated, indicated the caregiver or supervisor will receive orientation specifically to each individual client and the services to be provided. No further information provided.	{01180}		
{01245} SS=F	144A.4798, Subd. 1 TB Infection Control Subdivision 1.Tuberculosis (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	{01245}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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 16 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) guidelines to include: completion of a two-step tuberculin skin test (TST) or other evidence of a single interferon gamma release assay (IGRA) blood test for one of one employee (unlicensed personnel (ULP)-C) and a TB history and symptoms screening for one of one employee (ULP-E). 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 the clients). The findings include: The licensee completed a TB facility risk assessment, June 17, 2025, and is low-risk.	{01245}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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 17 TB TESTING: ULP-C was hired on May 27, 2025, to provide basic care services for the licensee's clients. ULP-C's employee record lacked documentation of a completed two-step TST. ULP-C had a single step TST completed on June 2, 2025, at 3:30 p.m., read on June 4, 2025, at 8:30 a.m. ULP-C's single step TST was read before the recommended timeframe of 48-72 hours. On June 18, 2025, at 3:56 p.m., care coordinator (CC)-A stated she had not completed two-step TST for ULP-C. On November 6, 2025, at 3:26 p.m., regional operations manager (ROM)-F stated ULP-C's employee file did not include completed TB testing. TB HISTORY AND SYMPTOM SCREENING: ULP-E was hired September 30, 2025, to provide basic care services for the licensee's clients. ULP-E's employee record lacked a TB history and symptoms screening. On November 6, 2025, at 3:26 p.m., ROM-F stated ULP-E's employee file did not include a TB history and symptoms screening. The plan of correction document dated November 6, 2025 (the day survey started), indicated the licensee shall ensure that a facility risk assessment is completed annually and prior to a survey beginning. The facility risk assessment shall be completed the beginning of June annually. The licensee's human resources department shall work in conjunction with its	{01245}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	R 11/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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 18 third-party vendor, AccuSource, to ensure that all personnel has completed the required 2-step TB skin test as well as the screening. The licensee's TB infection control policy, undated, indicated the licensee shall ensure that a facility risk assessment is completed yearly, and TB screening and 2-step TB skin test is required upon hire. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2024, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes: 1. Assessing for current symptoms of active TB disease. 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test. No further information was provided.	{01245}		

Electronically Delivered

September 24, 2025

Licensee
Allpro Staffnet LLC
2355 Highway 36 West Ste 421
Roseville, MN 55113

RE: Project Number SL40730016

Dear Licensee:

This is your **official notice** that you have been **granted your basic 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 June 18, 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.

