

Protecting, Maintaining and Improving the Health of All Minnesotans

November 20, 2021

Administrator Apria Healthcare LLC 601 Campus Drive Saint Paul, MN 55112

RE: Project Number(s) SL03501022

Dear Administrator:

On October 19, 2021, the Minnesota Department of Health completed a follow-up evaluation of your agency to determine if orders from the June 3, 2021, evaluation were corrected. The follow-up evaluation verified that the agency is in substantial compliance.

It is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

Jonathan Hill, Supervisor Health Regulation Division State Evaluation Team 85 East Seventh Place, Suite 220 P.O. Box 3879

St. Paul, MN 55101-3879

Email: jonathan.hill@state.mn.us

Telephone: 651-201-3993 Fax: 651-215-9697

HHH



Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically Delivered** 

August 27, 2021

Administrator Apria Healthcare LLC 601 Campus Drive Saint Paul, MN 55112

RE: Project Number(s) SL03501022

Dear Administrator:

On August 3, 2021, the Minnesota Department of Health completed a follow-up survey of your agency to determine correction of orders found on the survey completed on June 3, 2021. The follow-up survey determined your agency had not corrected all of the state licensing orders issued pursuant to the June 3, 2021, survey.

In accordance with Minn. Stat. § 144A.474, subd. 11, state licensing orders issued pursuant to the last survey completed on June 3, 2021, found not corrected at the time of the August 3, 2021, revisit and subject to penalty assessment are as follows:

0810-Individual Abuse Prevention Plan-144a.479, Subd. 6(b) - \$500.00 0825-Hbor Notification To Client-144a.4791, Subd. 1 0835-Statement Of Home Care Services-144a.4791, Subd. 3 0865-Service Plan, Implementation & Revisions-144a.4791, Subd. 9(a-E) 1035-Individualized Treatment/therapy Mgt Plan-144a.4793, Subd. 3 - \$500.00 1170-Content Of Orientation-144a.4796, Subd. 2 - \$500.00

The details of the violations noted at the time of this revisit completed on August 3, 2021 (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 August 3, 2021, we identified the following violation(s):

0560-Correction Orders-144a.474, Subd. 8 - \$500.00 1080-Contents Of Client Record-144a.4794, Subd. 3

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.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, **the total amount you are assessed is \$2,000.00**. You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

## **DOCUMENTATION OF ACTION TO COMPLY**

In accordance with Minn. Stat. § 144A.474, subd. 8(c), by the correction order date, the licensee 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 orders in future surveys, upon a complaint investigation, and as otherwise needed.

#### **IMPOSITION OF FINES:**

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

## **CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department of Health within 15 calendar days of the correction order receipt date. Please send your written request via email to the following:

Paula Bastian, Health Program Rep. Sr. Home Care Assisted Living Program Minnesota Department of Health P.O. Box 3879
85 East Seventh Place St. Paul, MN 55101
paula.bastian@state.mn.us

# **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 the Department of Health within 15 calendar days. Requests for hearing may be emailed to Paula Bastian at the address noted above.

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.

Apria Healthcare LLC August 27, 2021 Page 3

We urge you to review these orders carefully. If you have questions, please contact Jonathan Hill, Supervisor, at 651-201-3993 .

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your agency's Governing Body.

Sincerely,

Jonathan Hill, Supervisor

Home Care and Assisted Living Program

85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Email: jonathan.hill@state.mn.us

Telephone: 651-201-3993 Fax: 651-215-9697

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
			A. BUILDING.		R	
		H03501	B. WING			3/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
{0 000}	Initial Comments		{0 000}			
	*****ATTENTION***  HOME CARE PRO CORRECTION OR  In accordance with 144A.43 to 144A.45 been issued pursual Determination of whom corrected requires or requirements provious indicated below. Whom contains several ite of the items will be compliance.  INITIAL COMMENT Project # SL 03501  On August 2, through of this Department's the above provider pursuant to a surve At the time of the stationary sections.	VIDER LICENSING DER  Minnesota Statutes, section 32, this correction order(s) has ant to a survey.  The ther a violation has been compliance with all ded at the Statute number then Minnesota Statute ms, failure to comply with any considered lack of  TS:  1022  1133  124  125  126  127  128  139  130  130  130  130  130  130  130		Minnesota Department of Health i documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far left column entit Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement," Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Con PLEASE DISREGARD THE HEAITHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.  THE LETTER IN THE LEFT COLUMN USED FOR TRACKING PURPOS STATUTES.  THE LETTER IN THE LEFT COLUMN USED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144A.47 SUBDIVISION 11 (b)(1)(2).	oftware. Ito e Care ber led "ID ber and e Statute lies" s the he state This as eyors' rrection. DING OF THIS O O N FOR FATE  UMN IS ES AND EVEL	
0 560 SS=F	,	Correction Orders orders. (a) A correction order	0 560			

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R	
		H03501	B. WING	· · · · · · · · · · · · · · · · · · ·		3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
APRIA H	APRIA HEALTHCARE LLC 601 CAN SAINT P.			12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 560	may be issued whe upon survey or duri that a home care proor an employee of the compliance with see the correction order and document area time allowed for confection order to home care provider correction order and home care provider calendar days after each correction order documentation supshall be kept on file and public documentation and public documentation are to order. The commission to respond to surveys, upon a conton to respond to surveys.	never the commissioner finds ng a complaint investigation rovider, a managerial official, he provider is not in ctions 144A.43 to 144A.482. It is of noncompliance and the rection.  The shall cite the specific statute is of noncompliance and the rection.  The shall mail copies of any the last known address of the remail it to the last known of e-mail it to the last known of e-mail address, within 30 the survey exit date. A copy of the survey exit date. A copy of the survey exit date. A copy of the shall be made available for son upon request. Copies may ally.  In order date, the home care ment in the provider's records comply with the correction is single may request a copy of and the home care provider's of the correction order in future in the provider in future in the provider in future in the correction order in future in the record review, the insure complete documentation cords for actions taken to the ection orders issued from the	0 560			

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		08/0	R 1 <b>3/2021</b>
NAME OF	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 00/0	
			PUS DRIVE	51A1E, 211 GODE		
APRIA H	EALTHCARE LLC		UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 560	Continued From pa	ge 2	0 560			
0 560	This practice results violation that did no safety but had the public client's health or sa cause serious injury was issued at a wide problems are pervatailure that has affe a large portion or all include:  During the revisit er 2, 2021, at approximal (manager) and emposition of the previous survey Both employees stappre-scheduled staff implement their corlicensee's staff. Em	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and respread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings intrance conference on August mately 11:30 a.m., employee B coloyee C (regional compliance altiple steps had been taken to which had been identified from the completed on June 3, 2019, atted the licensee had a meeting on August 3, 2021, to rective action plan with the aployee B confirmed although	0 560			
	extensively updated orders issued, imple occurred due to the their active clients a impacted by the parthe implementation would be immediate training of the licens August 3, 2021, after The licensee's writt multiple revised pol During the revisit surand procedures, clierecords lacked evid	dures and forms had been d, related to the previous ementation had not yet ir primary responsibilities to and respiratory service delivery ndemic. Employee B stated of the corrective action plan e after presentation and see's staff, scheduled for ernoon.  en corrective action plan noted icies, procedures and forms.  urvey on August 2, 2021, to eview of the licensee's policies ent records, and employee lence to indicate the licensee the orders issued on June 3,				

