Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

December 9, 2025

Licensee
Comfort Keepers
524 Central Avenue
Osseo, MN 55369

RE: Project Number(s) SL33183006

Dear Licensee:

The Minnesota Department of Health (MDH) completed a survey on November 13, 2025, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the survey, MDH noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572 and/or Minn. Stat. Chapter 260E.

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

STATE CORRECTION ORDERS
The enclosed State Form documents the state correction orders. MDH documents state correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

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

DOCUMENTATION OF ACTION TO COMPLY
In accordance with Minn. Stat. § 144A.474, Subd. 8(c), the licensee must document actions taken to comply with the correction orders within the time period outlined on the state form; however, plans of correction are not required to be submitted for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s)

identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's client(s)/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

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

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

The MDH Health Regulation Division (HRD) values your feedback about your experience during the survey and/or investigation process. Please fill out this anonymous provider feedback questionnaire at your convenience at this link: **https://forms.office.com/g/Bm5uQEpHVa**. Your input is important to us and will enable MDH to improve its processes and communication with providers. If you have any questions regarding the questionnaire, please contact Susan Winkelmann at susan.winkelmann@state.mn.us or call 651-201-5952.

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

If you have any questions, please contact me.

Sincerely,

Jen Bahr, RN, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
Email: leann.huseth@state.mn.us
Telephone: (218) 332-5140 Fax:1-866-890-9290

HHH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H33183	A. BUILDING: _____ B. WING _____	11/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMFORT KEEPERS	524 CENTRAL AVENUE OSSEO, MN 55369

(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, these correction orders have 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: Project #: SL33183006 On November 12, 2025, through November 13, 2025, a surveyor of this Department's staff visited the above Comprehensive licensed provider and the following correction orders were issued. At the time of the survey, there were 36 clients receiving services under the Comprehensive license.	0 000		
0 265 SS=D	144A.44, Subd. 1(a)(2) Up-To-Date Plan/Accepted Standards Practice receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services This MN Requirement is not met as evidenced by:	0 265		

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0 265	Continued From page 1 Based on observation, interview, and document review the licensee failed to ensure staff transferred clients safely and according to their individualized plan of care for 1 of 2 clients (C3) observed during transfers. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client ' s health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: C3's care plan identified a diagnosis of diabetes, rheumatoid arthritis, was a fall risk, and required the assistance of one staff using a gait belt with all transfers. C3 had trouble standing, his left knee goes out frequently, has poor balance, and has a history of falls. During observation on 11/13/25 at 9:06 a.m., C3 was sitting in the bathroom in his wheelchair waiting to take a shower. Unlicensed personnel (ULP)-C pushed the front two wheels of C3's wheelchair over the lip of the shower (which was approximately 5 inches high), then assisted him to stand and pivot transfer onto shower bench. Once ULP-C finished giving C3 a shower, ULP-C dried him off, put the front wheels of the wheelchair over the lip of the shower and assisted him to transfer back into his wheelchair from the shower bench. Then ULP-C pushed C3 into the bedroom, and assisted him to stand and transfer onto the bed to complete hip and knee exercises. Once those were completed, he	0 265		

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0 265	Continued From page 2 assisted him to stand and transfer back into his wheelchair. ULP-C failed to use a gait belt or follow the plan of care when transferring C3 during the above observations. During interview on 11/13/25 at 9:44 a.m., ULP-C verified C3 had a gait belt but he didn't use it because the client "wanted to exercise his legs and keep his legs strong." ULP-C stated if C3 refused to wear the gait belt, he should have documented it his chart and let the nurse know but he didn't. During interview on 11/13/25 at 10:36 a.m., registered nurse (RN)-A stated employees should be following the client's care plan and if a client refused care it should be documented and the employee should be letting the nurse know. During interview on 11/13/25 at 11:02 a.m., registered nurse (RN)-B stated ULP-C should not have been transferring C3 into the shower by putting the first two wheels of the wheelchair over the lip of the shower due to safety. She further verified ULP-Cwas not following the care plan by transfering him in this manner nor had he been taught to transfer him this way. RN-B also verified C3 should be wearing a gait belt with all transfers and if the client refused, it should be documented, and the nurse should be made aware. A facility policy regarding following the service plan dated 4/2/24, indicated care and services will be provided according to the service plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 265		

