



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

November 7, 2024

Administrator

LIFESPRK HOME HEALTH
5320 W 23RD ST SUITE 130
SAINT LOUIS PARK, MN 55416

Re: Event ID: 648D0-H1

Dear Administrator:

A partial extended survey was completed at your agency on October 31, 2024, for the purpose of assessing compliance with Federal certification. At the time of survey, the survey team from the Minnesota Department of Health - Health Regulation Division, noted one or more deficiencies. Electronically attached is a copy of the Statement of Deficiencies (CMS-2567).

An acceptable plan of correction must contain the following elements:

- The plan of correcting the specific deficiency. The plan should address the processes that led to the deficiency cited;
- The procedure for implementing the acceptable plan of correction for the specific deficiency cited;
- The monitoring procedure to ensure that the plan of correction is effective, and that the specific deficiency cited remains corrected and/or in compliance with the regulatory requirements;
- The title of the person responsible for implementing the acceptable plan of correction; and,
- The date by which the correction will be completed.

The plan of correction should be directed to:

**Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N**

**P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558**

Please make a copy of your plan of correction for your records.

Failure to submit an acceptable written plan of correction of Federal deficiencies within ten calendar days may result in decertification and a loss of Federal reimbursement. Additionally, your continued certification is contingent upon corrective action.

Please feel free to call me with any questions.

Sincerely,



Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0000	<p>INITIAL COMMENTS</p> <p>On 10/29/24 - 10/31/24 a complaint survey was conducted. This resulted in a partial extended survey at Lifesprk. The agency was found to have not met the requirements at 42 CFR. Part 484 for Home Health Agencies.</p> <p>The cumulative effects of these findings resulted in the Home Health Agency's inability to ensure provision of quality of care.</p> <p>The following complaints were reviewed:</p> <p>H81189961C Intake 110580</p> <p>H81189962C Intake 110527</p> <p>H81189963C Intake 109887</p> <p>H81189964C Intake 109706</p> <p>H81189965C Intake 108226</p> <p>H81189966C Intake 106489</p>	G0000		
G0572	<p>Plan of care</p> <p>CFR(s): 484.60(a)(1)</p> <p>Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan.</p> <p>This STANDARD is NOT MET as evidenced by:</p> <p>Based on interview and record review the home health agency (HHA) failed to notify the provider when staff</p>	G0572		