Minnesota Department of Health

STATE FORM 20MV12 If continuation sheet 3 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING	B. WING		} 3/ <b>2021</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
APRIA H	EALTHCARE LLC		PUS DRIVE			
			UL, MN 551			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 560	Continued From pa	ge 3	0 560			
	2021.					
	employee B verified made for the orders survey.	at approximately 11:30 a.m. d all corrections had not been s issued on the June 3, 2021,				
	No further informati	on was provided.				
	TIME PERIOD FOF days	R CORRECTION: Seven (7)				
{0 810} SS=F		b) Individual Abuse	{0 810}			
	implement an indiving each vulnerable mind care services are proprovider. The plants review or assessments susceptibility to abusincluding other vuln person's risk of abusing or minors; and state measures to be tak abuse to that person or minors. For purp	e provider must develop and dual abuse prevention plan for nor or adult for whom home rovided by a home care shall contain an individualized ent of the person's use by another individual, erable adults or minors; the using other vulnerable adults ements of the specific en to minimize the risk of n and other vulnerable adults oses of the abuse prevention e includes self-abuse.				
	by: Based on observati review, the licensee abuse prevention p an individualized re person's susceptibi	ent is not met as evidenced on, interview and record e failed to ensure an individual lan was developed to include view or assessment of the lity to abuse by another other vulnerable adults; the				

Minnesota Department of Health

STATE FORM 20MV12 If continuation sheet 4 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H03501	B. WING			R <b>03/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APRIA H	IEALTHCARE LLC		PUS DRIVE UL, MN 5511	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
{0 810}	person's risk of abuand statements of taken to minimize thand other vulnerable (#5) with record revenue.  This practice result violation that did not safety but had the publication that did not safe	using other vulnerable adults; he specific measures to be he risk of abuse to that person e adults, for one of one client	{0 810}			
	pulmonary disease apnea (OSA).  Client #5's "Sales, 9 Agreement," dated services included a during sleep hours, evidence of a service.  Client #5's record laindividual abuse preclient #5's record "16, 2021, intended client's respiratory services (respiratory therapist the non-invasive versupplemental oxygonals).	July 16, 2021, indicated non-invasive ventilator used Client #5's record lacked				

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STATE FORM ZOMV12 If continuation sheet 5 of 25

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		R 08/0	3/2021
		1100001			00/0	J/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE			
7		SAINT PA	UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 810}	Continued From pa	ge 5	{0 810}			
	was moderately lim breathing problems	ited with activities due to				
	interview, employed lived in a private ho community provider oxygen equipment verified client #5 was thorough or comple susceptibility to aburisk of abusing other been completed, not any of the licenseed verified an individual assessment and plate Employee B stated their individual abusinterventions form,	an had not been developed. the license had redesigned se prevention assessment and and was ready to implement ration meeting, already				
	Requirements: Lice Patient Services" po 2021, noted the lice assessment for pot	spiratory Care/Minnesota nsed Clinician Ventilator olicy, dated as revised July 23, ensee would complete an ential abuse for every client f ongoing respiratory services.				
	No further informati	on was provided.				
{0 825} SS=C	144A.4791, Subd. 1	HBOR Notification to Client	{0 825}			
	to client. (a) The ho	e care bill of rights; notification me care provider shall provide nt's representative a written				

Minnesota Department of Health STATE FORM

ZOMV12 If continuation sheet 6 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		08/0	R 9 <b>3/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD		STATE, ZIP CODE	1 00/0	.G/2021
APRIA H	IEALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 825}	notice of the rights the date that service client. The provider efforts to provide no or the client's reprecient or client's reprecient of the statement of the comperson providing your may call, write, or your may call, write, or your may also contate for Long-Term Carefor Mental Health a Disabilities."  The statement shound number, website act mailing address, and of Health Facility Consument of Health Combudsman for Long of the Ombudsman for Long of the Ombudsman Developmental Disalso include the hor address, e-mail, teletitle of the person aproblems or complation include a state provider will not retain the consumer consum	under section 144A.44 before es are first provided to that shall make all reasonable office of the rights to the client sentative in a language the resentative can understand.  The text of the home care bill of 4A.44, subdivision 1, the intain the following statement le a complaint with these of laint about the provider or the bur home care services, you isit the Office of Health Facility sota Department of Health. Let the Office of Ombudsman er or the Office of Ombudsman	{0 825}			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		08/0	? 0 <b>3/2021</b>	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
APRIA H	EALTHCARE LLC		PUS DRIVE JUL, MN 5511	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
{0 825}	acknowledgment of acknowledgment mor the client's represented by:  This MN Requirements by: Based on interview licensee failed to end for the home care bill of was provided; and a receipt of the home obtained for one of reviewed.  This practice results violation that has not a minimal impact of health or safety), ar scope (when probled a systemic failure the potential to affect a clients).  Client #5 was admit licensee's communicient record indicated Care Bill of Rights for Providers," dated as Client #5's record la acknowledgment siclient's representation bill of rights.	ge 7  ghts or shall document why an annot be obtained. The ay be obtained from the client sentative. Acknowledgment of tined in the client's record.  ent is not met as evidenced and record review, the sure the current written notice rights under section 144A.44 a written acknowledgment of care bill of rights was one client (#5) with records  ed in a level one violation (a potential to cause more than the client and does not affect the dwas issued at a widespread ems are pervasive or represent that has affected or has large portion or all of the ed a "Minnesota [MN] Home or Licensed Only Home Care is revised October 3, 2011. The acked evidence of an gnature receipt by the client or ve or date of the home care  at 11:45 a.m. employee B					
	(manager) stated he	e was aware of the correct ted November, 2019, MN					

Minnesota Department of Health

STATE FORM 20MV12 If continuation sheet 8 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H02504	B. WING		F	
		H03501	J		08/0	3/2021
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 825}	home care bill of rig licensee had the cu distribute to all activ the licensee had a s August 3, 2021, to i distribution of the di thereafter. Employ licensee's clients ha of the MN home ca On August 3, 2021, confirmed client #5 version of the home B further verified cli	ghts for clients; and the rrent MN bill of rights ready to be clients. Employee B stated staff meeting planned for inform all staff and begin ocument immediately ee B verified none of the ad received the current version re bill of rights.  at 9:30 a.m. employee B had not received the correct excare bill of rights. Employee ent #5's record lacked	{0 825}			
	evidence of signed the (outdated) MN I none of the license signed receipt, as the form for this protect of the licensee's "Resequirements: Licensee Patient Services" proceeding a client in licensed profession set-up by providing bill of rights.	or acknowledged receipt of nome care bill of rights; and e's client records would have a he licensee had not initiated ocedure.  Spiratory Care/Minnesota ensed Clinician Ventilator olicy, dated as revised July 23, ensee would ensure upon not home care services the al would complete service a the current MN home care				
{0 835}		on was provided.  3 Statement of Home Care	{0 835}			
SS=C	Subd. 3.Statement to the date that sen client, a home care client or the client's	of home care services. Prior vices are first provided to the provider must provide to the representative a written entifies if the provider has a	,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		F 08/0	R 03/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 835}	basic or compreher services the provide which services the procare provider shall acknowledgment from provider has provide	nsive home care license, the er is authorized to provide, and provider cannot provide under byider's license. The home	{0 835}			
	by: Based on interview licensee failed to er home care services had a comprehensi services provided u	and record review, the asure the written statement of which identified the licensee we home care license and the nder the license, was given at on, for one of one client (#5) d.				
	violation that has no a minimal impact or health or safety), ar scope (when proble a systemic failure th	ed in a level one violation (a potential to cause more than the client and does not affect and was issued at a widespread are pervasive or represent that has affected or has large portion or all of the gs include:				
	and/or the client's rewith a written stater licensee as a compand the services proof on August 2, 2021,	acked evidence the client epresentative was provided ment that identified the rehensive home care provider ovided under their license. at approximately 11:45 a.m. ger) stated the licensee had				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501 B. WING			R <b>08/03/2021</b>	
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	,0/LUL 1
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
{0 835}	developed their state had planned to presstaff on August 3, 2 provision to each addistribution immediate the statement of hobeen presented to a clients. Employee I aware of the require statement, which id comprehensive hor the provider was auservices the provide scope of the provide time of admission. of the licensee's curequired document  On August 3, 2021, verified client #5 had home care services a comprehensive lenoted above.  The licensee's "Res Requirements: Lice Patient Services" po 2021, noted the lice accepting a client in licensed profession set-up by providing	tement of home care services, sent to their home care service 021, with implementation, i.e. citive client, intended for ately after. Employee B stated me care services had not any of the licensee's current B stated the licensee was ement of provision of a written entified the provider as a ne care license, the services athorized to provide, and which er could not provide under the er's license, to a client at the Employee B confirmed none rrent clients had received the at the time of admission.  at 9:15 a.m. employee B d not received a statement of a that identified the provider as evel home care provider, as experienced in the care provider as experienced as revised July 23, ensee would ensure upon the home care services the all would complete service a copy of the "Minnesota me Care Provider State of es" document.	{0 835}			