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,

Jodi Johnson, Supervisor
State Evaluation Team
Email: Jodi.Johnson@state.mn.us
Telephone: 507-344-2730 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
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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: SL40730016-0 On June 16, 2025, through June 18, 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 nine clients receiving services under the provider's Temporary Basic 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 USED PURSUANT TO 144A.474 SUBD. 11 (b) (1) (2).	
0 790 SS=F	144A.479, Subd. 3 Quality Management	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 790	Continued From page 1 Subd. 3.Quality management. The home care provider shall engage in quality management appropriate to the size of the home care provider and relevant to the type of services the home care provider provides. The quality management activity means evaluating the quality of care by periodically reviewing client services, complaints made, and other issues that have occurred and determining whether changes in services, staffing, or other procedures need to be made in order to ensure safe and competent services to clients. Documentation about quality management activity must be available for two years. Information about quality management must be available to the commissioner at the time of the survey, investigation, or renewal. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to engage in quality management activities appropriate to the size of the home care provider and relevant to the type of services the home care provider provided. 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: On June 16, 2025, at 1:41 p.m. during the	0 790		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 790	Continued From page 2 entrance conference with care coordinator (CC)-A, a request was made to review documentation of the licensee's quality management activities. At this time, CC-A stated they had met at least once a week over video chat; however, there was no documentation for the quality management meetings or program. The licensee's Quality Management Plan policy, undated, indicated the agency shall have a Quality Management Program binder. It is located in the agency Manager office and all staff have access to the binder. The binder is where the documentation for the QMP and each improvement strategy. It will be reviewed with staff as determined by the agency Manager, but at least annually. The Quality Improvement Implementation Strategy Worksheet shall be utilized for quality improvement strategies. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 790		
0 810 SS=E	144A.479, Subd. 6(b) Individual Abuse Prevention Plan (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	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 3 abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan was developed to include the required content for two of two clients (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 client's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a pattern scope (when more than a limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: The findings include: C2 and C3's records were reviewed and lacked evidence an individualized abuse prevention plan had been developed to include: -an individualized review or assessment of the person's susceptibility to abuse by another individual, including other vulnerable adults; -the person's risk of abusing other vulnerable adults; and -statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. On June 10, 2025, at 3:56 p.m., care coordinator (CC)-A stated she had not developed an individual abuse prevention plan with required	0 810		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 810	Continued From page 4 content for C2 and C3, as it was missed. The licensee's Individual Abuse and Prevention Plan policy, undated, indicated the licensee shall develop and implement an individual abuse plan for each client that services are provided for. The plan at minimum shall contain: -individualized assessment of the person's susceptibility to abuse by another individual, including other vulnerable individuals in the home; -the client's risks of abusing other vulnerable individuals; and -specific measures to be taken to minimize the risk of abuse No further information was provided. TIME PERIOD TO CORRECT: Seven (7) days	0 810		
0 815 SS=D	144A.479, Subd. 7 Employee Records Subd. 7.Employee records. The home care provider must maintain current records of each paid employee, regularly scheduled volunteers providing home care services, and of each individual contractor providing home care services. The records must include the following information: (1) evidence of current professional licensure, registration, or certification, if licensure, registration, or certification is required by this statute or other rules; (2) records of orientation, required annual training and infection control training, and competency evaluations;	0 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 815	Continued From page 5 (3) current job description, including qualifications, responsibilities, and identification of staff providing supervision; (4) documentation of annual performance reviews which identify areas of improvement needed and training needs; (5) for individuals providing home care services, verification that any health screenings required by infection control programs established under section 144A.4798 have taken place and the dates of those screenings; and (6) documentation of the background study as required under section 144.057. Each employee record must be retained for at least three years after a paid employee, home care volunteer, or contractor ceases to be employed by or under contract with the home care provider. If a home care provider ceases operation, employee records must be maintained for three years. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure employee records included the required content for one of one employee (unlicensed personnel (ULP)-C). 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	0 815		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 815	Continued From page 6 limited number of staff are involved or the situation has occurred only occasionally). The findings include: ULP-C had a hire date of May 27, 2025, to provide direct home care services to the licensee's clients. On June 17, 2024, at 2:45 p.m., the surveyor observed ULP-C assisting C2 with therapy exercise. ULP-C's employee record lacked documentation of a job description. On June 18, 2025, at 3:56 p.m., care coordinator (CC)-A stated ULP-C's employee record did not include a job description, and it was missed with onboarding. The licensee's Employee Records policy, undated, indicated the licensee maintains a personnel file on each employee. The personnel's file includes such information as the employee's job application, resume, records of training, annual evaluations, competency verifications, signed job description, reference checks, verification on credentials, records of TB screening, Hepatitis B, decline/acceptance form, bloodborne pathogen training. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 815		