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0572	<p>Continued from page 1 was unable to complete a service indicated on the plan of care for 1 of 3 patients (P1). P1's care plan indicated the HHA would be completing skin assessments. Due to P1's physical status the staff was unable to fully visualize P1's skin during visits. A concern arose that P1 had pressure ulcers on her back and the HHA was unaware of the potential ulcers.</p> <p>Findings include:</p> <p>P1's Home Health Certification and Plan of Care for certification period 10/2/24 – 11/30/24 indicated P1's pertinent diagnoses were contusion (a blunt force injury) of the abdomen wall, chronic congestive heart failure, morbid obesity, chronic respiratory failure, and chronic pain. P1 received skilled nursing (SN) visits weekly for symptom management, physical therapy (PT) and occupation therapy (OT). P1's order included skilled nurse to observe and assess integumentary (skin, hair, nails, and glands) status. SN to provide skilled teaching related to altered skin integrity including pathophysiology, nutrition, medication regimen. Skilled nurse to report significant changes in status to physician for early intervention.</p> <p>P1's skilled nursing admission visit note indicated P1 did not have any pressure ulcers (damage to the skin from constant pressure on the area), stasis ulcers (a sound caused by abnormal or damaged veins), or surgical wounds. P1's integumentary status was assessed, and bruising was noted. The note did not indicate the location of the bruising.</p> <p>P1's skilled nursing visit note dated 10/9/24 indicated P1's integumentary status was assessed and P1 had bruising. The note did not indicate what areas of skin were assessed or the location of the bruising.</p> <p>P1's skilled nursing visit note dated 10/18/24 indicated P1's integumentary status was assessed with no problems identified.</p> <p>P1's skilled nursing visit note dated 10/20/24 indicated P1's integumentary status was assessed with no problems identified.</p> <p>P1's skilled nursing visit note dated 10/22/24 indicated P1's integumentary status was assessed with</p>	G0572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0572	<p>Continued from page 2 no problems identified.</p> <p>Upon interview on 10/29/24 at 12:01 p.m. a first responder, indicated his team had been to P1's home multiple times to assist with transfers or falls. On 10/17/24 P1 called stating she had an emergency. Upon arrival the first responders found P1 in a hospital bed in her kitchen seated on multiple urine and feces soiled pads. He stated P1's weight 400+ lbs. When the team transferred P1 he noticed "bed sores" on her lower back and buttocks region. He described the area as open skin sores with redness covered in feces. P1 was taken to the emergency department for a complaint of abdominal pain.</p> <p>Upon interview on 10/29/24 at 3:18 p.m. P1 stated she was not certain whether she had skin ulcers on her back or not as she cannot visualize them. She stated she was not certain what the HHA was doing for her skin. P1 was offered a home visit by the state evaluator however declined the visit.</p> <p>Upon interview on 10/30/24 at 10:48 a.m. physical therapist (PT)-a stated he saw P1 for an evaluation visit. He got P1 to sit on the side of bed with taxing effort on her part and maximum effort on his part. He stated she was seated on a soiled disposable pad. P1 had a patient care assistant (PCA) through a different agency with her and PT-A held P1 in a seated position and the PCA changed the soiled pad. PT-A stated he did not notice P1's skin because he was not looking at her skin he was concerned with her mobility. He stated P1 was unable to reposition herself and unable to transfer safely with assistance of one staff member due to her weight and physical condition.</p> <p>Upon interview on 10/30/24 at 11:27 a.m. registered nurse (RN)-B stated she was told by P1 that she had gone to the emergency department on 10/17/24 and was released the same evening. P1 told RN-B that she was found covered in urine and feces because her irritable bowel syndrome (IBS) had acted up. RN-B stated she had not been able to assess P1's skin because P1 is bedbound and immobile in bed except for use of her arms. P1 was unable to reposition herself even with the use her siderails. RN-B stated was unable to position P1 to fully assess all her skin. RN-B stated she was not certain if P1's back and buttock had pressure ulcers. RN-B denied reporting her inability to assess P1's skin to the provider. RN-B stated she had a plan to complete one of her skilled nursing visits along with PT so both could attempt to position P1 audit her</p>	G0572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0572	<p>Continued from page 3 skin, but P1 cancelled the PT visit.</p> <p>Upon interview on 10/30/24 at 1:36 p.m. RN-C stated when she assessed P1, P1 was unable to "even roll herself from side-to-side", therefore she was unable to view the skin of her backside. She did not report to the provider that she was unable to complete the skin assessment. In addition, RN-C stated the HHA "probably" should have reported P1 as a vulnerable adult.</p> <p>Upon interview on 10/31/24 at 10:00 a.m. P1's providers nurse, RN-D stated the clinic did not receive any phone calls, emails, or fax documents with concerns for P1's skin. She stated the only information received was P1's recertification which indicated the HHA was assessing her integumentary status and a few notifications of delayed or missed visits.</p> <p>Upon interview on 10/31/24 at 1:12 p.m. the Administrator stated she was aware P1 had called emergency services often, but not aware the staff could not assess her skin fully. Her expectation was if staff cannot complete an order to notify the provider.</p> <p>An agency policy titled Monitory Patient's Response/Reporting to Physician with a revision date of 2022 indicated the patient's physician (or other authorized licensed independent practitioner) will be contacted on the same day when any of the following occur: F. When there is a problem implementing the plan of care.</p>	G0572		