6899

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.		R	
		H03501	B. WING			3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	APRIA HEALTHCARE LLC 601 CAM SAINT PA			12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
{0 865}	Continued From pa	ge 11	{0 865}			
{0 865} SS=C	144A.4791, Subd. 9 Implementation & F		{0 865}			
	revisions to service days after the date	n, implementation, and plan. (a) No later than 14 that home care services are ne care provider shall finalize rvice plan.				
	include a signature home care provider client's representation the services to be must be revised, if review or reassess 8. The provider must client about change	or other authentication by the rand by the client or the ve documenting agreement be provided. The service plan needed, based on client ment under subdivisions 7 and st provide information to the est to the provider's fee for contact the Office of the ing-Term Care.				
		provider must implement and required by the current				
	must be entered int	n and revised service plan the client's record, including in a client's fees when				
		nome care services must be rent written service plan.				
	by: Based on interview licensee failed to en after initiation of se	and record review, the nsure no later than 14 days rvices, the finalized service d as required, for one of one ord reviewed.				

Minnesota Department of Health

STATE FORM 20MV12 If continuation sheet 12 of 25

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		F 08/0	} 3/ <b>2021</b>
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•	
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{0 865}	Continued From pa	ge 12	{0 865}			
	violation that has no a minimal impact or health or safety), a widespread scope ( or represent a syste or has potential to a the clients). The fir	when problems are pervasive emic failure that has affected affect a large portion or all of				
	(manager) stated the use a standardized and Rental Agreem client as the service licensee had develor a service plan document and Continger each active client at the staff, scheduled addition, the service attachments, titled, Checklist (Invasive and a booklet titled, Instructions - Home Non-Invasive Use." the licensee's active plan document components, as the process of implements.	ne licensee had continued to template "Sales, Services, ent" individualized for each e plan. Employee B stated the oped a new form to be used as ment titled, "Apria Service ncy Plan" to be completed for fter the provider had trained I for August 3, 2021. In e plan would have two "Home Ventilator Orientation and Non-Invasive Ventilation)" "Patient/Caregiver ventilator: for Invasive and Employee B stated none of e clients had the new service upleted, noted above with all e provider was still in the				
	current written serv	acked evidence of a finalized ice plan within 14 days after care services were first				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.		R	
		H03501	B. WING			3/2021
NAME OF PRO	VIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA HEAL	LTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
CI ob	ient #5's 11 page greement," dated crvices included dentilator (continuor PAP) equipment auffering from sleep detailed list of reside the specific insuldition, the docume formation related esponsibility, Comparges, [and] Responsibility, [and]	oses included chronic ary disease (COPD) and	{0 865}			

Minnesota Department of Health

STATE FORM 20MV12 If continuation sheet 14 of 25

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		R	
		H03501	B. WING			3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{0 865}	Continued From pa	ge 14	{0 865}			
		acked a finalized service plan itiating respiratory home care				
	Requirements: Lice Patient Services" po 2021, noted the lice accepting a client in licensed profession set-up by providing	spiratory Care/Minnesota ensed Clinician Ventilator olicy, dated as revised July 23, ensee would ensure upon nto home care services the al would complete service a copy of the "Apria Service ncy Plan" document.				
	No further informati	ion was provided.				
{01035} SS=F	144A.4793, Subd. 3 Treatment/Therapy		{01035}			
	management plan. management of orc or therapy services care provider must service plan a writte or therapy services client. The provider maintain a current i	red treatment or therapy For each client receiving dered or prescribed treatments , the comprehensive home prepare and include in the en statement of the treatment that will be provided to the must also develop and individualized treatment and ent record for each client which st the following:				
	(1) a statement of t provided;	he type of services that will be				
	(2) documentation or relating to the treating administration;	of specific client instructions ments or therapy				
	(3) identification of	treatment or therapy tasks that				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		F 08/0	R 9 <b>3/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE JUL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	will be delegated to  (4) procedures for rappropriate license problem arises with services; and  (5) any client-specification of the rapy was administed to the rapy was administed the rapy was administed to the rapy was administed to the rapy be current and updated the rapy.  Based on interview licensee failed to procurrent individual transplan a written stated the rapy services the client for one of one prescribed treatment.  This practice results violation that did not safety but had the proclient's health or saccause serious injury was issued at a wide problems are pervaluation that has affer the rappropriate that has affer that has affer that has affer that has affer the rappropriate that has	unlicensed personnel; notifying a registered nurse or d health professional when a treatments or therapy  fic requirements relating to reatment and therapy in that all treatment and stered as prescribed, and ment or therapy to prevent ons or adverse reactions. The y management record must atted when there are any  ent is not met as evidenced and record review, the repare, develop and maintain reatment or therapy; and include in the service ment of the treatment or at would be provided to the eclient (#5) who had a	{01035}			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING			R 0 <b>3/2021</b>
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE AUL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
{01035}	Client #5 Client #5's record la statement on a serv respiratory treatmer services that would Client #5's prescribe Ventilation Form," of non-invasive (NIV) home device (intendapnea) during sleep Client #5's record la service plan with all include client specific provided.  On August 3, 2021, employee B confirmevidence of an indiversitient statement of the rapy management in the rapy mana	acked evidence of a written vice plan of the type of a tor therapy management be provided.  er order "Astral Non-Invasive lated June 24, 2021, noted a positive pressure ventilation ded for obstructive sleep o hours.  acked evidence of a written the required content to fic written respiratory services at approximately 9:20 a.m. and client #5's record lacked vidualized service plan with a fine specific treatment or ant services, to use of a NIV of device. Employee A stated ets current client records are of a written statement on a respiratory services provided. It is the specific treatment on a respiratory services provided.	{01035}			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
71101 1211	OF COTTLECTION	IDENTIFICATION NOISIBET.	A. BUILDING:			
		H03501	B. WING		08/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ΑΡΒΙΑ Η	EALTHCARE LLC		PUS DRIVE			
AI 10A 11			UL, MN 551		ı	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
{01035}	Continued From pa	ge 17	{01035}			
	statement of the type specific client instru					
01080 SS=C	144A.4794, Subd. 3	3 Contents of Client Record	01080			
	Subd. 3.Contents of client record. Contents of a client record include the following for each client:					
	(1) identifying information, including the client's name, date of birth, address, and telephone number;					
	an emergency cont	ess, and telephone number of act, family members, client's ny, or others as identified;				
	the client's health a	ses, and telephone numbers of nd medical service providers re providers, if known;				
	allergies, and when medications, treatm	on, including medical history, the provider is managing nents or therapies that require d other relevant health				
	(5) client's advance	edirectives, if any;				
	(6) the home care passessments and s	provider's current and previous service plans;				
	(7) all records of coclient's home care	mmunications pertinent to the services;				

wiinnesc	ita Department of He	aim					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
					F	R	
		H03501	B. WING		08/0	3/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
			PUS DRIVE				
APRIA H	EALTHCARE LLC		UL, MN 551	12			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIE	DAIL	
21222			0.4.000				
01080	Continued From pa	ge 18	01080				
	(8) documentation (	of significant changes in the					
		actions taken in response to					
		ent including reporting to the					
	appropriate supervi	sor or health care					
	professional;						
	(9) documentation (	of incidents involving the client					
		n response to the needs of the					
	client including reporting to the appropriate						
	supervisor or health						
	(40)						
		that services have been					
	provided as identilie	ed in the service plan;					
	(11) documentation	that the client has received					
		ome care bill of rights;					
		-					
		that the client has been					
	•	nent of disclosure on					
	subdivision 3;	es under section 144A.4791,					
	Subdivision 5,						
	(13) documentation	of complaints received and					
	resolution;	•					
		mary, including service					
		and related documentation,					
	when applicable; ar	id					
	(15) other documer	ntation required under this					
		nt to the client's services or					
	status.						
	TI: MALE :						
	•	ent is not met as evidenced					
	by: Based on interview	and record review, the					
		nsure the content of the client					
		I the required content in one of					
	two clients (#6) with						