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0 925	Continued From page 3	0 925		
0 925 SS=D	144A.4792, Subd. 6 Administration of Medication Medications may be administered by a nurse, physician, or other licensed health practitioner authorized to administer medications or by unlicensed personnel who have been delegated medication administration tasks by a registered nurse. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the licensee failed to ensure medication administration was delegated by a registered nurse for one 1 of 1 clients (C3) who were observed to receive medications during a home visit. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: C3's care plan indicated Comfort Keepers (CK) was "not to manage or set up any medications at this time." C3's medical record lacked a medication administration record (MAR). During observation on 11/13/25 at 9:06 a.m., unlicensed personnel (ULP)-C administered the following medications to C3: applied Santyl	0 925		

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0 925	Continued From page 4 ointment (prescription medication that removes dead tissue from wounds so they can start to heel) to right toe, A&D ointment to groin area, pain relieving cream to back, Betamethasone Valerate Lotion USP 0.1% to scalp, Clotrimazole cream 1% to bottom, and Refresh Classic lubricant eye drops (1 drop in each eye). During interview on 11/13/25 at 9:49 a.m., ULP-C stated he had received a general medication training upon hire but did not receive training specifically on C3's medications. ULP-C further stated C3 did not have a MAR in the home and was unable to explain how he knows when or how much of the medication to administer or apply. During interview on 11/13/25 at 10:36 a.m., registered nurse (RN)-A verified C3 was not supposed to be receiving medication management services and does not have a MAR. RN-A further verified ULP-C should not be administering medications to C3 because it would have to be on the care plan in order to administer them so they would know how administer them and the dose, etc. During interview on 11/13/25 at 11:02 a.m., registered nurse (RN)-B verified C3 was not receiving medication management services, does not have a MAR, and ULP-C was not supposed to administering C3 medications. Employees receive a general medication training upon hire and then when a resident required medications to be administered, the nurse will provide a medication plan, a MAR and will train the employees on the medications specifically to that client. The nurse will also observe the employee administering the medications to the client for the first time.	0 925		

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0 925	Continued From page 5 A facility policy regarding the administration of medication by unlicensed personnel dated 4/29/24, indicated unlicensed personnel that will provide assistance with medication administration will be trained and competency tested by the RN on the following: the complete procedures for checking the client's medication administration record and medication profile, infection control precautions that must be followed when administering medications, preparation of the medication for the client when necessary, administration of the medication to the client (or assist with self-administration), documentation after assistance with self-administration of medications or medication administration, consistent with our agency's procedures for documenting the MAR, and the procedure for staff to notify the RN of any medications or dietary supplements that are being used by the client and that are not included in the assessment for med management services. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	0 925		
01050 SS=D	144A.4793, Subd. 6 Treatment and Therapy Orders There must be an up-to-date written or electronically recorded order from an authorized prescriber for all treatments and therapies. The order must contain the name of the client, a description of the treatment or therapy to be provided, and the frequency, duration, and other information needed to administer the treatment or therapy. Treatment and therapy orders must be renewed at least every 12 months.	01050		

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01050	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the licensee failed to ensure hip and knee exercises were delegated by a registered nurse for one 1 of 1 clients (C3) who was ordered to receive excercise and was observed on a home visit. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client ' s health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: C3's service plan lacked indication of hip and knee exercises to be completed. During observation on 11/13/25 at 9:06 a.m. unlicensed personnel (ULP)-C assisted C3 to transfer onto his bed to complete hands on hip and knee exercises. ULP-C had a printed out sheet he was using to guide him through each exercise and how many times to complete it. The sheet was titled Care A'parent Physical Therapy Toolkit, hip and knee exercises-lying. The exercises ULP-C performed on C3 were as follows: moved each leg by holding under the knee and ankle and pushing the knee towards C3's chest, holding under the ankle and lifting his foot up towards the ceiling, pushing each knee outward by holding the knee and ankle, holding onto each knee with both hands and pushing knees side to side, and moving legs in and out to	01050		