0 855 SS=D	144A.4791, Subd. 7 Basic Individualized Client Review/Monitoring	0 855		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 855	Continued From page 7 Subd. 7.Basic individualized client review and monitoring. (a) When services being provided are basic home care services, an individualized initial review of the client's needs and preferences must be conducted at the client's residence with the client or client's representative. This initial review must be completed within 30 days after the date that home care services are first provided. (b) Client monitoring and review must be conducted as needed based on changes in the needs of the client and cannot exceed 90 days from the date of the last review. The monitoring and review 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 an individualized client review was conducted as required 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:	0 855		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
0 855	Continued From page 8 C3 began receiving basic home care services on May 8, 2025. C3's service plan signed on June 17, 2025, indicated C3's services included assistance with showers, meal prep, cooking meals, grocery shopping, housekeeping and laundry services. C3's record lacked timely documentation of an individual client review and monitoring completed within 30 days of providing services. On June 18, 2025, at 3:28 p.m., care coordinator (CC)-A stated the licensee did not have nursing coverage and the individual client review and monitoring was completed late. The licensee's Implementation policy, undated, indicated upon receiving the referral for the client, an intake must be completed within 24 hours. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 855		
0 865 SS=D	144A.4791, Subd. 9(a-e) Service Plan, Implementation & Revisions Subd. 9.Service plan, implementation, and revisions to service plan. (a) No later than 14 days after the date that home care services are first provided, a home care provider shall finalize a current written service plan. (b) The service plan and any revisions must include a signature or other authentication by the home care provider and by the client or the client's representative documenting agreement	0 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 865	Continued From page 9 on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provider must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan. This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure a service plan was finalized no later than 14 days after the date services began 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:	0 865		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 865	Continued From page 10 C3 began receiving basic home care services on May 8, 2025. C3's service plan signed on June 17, 2025, indicated C3's services included assistance with showers, meal prep, cooking meals, grocery shopping, housekeeping and laundry services. C3's record lacked evidence to indicate the client was provided with a written service plan that was finalized no later than 14 days after the date services were provided. On June 18, 2025, at 3:28 p.m., care coordinator (CC)-A stated the licensee did not have nursing coverage and the service plan was completed late. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-One (21) days	0 865		
0 870 SS=E	144A.4791, Subd. 9(f) Content of Service Plan (f) The service plan must include: (1) a description of the home care services to be provided, the fees for services, and the frequency of each service, according to the client's current review or assessment and client preferences; (2) the identification 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;	0 870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 870	Continued From page 11 (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 two of two clients (C2 and 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	0 870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 870	Continued From page 12 limited number of clients are affected, more than a limited number of staff are involved, or the situation has occurred repeatedly; but is not found to be pervasive). The findings include: C2 C2 began receiving basic home care services on May 22, 2025. C2's service plan signed on June 10, 2025, indicated C2's services included assistance with showers, exercise, meal prep, dressing, housekeeping and laundry services. C3 C3 began receiving basic home care services on May 8, 2025. C3's service plan signed on June 17, 2025, indicated C3's services included assistance with showers, meal prep, cooking meals, grocery shopping, housekeeping and laundry services. C2 and C3's service plans lacked the following required content: - the fees for services; - the frequency of each service; and - a contingency plan that included 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. On June 18, 2024, at 3:56 p.m., care coordinator (CC)-A stated the service plans did not include the above required content. The licensee's Service Plan Contents policy,	0 870		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 870	Continued From page 13 undated, indicated the service plan must include the following: frequency and duration of services and circumstances in which emergency medical services are not to be contacted. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	0 870		
01110 SS=D	144A.4795, Subd. 3(a) Unlicensed Personnel - Basic Subd. 3.Unlicensed personnel. (a) Unlicensed personnel providing basic home care services must have: (1) successfully completed a training and competency evaluation appropriate to the services provided by the home care provider and the topics listed in subdivision 7, paragraph (b); or (2) demonstrated competency by satisfactorily completing a written or oral test on the tasks the unlicensed personnel will perform and in the topics listed in subdivision 7, paragraph (b); and successfully demonstrated competency of topics in subdivision 7, paragraph (b), clauses (5), (7), and (8), by a practical skills test. Unlicensed personnel providing home care services for a basic home care provider may not perform delegated nursing or therapy tasks. (b) Unlicensed personnel performing delegated nursing tasks for a comprehensive home care provider must:	01110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
01110	Continued From page 14 (1) have successfully completed training and demonstrated competency by successfully completing a written or oral test of the topics in subdivision 7, paragraphs (b) and (c), and a practical skills test on tasks listed in subdivision 7, paragraphs (b), clauses (5) and (7), and (c), clauses (3), (5), (6), and (7), and all the delegated tasks they will perform; (2) satisfy the current requirements of Medicare for training or competency of home health aides or nursing assistants, as provided by Code of Federal Regulations, title 42, section 483 or 484.36; or (3) have, before April 19, 1993, completed a training course for nursing assistants that was approved by the commissioner. (c) Unlicensed personnel performing therapy or treatment tasks delegated or assigned by a licensed health professional must meet the requirements for delegated tasks in subdivision 4 and any other training or competency requirements within the licensed health professional scope of practice relating to delegation or assignment of tasks to unlicensed personnel. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure one of one unlicensed personnel (ULP-C) successfully completed training, competency evaluation, and demonstrated competency on the tasks the ULP would perform. This practice resulted in a level two violation (a	01110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