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING			R 03/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551 <sup>.</sup>	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01080	This practice resulte	ed in a level one violation (a	01080			
	a minimal impact or health or safety), ar scope (when proble a systemic failure th	o potential to cause more than the client and does not affect and was issued at a widespreaders are pervasive or represent that has affected or has large portion or all of the gs include:				
		ncked evidence of an initial ments, and a discharge d.				
	respiratory services respiratory monitori (RT), and equipmer non-invasive ventila for night time treatn	tted on May 15, 2020, for for including equipment setup, ng by a respiratory therapist nt maintenance of a Trilogy tion (NIV) mechanical devicement of chronic respiratory as discharged on July 22,				
	(manager) stated he (respiratory therapis of initial assessment Employee B stated been completed as procedure to initiate all client respiratory employee A most like correctly uploaded to into client #6's elect also verified client # a completed a discharge summary	at 11:00 a.m. employee B e had contacted employee A st) and confirmed completion at and 14 day assessments. he was also sure they had it was a standard operating and ensure compliance with services. Employee B stated the assessment information aronic record. Employee B section arge summary. Employee B had an updated standardized of form scheduled to be staff later that day; and, he was				

Minnesota Department of Health

STATE FORM 20 MV12 If continuation sheet 20 of 25

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		H03501	B. WING			{ 3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01080	Continued From pa	ge 20	01080			
{01170} SS=F	The licensee's "Res Requirements: Lice Patient Services" pounce of the lice documentation of the Up" [assessments] home care services to indicate the licenth which to complete a assessment. The professional would termination of service would be completed to indicate the licenth which to complete a No further information of services which to complete a No further information of services (1) an overview of subd. 2. Content. (at the following topics (1) an overview of subd. 2. Content. (at the following topics (2) introduction and policies and proceed of home care services (3) handling of emergency services (4) compliance with	spiratory Care/Minnesota ensed Clinician Ventilator olicy, dated as revised July 23, ensee would ensure he initial "Set Up and Follow upon accepting a client into s. The policy lacked language see's policy time frame in an initial and 14 day follow upolicy also noted the licensed ensure upon discharge or ces, a discharge summary d. The policy lacked language see's policy time frame in a client's discharge summary. Son was provided.  2 Content of Orientation  1) The orientation must contain in the orientation must contain in the created to the provision ces by the individual staff in the provider and reporting of the nors or vulnerable adults	{01170}			

Minnesota Department of Health STATE FORM

ZOMV12 If continuation sheet 21 of 25

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
					R		
		H03501	B. WING			3/2021	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
{01170}	Continued From pa	ge 21	{01170}				
	(5) home care bill o 144A.44;	f rights under section					
	complaints, and wh including information	ets' complaints, reporting of ere to report complaints n on the Office of Health and the Common Entry Point;					
	Ombudsman for Lo Ombudsman for Me Developmental Disa Ombudsman at the	abilities, Managed Care Department of Human anaged care advocates, or					
		nes of home care services the oviding and the provider's					
	orientation may also services to clients v on hearing loss pro must be high quality	e topics listed in paragraph (a), o contain training on providing with hearing loss. Any training vided under this subdivision y and research-based, may ng, and must include training he following topics:					
		of age-related hearing loss itself, its prevalence, and to communication;					
		loss, such as increased itia, falls, hospitalizations,					
	(3) information about	ut strategies and technology					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		08/0	R 03/2021
	PROVIDER OR SUPPLIER	601 CAME	PUS DRIVE	STATE, ZIP CODE		
		SAINT PA	UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
{01170}	Continued From pa	ge 22	{01170}			
	assistive listening d and tactile alerting d	ing communication strategies, evices, hearing aids, visual devices, communication and closed captions.				
	by: Based on interview licensee failed to er received orientation	ent is not met as evidenced and record review, the asure one of one employee (D) to home care licensing egulations to include all of the s.				
	violation that did no safety but had the p client's health or sa cause serious injury is issued at a wides are pervasive or rep has affected or has	ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and pread scope (when problems present a systemic failure that the potential to affect a large clients). The findings include:				
	the employee had r care on the followin (1) an overview of s 144A.4798; and (2) consumer advoc Ombudsman for Lo Ombudsman for Me Developmental Disa Ombudsman at the Department of Hum	cacy services of the Office of ng-Term Care, Office of ental Health and abilities, Managed Care				
	Employee D (unlice	nsed personnel/patient				

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY LETED
					R	
		H03501	B. WING		08/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE	10		
	OLIMANA DV. OTA		UL, MN 551		ON!	0.50
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	D BE	(X5) COMPLETE DATE
{01170}	Continued From pa	ge 23	{01170}			
	2018, to provide ge to respiratory home licensee's clients w treatments and thei included transporta checks of the equip reinforcing basic infrespiratory equipme.  On August 3, 2021, employee B confirm the licensee's supp employee A (respiratory provide any hands clients. Employee I been a full-time em	had hire date of June 11, neral technical support related a care services, for all of the ho received respiratory rapies. The technical support tion, set up, and maintenance ament in a client's home and formation related to use of the ent.  at approximately 10:30 a.m. and employee D was one of cort staff, under the direction of atory therapist), and did not on services to the licensee's B verified employee D had ployee who had provided as noted above, since his				
	numerous pages of (electronic) multiple year 2018 through 2 lacked evidence of completed in the two On August 3, 2021, employee B (manarequired overview of statutes and a review services, inclusive of time of hire. Employee the required for presentation to the afternoon.  Employee B confirm	D's record indicated transcripts for on-line training topics dated from the 2021. Employee D's record orientation and training to topic areas, as noted above.  at approximately 10:45 a.m. ger) stated he was aware of a of Minnesota (MN) home care ew of MN consumer advocacy of the Ombudsman, at the open B stated the licensee had ed orientation curriculum to a topics; and, it was scheduled the licensee's staff later that the med employee D, nor any of thad not completed all required				

Minnesota Department of Health

STATE FORM ZOMV12 If continuation sheet 24 of 25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING		F		
		H03501	1		08/0	3/2021	
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  601 CAMPUS DRIVE						
APRIA H	IEALTHCARE LLC		.UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE	
{01170}	Continued From pa	ge 24	{01170}				
		to provision of home care the two topics noted above.					
	Requirements: Lice Patient Services" po 2021, noted the lice employees would "u patients, all clinical complete the follow Orientation to Home referenced the docu						



Protecting, Maintaining and Improving the Health of All Minnesotans

**Electronically Delivered** 

June 16, 2021

Administrator Apria Healthcare LLC 601 Campus Drive Saint Paul, MN 55112

RE: Project Number(s) SL03501022

Dear Administrator:

The Minnesota Department of Health completed a survey on June 3, 2021, for the purpose of assessing compliance with state licensing statutes. At the time of the survey the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statutes, Chapter 144A and/or Minn. Stat. § 626.5572.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing 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 . . ."