G0580	<p>Only as ordered by a physician</p> <p>CFR(s): 484.60(b)(1)</p> <p>Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner.</p> <p>This ELEMENT is NOT MET as evidenced by:</p> <p>Based on interview and record review the home health agency (HHA) failed to administer a treatment ordered by the physician for 1 of 3 patients (P3). P3's provider placed an order with the HHA to measure and fit P3 for specialized leg wraps on 6/19/24. The agency did not order P3's leg wraps until 9/18/24.</p> <p>Findings include:</p>	G0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0580	<p>Continued from page 4</p> <p>P3's Providers order dated 6/19/24 indicated to please measure/fit patient for Farrow wrap 4000 or Sigvaris Compreflex wraps. Please ensure patient has wraps available to bring to his clinic appointment in one week for reapplication.</p> <p>P3's Providers order dated 7/11/24 indicated to measure/fit patient for Farrow wrap 4000 or Sigvaris Compreflex and send to his next clinic appointment. Please ensure patient has wraps available to bring to clinic appointment for reapplication.</p> <p>P3's Home Health Certification and Plan of Care for certification periods 7/31/24 - 9/28/24 indicated P3's pertinent diagnoses were chronic venous insufficiency (improper functioning of the vein valves in the leg causing swelling and skin issues) and non-pressure ulcer of the right lower leg with fat layer exposed. P3 required skilled nursing (SN) weekly for wound complications.</p> <p>A telephone voicemail recorded message dated 9/17/24 at 10:36 a.m. between the provides licensed practical nurse (LPN)-A and the HHA registered nurse (RN)-A indicated LPN-A called the HHA and spoke to RN-A with concerns that P3 had orders for wraps faxed in July and August and concerned that he didn't have them at his appointment on 9/13/24. RN-A clarified receiving the orders from July and August and stated she didn't order the wraps because P3's diagnosis wasn't lymphedema therefore the HHA could not order the wraps. LPN-A verified the wraps were for chronic venous hypertension not lymphedema. RN-A stated she wasn't sure if anyone from the HHA had ordered P3's wraps and she would get back to LPN-A. LPN-A stated the provider would have ordered the wraps, but since P3 was on a skilled home care Medicare episode the HHA has to order all supplies per Medicare guidelines.</p> <p>A second telephone voicemail recording dated 9/17/24 with no time stamp indicated RN-A placed a call to LPN-A and stated the HHA measured P3 but did not order the Farrow wraps. She also stated she had spoken with the management team at the HHA, and the agency needed to discharge P3, but she would get the wraps sent to the HHA office and get the wraps to P3.</p> <p>A third telephone voicemail recording dated 9/19/24 with no time stamp indicated RN-A returned a call to LPN-A indicating the HHA discharged P3 and the HHA did have an extra visit and they would provide a visit to measure for P3's wraps.</p> <p>P3's occupational therapy visit note dated 9/18/24</p>	G0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0580	<p>Continued from page 5 indicated the therapist took P3's measurements and educated P3 on the nature of the lymphedema and strategies for donning/doffing the wraps along with the wearing schedule. The HHA's clinical manager ordered the wraps. The note did not indicate how or when P3 would receive the wraps.</p> <p>Upon interview on 10/29/24 at 11:54 a.m. P3's provider stated he had been treating P3 for pressure ulcers and placed orders with the HHA two months in a row to order leg wraps for P3 and the order wasn't completed. P3 was discharged from the agency on 9/13/24 as the agency indicated the wounds had healed and P3 came to the clinic 9/17/24 with no leg wraps and the ulcer had re-opened. The provided stated the unhealed ulcers were a chronic concern and P3 really needed the wraps.</p> <p>Upon interview on 10/30/24 at 8:31 a.m. P3 stated he did receive the wraps following his discharge from the HHA and was aware he should have had them sooner than than he received them.</p> <p>Upon interview on 10/30/24 at 11:45 a.m. RN-A stated she did review P3's orders and saw the order from 6/19/24 and stated she didn't think the HHA was responsible for ordering wraps. In addition, she stated Farrow wraps are for lymphedema and the agency was not treating him for lymphedema. RN-A spoke the HHA with management team, the wraps were ordered, and an occupational therapy visit was created to measure P3 on 9/18/24. RN-A was not certain if P3 had the wraps or not at the time of the state survey.</p> <p>Upon interview on 10/31/24 at 11:01 a.m. LPN-A stated P3's wraps were originally ordered on 6/19/24 and the provider wanted P3 to have dressing changes twice a week, once by the HHA and once in the clinic. The HHA was to cleanse the wound, cover and place the wraps on P3 and then clinic would do the same. P3 saw the provider monthly and clinical staff weekly. LPN-A stated when P3 saw the provider on 8/26/24 he didn't have the wraps, so the provider ordered them again. On P3's provider appointment on 9/17/24 he still didn't have the wraps, and P3 had been discharged from the HHA that was when LPN-A called the HHA for clarification.</p> <p>Upon interview on 10/31/24 at 1:12 p.m. the Administrator stated she was unaware of the order for wraps back in July and stated that when a client is on Medicare services the HHA is required to order the supplies. The Administrators expectations were staff follow all provider orders.</p> <p>A policy regarding provider orders was not obtained.</p>	G0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248118	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
G0580		G0580		



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

November 7, 2024

Administrator
LIFESPRK HOME HEALTH
5320 W 23RD ST SUITE 130
SAINT LOUIS PARK, MN 55416

Re: Event ID:648D0-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on October 31, 2024 for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted no violations of the requirements under Minnesota Statutes Sections 144A.43 to 144A.482.

Attached is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Melissa Poepping'.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/31/2024
NAME OF PROVIDER OR SUPPLIER LIFESPRK HOME HEALTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5320 W 23RD ST SUITE 130 , SAINT LOUIS PARK, Minnesota, 55416	
(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
00000	Initial Comments On 10/29/24 - 10/31/24 an abbreviated complaint survey was conducted. No licensing orders were issued during this survey.	00000		

Office of Primary Care and Health Systems Management

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