Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email

September 17, 2025

Administrator
SEFERTT HEALTH CARE LLC
3621 85TH AVENUE NORTH STE 103
BROOKLYN PARK, MN 55443

Re: Event ID: 1D4453-H1

Dear Administrator:

A partial extended survey was completed at your agency on August 26, 2025, 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.

A provider or supplier is expected to take the steps necessary to achieve compliance within 60 days of the exit interview. If possible, please type your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original to the following address within ten calendar days of your receipt of this notice:

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

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: 248147	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEFERTT HEALTH CARE LLC	3621 85TH AVENUE NORTH STE 103 , BROOKLYN PARK, Minnesota, 55443

(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	INITIAL COMMENTS On 8/21/25 & 8/25/25 - 8/26/25 a complaint survey was conducted. This resulted in a partial extended survey at Sefertt Health Care LLC. The agency was found to have not met)the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative eûects of these ûndings resulted in the Home Health Agency's inability to ensure provision of quality of care. The following complaints were reviewed: H81472247C / Intake 2589097	G0000		
G0486	Protect patient during investigation CFR(s): 484.50(e)(1)(iii) (iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the home health agency (HHA) failed to conduct a thorough investigation for 1 of 1 patient (P1) reviewed. The agencies investigation did not provide a resolution of the complaint. P1's was ventilator dependent and ordered to have skilled nursing 24-hours a day. On 8/8/25 7:46 a.m. P1's ventilator alarm sounded for eight minutes and three seconds because her tubing fell out leaving her without oxygen. Findings include: P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube	G0486		

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

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G0486	Continued from page 1 through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1'sa functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. An incident note dated 8/8/25 by registered nurse (RN)-B indicated she arrived at 7:00 a.m. and received report from the night nurse who stated P1 had been suctioned more than usual. P1's alarm triggered at 7:30 a.m. and RN-B suctioned her and got a small amount of clear secretions. A personal care attendant (PCA)-A arrived at 7:45 a.m. when RN-B was preparing medications for P1. RN-B asked PCA-A to listen for P1's alarm and notify her of concerns. Before RN-B finished the medications with P1, PCA-A informed RN-B that P1's alarm was sounding. RN-B immediately connected the tubing back in place and suctioned P1. P1 was then breathing o.k. and not in any distress. By the time she finished the other two members had arrived. RN-B did not indicate the time the alarm sounded or the time she reconnected. In later interview RN-B stated RN-C had been in the house, just using the bathroom in the basement. A facility schedule dated 8/8/25 indicated RN-B, RN-C and RN-D were scheduled to work at the home from 7:00 a.m. to 7:00 p.m. The schedule did not indicate which nurse was assigned to which client. P1's timesheet dated 8/8/25 indicated RN-D arrived at 8:10 on 8/8/25. P1 sent an email message on 8/8/25 indicating she needed camera footage for the morning of 8/8/25 because took the nurse ten minutes to respond to her ventilator alarm. P1 was responded to immediately via email, but unable to send the camera footage due to the writers location. Writer explained what the footage covered at the time and investigation conducted immediately. Staff explained how the P1's alarm went off and PCA-A called RN-B from another client's room and responded	G0486		

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G0486	Continued from page 2 immediately. RN-B was instructed to write an incident report. P1's Patient Communication Log dated 8/8/25 indicated at 10:30 a.m. the DON called P1 to ask if she felt safe in the home until the writer returned from vacation P1 stated she was but was upset that the nurse did not tell other staff what took place. P1's nurse (uncertain which nurse) explained that she had been having issues with her tracheostomy and the respiratory therapist (RT) had been called to check all the ventilator settings. P1 was encouraged to have the staff change her tracheostomy tubing which she agreed to allow staff to change later in the afternoon. Writer would follow-up later. P1's Patient Communication Log dated 8/8/25 indicated the DON called P1 back at 4:00 p.m. Staff stated the tracheostomy change was successful and P1 was doing o.k. P1 also sent a text message at 4:08 p.m. indicated tracheostomy had been changed and everything was o.k. now. The DON instructed the nurse in question to make sure the report was filled out and in P1's chart until the writer got back from vacation. An email from P1 to the clinical manager, her county case worker and the DON dated 8/8/25 at 1:28 p.m. Indicated R1 was inquiring if the staff notified the HHA leadership about the incident. The body of the email indicated P1 was in dire need of help. There was only one nurse in the home the time of the incident (RN)-B. A couple of minutes before 8:00 a.m. at 7:58, P1's ventilator popped off. She had thick secretions blocking the top of the airway. RN-B was in P4's room, passing meds. P1 was off the vent, airway blocked, barely able to breathe, for almost ten minutes. At 8:07 before RN-B arrived. P1 indicated, nothing was even passed on to the other staff when they arrived. No incident report, nothing. When RN-D asked RN-B about it, she only minimized it." Arguing that there is no way it was as long, I might be off by 1 minute. Nobody had bothered to ask me how I am feeling, if I am OK, or even taken my vitals! Acting like it is no big deal when it is a life-threatening situation, says it all. If my trach cuff had not been leaking enough for me to get the tiny bit of air I got, I would not be typing this & there would be one hell of a lawsuit from my grieving family. It was all caught on camera. Will need a copy of that video footage & a copy of the formal incident report right away. Three to five business days should	G0486		