#### **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 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 for widespread violations;
- Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144A.475.
- Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144A.475.

In accordance with Minn. Stat. § 144A.474, subd. 11(a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2,

Apria Healthcare LLC June 16, 2021 Page 2

9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144A.474, subd. 11(a)(6), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144A.43 to 144A.482, no immediate fines are assessed.

#### **DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144A.474, subd. 8(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction 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 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 calendar days.

A state licensing order under Minn. Stat. § 144A.44 subd. 1(14), Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to Paula at: paula.bastian@state.mn.us.

Please address your cover letter for general reconsideration requests to:
Paula Bastian, Health Program Rep. Sr.
Home Care Assisted Living Program
Minnesota Department of Health
P.O. Box 3879
85 East Seventh Place
St. Paul, MN 55101

Free from Maltreatment reconsideration requests should addressed to:
 Lindsey Krueger, Director
Office of Health Facility Complaints
Minnesota Department of Health
 P.O. Box 64970
85 East Seventh Place
St. Paul, MN 55164-0970

## **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 the Department of Health within 15 calendar days. Requests for hearing may be emailed to Paula Bastian at the address noted above.

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.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,

Jonathan Hill, Supervisor

foundhans

Home Care and Assisted Living Program 85 East Seventh Place, Suite 220

P.O. Box 3879

St. Paul, MN 55101-3879

Email: jonathan.hill@state.mn.us

Telephone: 651-201-3993 Fax: 651-215-9697

HHH

PRINTED: 06/16/2021 FORM APPROVED

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDERAND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			D WING			
		H03501	B. WING		06/0	3/2021
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S PUS DRIVE	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 000	Initial Comments		0 000			
	In accordance with 144A.43 to 144A.45 been issued pursual Determination of which corrected requires a requirements provide indicated below. Which contains several ite of the items will be compliance.  INITIAL COMMENTAINED Project # SL 03501  On June 2, through this Department's so Comprehensive house time of the survey,	VIDER LICENSING DER  Minnesota Statutes, section 32, this correction order(s) has ant to a survey.  hether a violation has been compliance with all ded at the Statute number hen Minnesota Statute ms, failure to comply with any considered lack of		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far left column entit Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corplease DISREGARD THE HEALTHE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY. WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES.	oftware. I to e Care ber tled "ID ber and e Statute ies" s the ne state This as eyors' rrection. DING OF	
0 810 SS=F		b) Individual Abuse	0 810			
	implement an indivi each vulnerable mi care services are p	e provider must develop and dual abuse prevention plan for nor or adult for whom home rovided by a home care shall contain an individualized ent of the person's				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

AND PLAN OF CORRECTION	DENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	H03501	B. WING	<del></del>	06/0	3/2021	
NAME OF PROVIDER OR SUPPLIER  APRIA HEALTHCARE LLC	601 CAMP	DRESS, CITY, S PUS DRIVE UL, MN 551	STATE, ZIP CODE			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
including other vulne person's risk of abus or minors; and state measures to be take abuse to that person or minors. For purpout plan, the term abuse.  This MN Requirements by: Based on interview a licensee failed to ensure prevention plan was individualized review person's susceptibilic individual, including person's risk of abuse and statements of the taken to minimize the and other vulnerable (#2, #3) with record.  This practice resulted violation that did not safety but had the person of the person of the taken to minimize the and other vulnerable (#2, #3) with record.  This practice resulted violation that did not safety but had the person of the	se by another individual, crable adults or minors; the sing other vulnerable adults ments of the specific en to minimize the risk of an and other vulnerable adults be seen of the abuse prevention expected in and record review, the sure an individual abuse developed to include an avor assessment of the sity to abuse by another other vulnerable adults; the sing other vulnerable adults; the sing other vulnerable adults; the se specific measures to be expected in a level two violation (a harm a client's health or otential to have harmed a ety, but was not likely to appread scope (when sive or represent a systemic sted or has potential to affect of the clients). The findings	0 810				

Minnesota Department of Health

STATE FORM 5699 ZOMV11 If continuation sheet 2 of 28

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H03501	B. WING	<del></del>	06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE .UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 810	Continued From pa	ge 2	0 810			
	services to include concentrator used of record lacked evide.  Client #2's one pag. Assessment/Plan - 2021, only noted the patients receiving many risk factors related would impact on his	May 7, 2021, indicated supplemental oxygen continuously daily. Client #2's ence of a service plan.  e "Abuse Risk Minnesota" dated April 20, e client did not "live with other nedical care", had no potential to physical disabilities that is independence with activities lid not have "a sufficient"				
	2021, intended as a respiratory status, s (respiratory therapis supplemental oxyge many times weekly was moderate to ve breathing problems employee A gave ve and two caregivers	ome Setup" dated April 20, an assessment of the client's signed by employee A st/RT) noted the client was on en, was short of breath four to with physical activities; and ery limited with activities due to . A narrative note indicated erbal instructions to client #2 related to setup of his ly" unit (mechanical device to g.)				
	lacked developmen client's susceptibility individual, including person's risk of abu and statements of t	al abuse prevention plan t of an assessment of the y to abuse by another other vulnerable adults; the ising other vulnerable adults; he specific measures to be ne risk of abuse to that person e adults.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			TE SURVEY MPLETED	
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NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	-		
APRIA H	EALTHCARE LLC		UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
0 810	Continued From pa	ge 3	0 810				
	respirator failure, of diabetes, gastric-es (GERD) and severe Client #3's "Sales, S Agreement" dated I services to include non-invasive Trilogy night and as neede	Service and Rental December 29, 2020, indicated supplemental oxygen via a y unit used continuously at d during the day. Client #3's					
	record lacked evide	ence of a service plan.					
		acked evidence of a licensed idual abuse prevention an.					
	29, 2020, intended client's respiratory s noted the client was a weekly basis was three or more times times weekly with p	ome Setup" dated December as an assessment of the status, signed by employee A son supplemental oxygen, on short of breath swhile at rest, four to many hysical activities; and was tivities due to breathing					
	indicated the client for ambulation, lived that the client and/o	Care" dated January 29, 2021 required an assistive device d with family as caregiver, and or daughter had received ns and review of the ent.					
	interview, employed in a group home wit alternate communit	t approximately 3:30 p.m. e A (RT) stated client #2 lived th other adults; and the y provider's staff delivered all ervices. Employee A					

Minnesota Department of Health

STATE FORM 5699 ZOMV11 If continuation sheet 4 of 28

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.				
		H03501	B. WING		06/0	3/2021	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE	
0 810	verified client #2 was thorough or comples susceptibility to aburisk of abusing other been completed. Elicensee's current of complete individual and plan developed was required, given service was primari equipment setup ar The licensee's "Clir Requirements" polithe licensee would potential abuse for	as a vulnerable adult and a sete assessment of client #2's use by others, or the person's er vulnerable adults had not employee A stated none of the elients would have had a abuse prevention assessment d, as he had not understood it in the licensee's home care ally respiratory support	0 810				
	language to indicate specifically develop prevention plan to indevelop measures base on identified in No further information.	e the licensee would an individual vulnerable adult dentify vulnerability risks and to minimize maltreatment information.					
0 825 SS=C	Subdivision 1.Home to client. (a) The hot the client or the clien notice of the rights the date that servic client. The provider	HBOR Notification to Client e care bill of rights; notification ome care provider shall provide ent's representative a written under section 144A.44 before es are first provided to that shall make all reasonable otice of the rights to the client	0 825				

