DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email

March 21, 2019

Administrator
Mary T Home Health
299 Coon Rapids Blvd Suite 105
Coon Rapids, MN 55433

Re: OTMH11

Dear Administrator:

An abbreviated standard survey was completed at your agency on April 27, 2021 by the Minnesota State Department of Health, for the purpose of investigating a complaint and assessing compliance with federal regulations and state licensing statutes. At the time of survey, the complaint was substantiated but no deficiencies were issued, because corrective action was taken prior to the survey. A plan of correction is not required.

Enclosed is your copy fo the Federal Form CMS-2567 and State Form.

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	247292	A. BUILDING _____ B. WING _____	C 04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY T HOME HEALTH	**299 COON RAPIDS BLVD SUITE 105 COON RAPIDS, MN 55433**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An abbreviated survey was conducted at your agency on 4/26/21 to 4/27/21 at Mary T Home Care for complaint investigation and was found to be in compliance with requirements at 42 CFR Part 484, requirements for Home Health Agencies. The following complaint was found to be SUBSTANTIATED: H7292042C/MN72164 However, no citations were issued due to corrective action taken prior to the survey. The following complaint was found to be UNSUBTANTIATED: H7292041C/MN65574	G 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	H03136	A. BUILDING: _____ B. WING _____	C 04/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MARY T HOME HEALTH	**299 COON RAPIDS BLVD SUITE 105 COON RAPIDS, MN 55433**

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0 000	Initial Comments On 4/26/21 to 4/27/21, a surveyor of this Department ' s staff visited the above provider. As a result of the survey, no correction orders were issued.	0 000		