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G0486	Continued from page 3 be more than adequate." Upon interview on 8/21/25 at 9:59 a.m. P1 stated on 8/8/25 her ventilator tubing popped off, so she was not able to get much air, and it took eight minutes before the staff responded to her ventilator alarm sounding. P1 stated her cares were ordered to be twenty-four hours of skilled nursing every day. On 8/8/25 the nurse assigned to her had not shown up until 8:10 a.m. There was only one nurse in the house for three residents. P1 was later told that there was another nurse who was in the basement in the bathroom when her alarm was sounding. P1 stated she felt angry, depressed, and unheard because staff was telling she could not have been off the ventilator for eight minutes, that it was only about one minute. P1 stated she had her eyes on a clock the entire time she was fighting for air. Upon interview on 8/25/25 at 12:34 p.m. RN-D stated he was scheduled to work with P1 on 8/8/25 and did clock in at between 8:10 and 8:15 a.m. He stated RN-B reported the incident to him when he arrived. RN-E called the house and spoke with all the staff to obtain information about the incident. The DON instructed the staff the fill out an incident report. RN-D was not certain how long P1 was off the ventilator and had not heard from the agencies leadership since 8/8/25 about the investigation. Upon interview on 8/26/25 at 2:10 p.m. RN-B stated on 8/8/25 P1's nurse was not onsite. She needed to care for P1, so she asked PCA-A to listen for P1's are. She stated she was not certain of the time, "a little before 8:00 a.m." PCA got her, and she responded immediately to P1's alarm. She denied hearing the alarm from P4's room. RN-B stated the DON reached out the staff a few times on 8/8/25 about P1's staff. RN-B denied ever hearing how long P1 was off the ventilator or if there were any changes to staffing to ensure all client have the staff at the home. Upon interview on 8/26/25 at 3:26 p.m. the DON stated she conducted the investigation and made sure P1 was safe. She instructed staff to fill out an incident report and to change P1's ventilator tubing. She denied finding out how long P1's ventilator was alarming or how many staff were in the home. She denied following up with P1's request to see the video monitoring taken in her room and denied finding a root cause why it took	G0486		

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G0486	Continued from page 4 staff eight minutes and three seconds to respond. A facility policy titled Client; Family Complaint/Grievance Policy dated 2014 indicated clients of the agency are provided with written information and how to address their concerns related to their cares. The agency must maintain documentation of its efforts and demonstrate compliance with state requirement.	G0486		
G0572	Plan of care CFR(s): 484.60(a)(1) 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. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record review the home health agency (HHA) failed to provide a reasonable expectation for use of call lights for 4 of 4 patient (P1, P2, P3, P4) reviewed for assistance. P2 had to knock on her wall to call for assistance, P3 yelled out for assistance and P4 had no way of calling for assistance. P1 recently received a touch call button on her own following an incident at the home. Findings include: P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of	G0572		

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G0572	Continued from page 5 daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. Upon observation and interview on 8/21/25 at 9:59 a.m. P1 was seated in her specialized wheelchair in the commons area of the home. She was breathing through her ventilator using her Dynavox (a speech generating device in which P1 used her eyes to generate the device to speak). She stated she had an incident at the agency where her tracheostomy tube fell out and it took several minutes for the staff to respond. Following the incident P1 met with a speech therapist and got assistance with getting a touch call button that she can slightly move with her feet to call for staff assistance. She asked for the call button because of her anxiety from the incident when tracheostomy tube falling out and she was "tired" of using her Dynavox to reach out to staff as they could not always hear it from her room. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. Upon observation and interview on 8/21/25 at 2:45 p.m. P2 was in bed. P2 could not speak, however could make her needs met by mouthing the words. P2 stated to call for help she knocked on her wall when she required staff assistance. P2 stated staff could not hear her knocking on the wall, but during the day when P1 was in	G0572		

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G0572	Continued from page 6 the living room P1 would use her Dynavox machine to notify staff when P2 required assistance. P2 had never been offered a call bell of any kind. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days. Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. Upon observation and interview on 8/25/25 at 1:12 p.m. P3 was lying flat in his bed, he had his cell phone attached to a bar above his head. He used his tongue to scroll on his phone. He stated when he required assistance he would yell. He would yell loud enough to get staffs attention, however sometimes it took a "while." He stated If he needed, he could use phone to call the home and ask for staff. P3 denied ever being asked for another way to notify staff of when he required assistance. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental	G0572		