Minnesota Department of Health

STATE FORM 6899 If continuation sheet 5 of 28 ZOMV11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1. 20122.110.1			
		H03501	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 825	Continued From pa	ge 5	0 825			
		sentative in a language the resentative can understand.				
	rights in section 14- notice shall also co	e text of the home care bill of 4A.44, subdivision 1, the ntain the following statement le a complaint with these				
	person providing you may call, write, or v Complaints, Minnes You may also conta	plaint about the provider or the pur home care services, you isit the Office of Health Facility sota Department of Health. Let the Office of Ombudsman e or the Office of Ombudsman and Developmental				
	number, website ad mailing address, ar of Health Facility Co Department of Hea Ombudsman for Lo of the Ombudsman Developmental Dis- also include the hor address, e-mail, tel title of the person a problems or compla also include a state	ald include the telephone ddress, e-mail address, ed street address of the Office omplaints at the Minnesota lth, the Office of the ong-Term Care, and the Office for Mental Health and abilities. The statement should me care provider's name, ephone number, and name or the provider to whom aints may be directed. It must ment that the home care aliate because of a complaint.				
	acknowledgment of home care bill of rig acknowledgment ca acknowledgment m	provider shall obtain written f the client's receipt of the ghts or shall document why an annot be obtained. The lay be obtained from the client sentative. Acknowledgment of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 825	Continued From pa	ge 6	0 825			
	receipt shall be reta	nined in the client's record.				
	by: Based on interview licensee failed to er of home care bill of was provided; and a receipt of the home obtained for two of reviwed.  This practice result violation that has no a minimal impact of health or safety), ar scope (when proble a systemic failure th	and record review, the assure the current written notice rights under section 144A.44 a written acknowledgment of care bill of rights was two client (#2, #3) with records and a level one violation (a potential to cause more than an the client and does not affect and was issued at a widespread arms are pervasive or represent that has affected or has				
	potential to affect a clients).  Client #2 and client 2021, and Decemb the licensee's common The client records i Home Care Bill of F Care Providers" day October 3, 2011. Bevidence of an acknown by the client or client On June 2, 2021, a (respiratory therapis the correct version 2019, MN home ca Employee A verified correct version of the would any of the licents of the correct version of the licents of th	#3 were admitted on April 20, er 29, 2020, respectively, to munity home care services. Indicated a "Minnesota [MN] Rights for Licensed Only Home ted July, 2007, revised oth clients' records lacked nowledgment signature receipt nt's representative or date.  It 3:45 p.m., employee A st) stated he was not aware of of the updated November, re bill of rights for clients. It client #2 had not received the ne home care bill of rights; nor ensee's clients received the nolovee A verified client #2's				

Minnesota Department of Health

STATE FORM 20MV11 If continuation sheet 7 of 28

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
0 825 0 835 SS=C	rights; and none of would have a signe not have a form for The licensee's "Clir Requirements" policall clients would recibill of rights on adm The licensee's policithe current, Novem homecare bill of rig No further information TIME PERIOD FOR Twenty-One (21) dates	ence of signed or sipt of the home care bill of the licensee's client records d receipt, as the licensee did this procedure.  Inical Respiratory Services by dated July 1, 2014, noted seive th Minnesota homecare hission to home care services. By manual lacked evidence of ber, 2019, Minnesota hts.  In was provided.	0 825 0 835			
	to the date that servicent, a home care client, a home care client or the client's statement which ide basic or compreher services the provide which services the the scope of the procare provider shall acknowledgment from provider has provided document why the packnowledgment.	of home care services. Prior vices are first provided to the provider must provide to the representative a written entifies if the provider has a nsive home care license, the er is authorized to provide, and provider cannot provide under ovider's license. The home obtain written om the clients that the ed the statement or must provider could not obtain the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		06/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	HEALTHCARE LLC		PUS DRIVE .UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0 835	by: Based on interview licensee failed to enhome care services had a comprehensing services provided to the time of admissing the time of a minimal impact on the alth or safety), and widespread scope or represent a system or has potential to a the clients). The first the client and/or the provided with a write the licensee as a comprovider, and the selicense.  On June 2, 2021, and the selicense.  On June 2, 2021, and a memployee B (mana somewhat familiar rules and regulations). The time the provider was at services the provider of the provider of the provider was at services the provider of the pro	and record review, the insure the written statement of a which identified the licensee we home care license and the under the license, was given at on, for two of two clients (#2, viewed.  ed in a level one violation (a potential to cause more than in the client and does not affect and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of indings include:  #3's records lacked evidence exclient's representative was sten statement that identified imprehensive home care ervices provided under their  t approximately 12:30 p.m. ger) stated he thought he was with the current home care				

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
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0 835	Continued From pa	ge 9	0 835			
	however, then verifinot received a state Employee B stated the need for a clien requirement.	•				
	Requirements" policall clients would red Comprehensive Ho	nical Respiratory Services by dated July 1, 2014, noted beive the "Minnesota me Care Provider Statement dices" on admission to home				
	No further informati	on was provided.				
	TIME PERIOD FOR Twenty-One (21) da					
0 865 SS=C	144A.4791, Subd. 9 Implementation & F		0 865			
	revisions to service days after the date	n, implementation, and plan. (a) No later than 14 that home care services are ne care provider shall finalize rvice plan.				
	include a signature home care provider client's representati on the services to b must be revised, if review or reassess 8. The provider must	or and any revisions must or other authentication by the rand by the client or the ve documenting agreement be provided. The service plan needed, based on client ment under subdivisions 7 and st provide information to the es to the provider's fee for				

6899

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/	03/2021	
	PROVIDER OR SUPPLIER	601 CAM	DDRESS, CITY, S' PUS DRIVE AUL, MN 5511	•			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE	
0 865	services and how to Ombudsman for Locombudsman for Locombus for Locombu	contact the Office of the ing-Term Care.  provider must implement and required by the current  and revised service plan to the client's record, including in a client's fees when  come care services must be rent written service plan.  The provider must implement and revised service plan.  The provider must be rent written service plan.  The provider must implement and record review, the finalized service do as required, for two of two records reviewed.  The provider must implement and the service plan and the client and days revices, the finalized service do as required, for two of two records reviewed.  The provider must implement and record review, the must be remarked as required as required, for two of two records reviewed.  The provider must implement and required in a level one violation (a potential to cause more than and the client and does not affect and was issued at a potential to cause more than and the client and does not affect and was issued at a potential to cause more than and the client and does not affect and was issued at a potential to cause more than and the client and does not affect and was issued at a potential to cause more than and the client and does not affect and the control of the control o					

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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_	PROVIDER OR SUPPLIER	601 CAME	DRESS, CITY, S PUS DRIVE UL, MN 551	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
0 865	respiratory equipme client; and the docu equipment setup, d	ent to be provided to each ment included services of elivery, maintenance of our availability of a licensed	0 865			
	Client #2 Client #2's record lacked evidence of a finalized current written service plan within 14 days after the date that home care services were first provided					
	Client #2 had diagnoses included chronic obstructive pulmonary disease (COPD) and chronic respiratory failure (CRF).					
	Agreement" dated I services to include concentrator used 2 noted a detailed list supplies and the sp In addition, the doc information related Responsibility, Com	e "Sales, Service and Rental May 7, 2021, indicated supplemental oxygen 24 hours daily. The document of respiratory equipment secific insurances to be billed. ument noted categories of to the client's: "Financial inmunications, Recurring instating Prior Recurring				
	2021, intended as a respiratory status, s (respiratory therapis supplemental oxygo	ator (medical device used to				
	Client #3 Client #3's record la	acked evidence of a finalized				