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01050	Continued From page 7 the side while hanging onto the ankle. During interview on 11/13/25 at 9:44 a.m., ULP-C stated he was not aware of here the direction came from and stated they were just "there one day, when I came in for my shift." C3 then stated the exercises were "from the VA [Veterans Adminstration]" and they were "from a long time ago." During interview on 11/13/25 at 10:36 a.m., registered nurse (RN)-A verified C3 was not supposed to be receiving assistance with exercises because it wasn't on the service plan. During interview on 11/13/25 at 11:02 a.m., registered nurse (RN)-B verified C3 was not supposed to be receiving assistance with hip and knee exercises and he did not have a treatment plan. A facility policy regarding treatment and therapy management services dated 4/3/24, indicated the RN will assure that unlicensed personnel (ULP) are trained, competent and oriented to the client whenever ULP are to perform treatment or therapy management services for the client. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01050		
01252 SS=D	144A.4798, Subd. 3 Infection Control Program A home care provider must establish and maintain an effective infection control program that complies with accepted health care, medical, and nursing standards for infection control. This MN Requirement is not met as evidenced	01252		

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01252	Continued From page 8 by: Based on observation, interview, and document review the licensee failed to ensure infection control techniques and practices were followed during home visits for 1 of 3 clients (C3) observed during cares/home visits. This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client ' s health or safety, but was not likely to cause serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of clients are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally). The findings include: C3's care plan dated indicated diagnoses of diabetes, rheumatoid arthritis, and required assistance full assistance with with showering two times per week. During observation on 11/13/25 at 9:06 a.m., C3 was sitting in the bathroom in his wheelchair. Unlicensed personnel (ULP)-C put on gloves and assisted C3 into the shower. ULP-C washed C3's lower part of his body first (which included his groin area, legs, and feet) and then assisted him to stand up and washed his bottom. Once he was seated again, ULP-C then washed C3's face and head. ULP-C dried C3 off and assisted him to transfer back into his wheelchair. ULP-C then applied the following medications: Santyl ointment (prescription medication that removes dead tissue from wounds so they can start to heel) to his right toe, A&D ointment to his groin area, CVS healing ointment to his bottom, pain relieving cream to back, and Betamethasone Valerate	01252		

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01252	Continued From page 9 Lotion USP 0.1% to his scalp. Then he put on his socks and assisted him to get dressed. ULP-C then assisted the resident to stand up and applied Clotrimazole cream 1% to is bottom, pulled up his pants, and assisted him to sit back down in his wheelchair. ULP-C then wet two washcloths and put them on the arm rests of his wheelchair, pushed the client into bedroom, cleaned up the bathroom, assisted him to stand and pivot onto the side of his bed and lay down. ULP-C then provided hands on assistance with hip and knee exercises. Once the exercises were complete, ULP-C assisted C3 to transfer back into his wheelchair and administered Refresh Classic lubricant eye drops (1 drop in each eye). ULP-C failed to appropriately assist C3 with bathing by not washing him from clean to dirty areas, failed to change his gloves and wash his hands throughout the above observation. During interview on 11/13/25 at 9:49 a.m., ULP-C verified he washed C3's lower body first (legs, groin area, bottom) and then washed his head and face, stating that was the way the client preferred it. He also verified he did not change his gloves or wash his hands in between because he was using a "scrubber" when he was washing the client's lower body and only used his hands to wash his upper body. There was no communication to nursing regarding C3's request. During interview on 11/13/25 at 10:36 a.m., registered nurse (RN)-A stated all staff were trained on when to use/change gloves and when to perform hand hygiene. RN-A verified employee's should be assisting to wash residents from clean to dirty areas, specifically that the groin and coccyx area should be washed last. She further verified that employees should be removing their gloves after showering the clients,	01252		

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01252	Continued From page 10 washing their hands, and applying new gloves, after each care. They should also be doing this in between applying different topical medications and when administering eye drops. During interview on 11/13/25 at 11:02 a.m., RN-B stated when employees were giving client's a shower they should be washing them from clean to dirty, changing gloves and washing their hands in between cares and when applying topical medications, and administering eye drops. A facility policy regarding handing washing dated 4/2024, indicated hand washing shall be performed between client cares and whenever direct physical contact with a client takes place. Use of gloves does not replace hand washing. Hands should be washed or decontaminated: before and after direct contact with a client, if moving from a contaminated-body site to a clean-body site during client care, after contact with environmental surfaces or equipment in the immediate vicinity of the client, after removing gloves and gowns, and before eating and after using the restroom. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	01252		