01110	Continued From page 15 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: ULP-C was hired on May 27, 2025, to provide basic home care services for the licensee's clients. On June 17, 2024, at 2:45 p.m., the surveyor observed ULP-C verbally assisting C2 with therapy exercises. ULP-C's employee record lacked evidence ULP-C had demonstrated competency by satisfactorily completing a written or oral test on the tasks they would perform and successfully demonstrated competency by a practical skills test. On June 18, 2025, at 3:08 p.m., ULP-C stated she did not get written or oral tested or competency tested by a practical skills test. On June 18, 2025, at 3:56 p.m., care coordinator (CC)-A stated she was unable to locate any employee training or competency information; however, she was aware this needed to be completed. The licensee's Unlicensed Personnel - Basic Training policy, undated, indicated unlicensed personnel providing basic home care services	01110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
01110	Continued From page 16 must have successfully completed training and competency evaluation by the home care provider. Unlicensed personnel shall have training and competency evaluations for the following: -documentation requirements for all services provided; -reports of changes in the client's condition to the supervisor designated by the agency; -basic infection control, including blood-borne pathogens maintenance of a clean and safe environment; -appropriate and safe techniques in personal hygiene and grooming, including hair care and bathing, care of teeth, gums, and oral prosthetic devices, care and use of hearing aids, dressing and assisting with toileting; -training on prevention of falls for providers working with the elderly or individuals at risk of falls; -standby assistance techniques and how to perform them; -medication, exercise, and treatment reminder; -basic nutrition, meal preparation, food safety, and assistance with eating; -preparation of modified diets as ordered by a licensed health professional; -communication skills that include preserving the dignity of the client and showing respect for the client and the client's preferences, cultural background, and family; -awareness of confidentiality and privacy; -understanding appropriate boundaries between staff and clients and the client's family; -procedures to utilize in handling various emergency situations; and	01110		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
01110	Continued From page 17 -awareness of commonly used health technology equipment and assistive devices. No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01110		
01180 SS=D	144A.4796, Subd. 4 Orientation to Client Subd. 4.Orientation to client. Staff providing home care services must be oriented specifically to each individual client and the services to be provided. This orientation may be provided in person, orally, in writing, or electronically. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the licensee failed to ensure the employee record included documentation of orientation to the client for one of one employee (unlicensed personnel (ULP)-C). 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: ULP-C was hired on May 27, 2025, to provide	01180		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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
01180	Continued From page 18 basic care services for the licensee's clients. On June 17, 2024, at 2:45 p.m., the surveyor observed ULP-C verbally assisting C2 with therapy exercise. ULP-C's employee record lacked documentation of orientation to each client and services provided. On June 18, 2025, at 3:08 p.m., ULP-C stated she was not orientated to each client and their services upon hire. On June 18, 2025, at 3:56 p.m., care coordinator (CC)-A stated she was unable to locate any employee training or competency information; however, she was aware this needed to be completed. The licensee's Orientation to Client policy, undated, indicated the caregiver or supervisor will receive orientation specifically to each individual client and the services to be provided. No further information provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	01180		
01245 SS=F	144A.4798, Subd. 1 TB Infection Control Subdivision 1.Tuberculosis (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	01245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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 19 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 establish and maintain a tuberculosis (TB) prevention program, based on the most current Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) guidelines to include: a current provider TB facility risk assessment; completion of a two-step tuberculin skin test (TST) or other evidence of a single interferon gamma release assay (IGRA) blood test for one of one employee (unlicensed personnel (ULP)-C). 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 the clients). The findings include: The licensee completed a TB facility risk assessment, June 17, 2025, after the survey had	01245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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 20 already started. ULP-C was hired on May 27, 2025, to provide basic care services for the licensee's clients. ULP-C's record lacked documentation of a completed two-step TST. ULP-C had a single step TST completed on June 2, 2025, at 3:30 p.m., read on June 4, 2025, at 8:30 a.m. ULP-C's single step TST was read before the recommended timeframe of 48-72 hours. On June 18, 2025, at 3:56 p.m., care coordinator (CC)-A stated she had not completed a TB Facility Risk Assessment, or completed two-step TST for ULP-C employee. The licensee's TB infection control policy, undated, indicated the licensee shall ensure that a facility risk assessment is completed yearly, and a 2-step TB skin test is required upon hire. The MN Department of Health Facility Tuberculosis (TB) Risk Assessment Instructions and Worksheet for Health Care Setting Licensed by MDH updated June 2024, indicated: Settings should perform a facility risk assessment on an annual basis. The worksheet further indicated baseline TB screening is required at the time of hire for all health care personnel in Minnesota. Baseline TB screening includes: 1. Assessing for current symptoms of active TB disease. 2. Assessing TB history, and 3. Testing for the presence of infection with Mycobacterium tuberculosis by administering either a two-step tuberculin skin test (TST) or single TB blood test.	01245		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H40730	A. BUILDING: _____ B. WING _____	06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLPRO STAFFNET LLC	2355 HIGHWAY 36 WEST STE 421 ROSEVILLE, MN 55113

(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 21 No further information was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01245		