Minnesota Department of Health

STATE FORM 5899 ZOMV11 If continuation sheet 12 of 28

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
0 865	Continued From pa	ge 12	0 865			
	current written service plan within 14 days after the date that home care services were first provided					
	Client #3's diagnoses included COPD, chronic respirator failure, obstructive sleep apnea, diabetes, gastric-esophageal reflux disorder (GERD) and severe obesity.					
	Agreement" dated I services to include non-invasive Trilogy night. The document respiratory equipments insurances to be bit noted categories of client's: "Financial F	Recurring Charges, [and]				
	29, 2020, intended client's respiratory s noted the client was	ome Setup" dated December as an assessment of the status, signed by employee As on supplemental oxygen via ve ventilator for night time				
	approximately 3:25 therapist/RT) verifically assistance with restriction the initial RT home Employee A stated assessments were standardized "Initiathe specific type of used. Employee A completed a service.	on June 2, 2021, at p.m., employee A (respiratory ed client #2 received piratory services as noted on setup assessment form. all his initial client completed on the licensee's I Home Setup" form and noted respiratory equipment to be confirmed he had not e plan for client #2, or for any ents, as the provider only used				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
0 865	the "Sales, Service document. Employ all the licensee's cliplan within 14 days care services.  The licensee's "Clin Requirements" policall clients would have Plan and Continger initiation of respirators.	and Rental Agreement" ee A confirmed client #2, and ents, lacked a finalized service of initiating respiratory home  lical Respiratory Services by dated July 1, 2014, noted we a form titled "Apria Service licy Plan" completed upon bry home care services.	0 865			
01035 SS=F	Treatment/Therapy Subd. 3.Individualiz management plan. management of ord or therapy services, care provider must service plan a writte or therapy services client. The provider maintain a current in therapy manageme must contain at leas  (1) a statement of th provided;	ed treatment or therapy For each client receiving lered or prescribed treatments the comprehensive home prepare and include in the en statement of the treatment that will be provided to the must also develop and individualized treatment and int record for each client which est the following:  The type of services that will be of specific client instructions	01035			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		06/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 14	01035			
	will be delegated to	treatment or therapy tasks that unlicensed personnel;				
	appropriate license	notifying a registered nurse or d health professional when a treatments or therapy				
	documentation of tr received, verificatio therapy was admini monitoring of treatn possible complication treatment or therapy	ic requirements relating to reatment and therapy in that all treatment and stered as prescribed, and nent or therapy to prevent ons or adverse reactions. The y management record must ated when there are any				
	by: Based on interview licensee failed to pr current individual se statement of the tre that would be provided.	and record review, the repare, develop and maintain a ervice plan with a written eatment or therapy services ded to the client, for two of two had a prescribed treatment or				
	violation that did no safety but had the p client's health or sa cause serious injury was issued at a wid problems are perva failure that has affer	ed in a level two violation (a t harm a client's health or obtential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 00/0	
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01035	Continued From pa	ge 15	01035			
	statement on a services respiratory treatment services that would Client #2's prescrib Prescription/Letter (February 9, 2021, rminute, continuous #2's prescriber order Ventilation [NIV] For noted a the home wobstructive sleep and needed while awak Client #2's record la service plan with all	er orders "Oxygen of Medical Necessity" dated noted oxygen at three liters per , via nasal cannula. Client ers "Trilogy Non-Invasive rm" dated April 16, 2021, rentilator device (intended for onea) during sleep and as				
	statement on a services respiratory treatment services that would Client #3's prescrib Concentrator Order noted oxygen at two via nasal cannula. Therapist (RT) "Initial dated December 25 indicated a respirat non-invasive ventilad device, intended for	er orders "Portable Oxygen r Form" dated March 12, 2021, b liters per minute, continuous, Client #2's respiratory al Home Setup" narrative note, 9, 2020, by employee A, ory assessment for a Trilogy ation [NIV], (a home ventilation r obstructive sleep apnea and pulmonary disease) during				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			71. BOILDING.				
		H03501	B. WING	<del> </del>	06/0	3/2021	
NAME OF I	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE			
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01035	Continued From pa	ge 16	01035				
	service plan with all	acked evidence of a written I the required content to fic written respiratory services					
	employee A (respiration of the content #2's lacked enderwise plan with a specific treatment of services, to include and use of a NIV ni Employee A stated client records would	t approximately 3:10 p.m. atory therapist/RT) confirmed vidence an individualized written statement of the or therapy management continuous oxygen therapy ght time ventilator device. none of the licensee's current d have evidence of a written vice plan of the respiratory					
	The licensee's "Clinical Respiratory Services Requirements" policy dated July 1, 2014, noted all clients would have a form titled "Apria Service Plan and Contingency Plan" completed upon initiation of respiratory home care services and the form would include the frequency of follow-ups.  No further information was provided.						
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					
01080 SS=A	144A.4794, Subd. 3	3 Contents of Client Record	01080				
		f client record. Contents of a e the following for each client:					
		nation, including the client's , address, and telephone					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		H03501	B. WING		06/0	3/2021
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APRIA H	EALTHCARE LLC		PUS DRIVE	10		
		UL, MN 551		ON.	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	MEMONI OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
01080	Continued From pa	ge 17	01080			
	(2) the name, address, and telephone number of an emergency contact, family members, client's representative, if any, or others as identified;					
	(3) names, addresses, and telephone numbers of the client's health and medical service providers and other home care providers, if known;					
	(4) health information, including medical history, allergies, and when the provider is managing medications, treatments or therapies that require documentation, and other relevant health records;					
	(5) client's advance	directives, if any;				
	(6) the home care passessments and s	provider's current and previous ervice plans;				
	(7) all records of co client's home care s	mmunications pertinent to the services;				
	client's status and a	of significant changes in the actions taken in response to ent including reporting to the sor or health care				
	and actions taken in	of incidents involving the client or response to the needs of the orting to the appropriate or care professional;				
		that services have been ed in the service plan;				
	` ,	that the client has received ome care bill of rights;				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:  (X3) DATE COM			SURVEY LETED
		H03501	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	. 227	
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
01080	Continued From pa	ge 18	01080			
	provided the statem	that the client has been nent of disclosure on es under section 144A.4791,				
	(13) documentation resolution;	of complaints received and				
		mary, including service and related documentation, and				
		ntation required under this nt to the client's services or				
	by: Based on interview licensee failed to er contained a dischar service termination	or one of one clients (#4)				
	violation that has no a minimal impact or health or safety), ar scope (when one or are affected or one	ed in a level one violation (a potential to cause more than the client and does not affect and was issued at an isolated r a limited number of clients or a limited number of staff situation has occurred only findings include:				
	Client #4's record la summary complete	acked evidence of a discharge d.				
1		tted on February 2, 2021, for ces to include equipment				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7t. Boilebiiva.				
		H03501	B. WING	· · · · · · · · · · · · · · · · · · ·	06/0	3/2021	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
01080	therapist (RT), and Trilogy non-invasive device for night time obstructive pulmondischarged on February on June 2, 2021, a confirmed he had not summary on client complete the written record. Employee a standardized discharged on the complete the written record.	nonitoring by a respiratory equipment maintenance of a eventilation (NIV) mechanical e treatment of chronic ary disease. Client #4 was	01080				
	Requirements" policall clients would have completed upon disclinical respiratory scompleted form wo record. The policy lies and the second sec	nical Respiratory Services by dated July 1, 2014, noted we a discharge summary scharge or termination from services. In addition, the uld be placed in the client's acked language to indicate the ne frame in which to complete summary.					
	No further informati	ion was provided.					
	TIME PERIOD FOR Twenty-One (21) da						
01170 SS=C	144A.4796, Subd. 2	2 Content of Orientation	01170				
55=0	Subd. 2.Content. (a the following topics	The orientation must contain :					
	(1) an overview of s	sections 144A.43 to					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
NAME OF I	PROVIDER OR SUPPLIER		INRESS CITY S	STATE, ZIP CODE	1 00/0	0/2021
			PUS DRIVE	57/11 E, 211 GGBL		
APRIA H	APRIA HEALTHCARE LLC SAINT PA			12		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
01170	Continued From pa	ge 20	01170			
	144A.4798;					
	policies and proced	I review of all the provider's lures related to the provision ces by the individual staff				
	(3) handling of eme emergency service	ergencies and use of s;				
	(4) compliance with and reporting of the maltreatment of minors or vulnerable adults under sections 626.556 and 626.557;					
	(5) home care bill o 144A.44;	f rights under section				
	complaints, and whincluding information	nts' complaints, reporting of ere to report complaints on on the Office of Health and the Common Entry Point;				
	Ombudsman for Lo Ombudsman for Mo Developmental Dis Ombudsman at the	abilities, Managed Care Department of Human anaged care advocates, or				
		pes of home care services the coviding and the provider's				
	orientation may also services to clients we on hearing loss pro	e topics listed in paragraph (a), o contain training on providing with hearing loss. Any training vided under this subdivision y and research-based, may				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/	03/2021
	PROVIDER OR SUPPLIER	601 CAM	DDRESS, CITY, S PUS DRIVE AUL, MN 551	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
01170	include online traini on one or more of to (1) an explanation of and how it manifest challenges it poses (2) health impacts rage-related hearing incidence of demer isolation, and depressolation, and depressolation include assistive listening of and tactile alerting of access in real time,  This MN Requirements y: Based on interview licensee failed to er (B, A) received orier requirements and required eight topic.  This practice resultation that did not safety but had the policient's health or sa cause serious injury is issued at a wides are pervasive or rephas affected or has portion or all of the	ng, and must include training he following topics:  of age-related hearing loss is itself, its prevalence, and to communication;  elated to untreated loss, such as increased itia, falls, hospitalizations, ession; or  ut strategies and technology communication and ing communication strategies, levices, hearing aids, visual devices, communication and closed captions.  ent is not met as evidenced and record review, the insure two of two employees intation to home care licensing egulations to include all of the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		H03501	B. WING		06/0	3/2021
NAME OF PROVID	DER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
APRIA HEALTHCARELLC			PUS DRIVE UL, MN 551	12		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
orier of: (1) a 1444 (2) c Omb Omb Deve Omb Deve Omb Dep care serv  Emp Emp 2015 licer serv rece On a durir confi man licer prov hom clier  Emp of train May "Dec Com reco chec train	an overview of standard and a consumer advocudsman for Locudsman for Melopmental Disabudsman at the artment of Human advocates, or cices.  Soloyee B Soloyee B (mana 5, to provide gensee's operation ices, for all of the cived respiratory)  June 2, 2021, and the entrance irred he was the entrance irred he was the care services and the consumer and the care services and the care services and the consumer and the care services and the consumer and	care on the following topics sections 144A.43 to cacy services of the Office of ong-Term Care, Office of ental Health and abilities, Managed Care	01170			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		H03501	B. WING		06/0	3/2021
	F PROVIDER OR SUPPLIER HEALTHCARE LLC	601 CAMI	DRESS, CITY, S PUS DRIVE UL, MN 551	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
0117	training completed noted above.  Employee A (respired date of May 5, 2003 care services to the Con June 2, 2021, a employee A stated RT available for produce and treatment home metropolitan area of the had provided as services for client #  Employee A's record of transcripts for on training topics dated May, 2021. Employe Compliance Training 5,2021. Employee a training or oriental intended as verificate completed at hire, 2 Employee B's recordination and train areas, as noted about the Complete Complet	in the two topic areas, as atory therapist/RT) had hire B, to provide respiratory home e licensee's clients.  It approximately 2:10 p.m. he was the licensee's current ovision of respiratory therapy e care services for the lients. Employee A confirmed sistance with respiratory 2 and client #3 in 2021.  It dindicated numerous pages line (electronic) multiple d from the year 2020 through ee A's record noted a i-Annual Government g" completed on January A's record lacked evidence of tion checklist document, tion of training topics 2003 (18 years past). It dacked evidence of ning completed in the two topic	01170			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021	
NAME OF P	ROVIDER OR SUPPLIER			STATE, ZIP CODE			
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01170	2010, that reference statutes of MN Rule employee's orientat B stated he was unlonger current, i.e. of confirmed employer all required training requirements, prior services to include a The licensee's "Clin Requirements" policall employees would seeing patients, all complete the follow "Minnesota Orienta which referenced that to Home Care Services to Mo further informations.	re Services" dated November, ed obsolete Home Care es 4668.0075, as part of an ion at time of hire. Employee aware the document was no outdated. Employee B e A, nor he had not completed and orientation to home care to provision of home care the two topics noted above.  Inical Respiratory Services by dated July 1, 2014, noted d'upon hire and prior to clinical staff employees shall ing," inclusive of the tion to Home Care Training" he document, "MDH - A Guide ices" dated November, 2010.	01170				
01245 SS=F	Subdivision 1.Tuber (a) A home care promaintain a comprehence control program accumulation the United States Cand Prevention (CE Elimination, as publicand Mortality Week	TB Infection Control rculosis (TB) infection control. ovider must establish and nensive tuberculosis infection cording to the most current on control guidelines issued by renters for Disease Control OC), Division of Tuberculosis lished in the CDC's Morbidity ly Report. This program must sis infection control plan that	01245				

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-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		H03501	B. WING		06/0	3/2021
	PROVIDER OR SUPPLIER	601 CAMP	DRESS, CITY, S PUS DRIVE UL, MN 551	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
01245	commissioner shall regarding implement (b) The home care evidence of compliar This MN Requirement by: Based on interview licensee failed to est (tuberculosis) preventions and inferent established to inclusive assessment with restablished to include assessment with restablished to inclusive assessment with restablished to i	provide technical assistance ntation of the guidelines.  provider must maintain written ance with this subdivision.  ent is not met as evidenced  and record review, the stablish and maintain a TB ention and control program current guidelines issued by ease Control and Prevention and addition, the licensee failed thensive tuberculosis (TB) ction control program was de a provider TB facility risk cords reviewed.  ed in a level two violation (a tharm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and despread scope (when sive or represent a systemic cted or has potential to affect I of the clients). The findings	01245			
	review the licensee program that includ	supervisory responsibility for ntrol program;				

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PRINTED: 06/16/2021 FORM APPROVED

Minnesota Department of Health

	A. BUILDING: _	<del></del>	(X3) DATE SURVEY COMPLETED	
H03501	B. WING		06/0	3/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDR	RESS, CITY, S	TATE, ZIP CODE		
APRIA HEALTHCARE LLC 601 CAMPU SAINT PAUL	_	2		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
- written infection control policies and procedures and education for handling infectious TB clients; and, - the specific content of TB training for healthcare workers including basic information about TB pathogenesis and transmission, handling a potentially infectious TB client, and the employee's role in the TB infection control program.  Employee B stated he was unsure of the requirement for a facility risk assessment and was also unsure if the assessment had been completed.  On June 3, 2021, at 1:50 p.m. employee B confirmed a TB facility risk assessment had not been completed as required.  The licensee's "Tuberculosis Exposure Control Plan" policy dated July 1, 2014, noted "Evaluation, Surveillance, and Monitoring - All Company locations shall follow OSHA regulations, CDC guidelines and state regulations for reporting requirements. For state specific requirements, follow the state specific process."  The Minnesota Department of Health (MDH) guidelines, "Regulations for Tuberculosis Control in Minnesota Health Care Settings", dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include the following: a team responsible for TB infection control; a facility TB risk assessment; written TB infection control procedures; and HCW education. The guidelines also indicate an employee may begin working with patients after a negative TB history and symptom screen (no symptoms of active TB disease) and a negative IGRA (serum blood test) or TST (first step) dated	01245			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		H03501			06/0	3/2021	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	•		
APRIA H	EALTHCARE LLC		PUS DRIVE UL, MN 551	12			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE	
01245	Continued From pa	ge 27	01245				
	be performed after	re hire. The second TST may the HCW starts working with TB screening should be employee's record.					
	No further informati	ion was provided.					
	TIME PERIOD FOR days	R CORRECTION: Seven (7)					

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