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G0572	Continued from page 7 status was oriented and forgetful. Upon observation and interview on 8/21/25 at 9:00 a.m. P4 was laying in his bed, his arms were contracture and bent at the elbows with his hands by his face. He could move his eyes and make small gestures with his mouth. R4's family member (FM)-A was with him at his bedside. She stated his arms were also in the contracture position and he would not be able to call for assistance. FM-A stated that was one of the reasons she spent most of her days with him. Upon interview on 8/21/25 at 12:45 p.m. registered nurse (RN)-A stated P1 now has a way to call for staff since she has the touch alarm she used with her foot. P2 used the wall to knock and verified P1 often will notify staff when P2 is knocking on her wall. P3 yells out of his room, and he was close to the kitchen, allowing staff hears him. P4 was unable to call for help, staff needed to check on him often. Upon interview on 8/26/25 at 3:30 p.m. the clinical manager (CM) stated she was aware P1 got herself a touch alarm. The agency had given P2 a call light in the past and P2 did not use the light, so the agency removed it. P3 yelled for help and P4 was able to use a call light. A policy regarding client communication notification was requested however none was received.	G0572		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on observation, interview, and record review the home health agency (HHA) failed to conform with practitioner orders for the services for 4 of 4 (P1, P2, P3 and P4). P1, P2, P3, and P4 were all ordered to receive 24-hour extended skilled nursing services and the agency only staffed three nurses daily from 7:00 p.m. to 7:00 a.m. In addition, on 8/8/25 P1's ventilator tubing fell out and it took staff eight minutes and three seconds to tend to her because her assigned nurse was not in the home.	G0580		

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G0580	Continued from page 8 Based on observation, interview, and record review the home health agency (HHA) failed to conform with practitioner orders for the services for 4 of 4 patients (P1, P2, P3 and P4) reviewed. P1, P2, P3, and P4 were all ordered to receive 24-hour extended skilled nursing services and the agency only staffed three nurses daily from 7:00 p.m. to 7:00 a.m. In addition, on 8/8/25 P1's ventilator tubing fell out and it took staff eight minutes and three seconds to tend to her because her assigned nurse was not in the home. Findings include: The agency staffing schedules reviewed for dates 7/1/25 to 8/31/25 for the Oakdale house where P1, P2, P3, and P4 reside indicated from daily from 7:00 a.m. to 7:00 p.m. four nursing staff were scheduled. From 7:00 p.m. to 7:00 a.m. only three nurses were scheduled. P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing	G0580		

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G0580	Continued from page 9 assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days. Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental status was oriented and forgetful. An incident note dated 8/8/25 by registered nurse (RN)-B indicated she arrived at 7:00 a.m. and received report from the night nurse who stated P1 had been	G0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248147	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEFERTT HEALTH CARE LLC	3621 85TH AVENUE NORTH STE 103 , BROOKLYN PARK, Minnesota, 55443

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G0580	Continued from page 10 suctioned more than usual. P1's alarm triggered at 7:30 a.m. and RN-B suctioned her and got a small amount of clear secretions. A personal care attendant (PCA)-A arrived at 7:45 a.m. when RN-B was preparing medications for P4. RN-B instructed PCA-A to listen for P1's alarm and notify her of concerns. Before RN-B finished the medications with P4, PCA-A informed RN-B that P1's alarm was sounding. RN-B immediately connected the tubing back in place and suctioned P1. P1 was then breathing o.k. and not in any distress. By the time she finished connecting tubing the other twos staff members had arrived. An email from P1 to the clinical manager, her county case worker, and the director of nursing (DON) dated 8/8/25 at 1:28 p.m. Indicated R1 was inquiring if the staff notified the agencies leadership. The body of the email indicated: P1 was in dire need of help. There was only one nurse in the home the time of the incident (RN)-B. A couple of minutes before 8:00 a.m. at 7:58, P1's ventilator popped off. She had thick secretions blocking the top of the airway. RN-B was in P4's room, passing meds. P1 was off the vent, airway blocked, barely able to breathe, for almost ten minutes. At 8:07 before RN-B arrived. Upon interview on 8/21/25 at 9:59 a.m. P1 stated on 8/8/25 her ventilator tubing popped off, so she was not able to get much air, and it took eight minutes before the staff responded to her ventilator alarm sounding. P1 stated her cares were ordered to be twenty-four hours of skilled nursing every day. On 8/8/25 the nurse assigned to her had not shown up until 8:10 a.m. There was only one nurse in the house for three residents. Upon interview on 8/25/25 at 10:18 a.m. P1's county case manager stated P1 to be receiving one-to-one skilled nursing care twenty-fours a day. There was no shared nursing services ordered. P1 was very dependent and required constant supervision. Upon interview on 8/25/25 at 12:34 p.m. RN-D stated he was scheduled to work with P1 on 8/8/25 arrived at the house between 8:10 and 8:15 a.m. He stated RN-B reported the incident to him when he arrived. Upon interview on 8/25/25 at 3:58 p.m. RN-C stated he was in the house on 8/18/25 at 7:00 a.m., however he was using the bathroom in the basement of the home for	G0580		

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G0580	Continued from page 11 15-20 minutes when P1's alarm sounded. He stated he heard the alarm for a minute and figured she had relieved assistance. RN-B was giving medications to the patient RN-C was scheduled to care for on the day of 8/8/25. Upon interview on 8/26/25 at 1:10 p.m. patient care assistant (PCA)-B stated on 8/8/25 he left the home following his shift a little after 7:00 a.m. and there was only one nurse in the home, RN-B. He stated he had never been asked to stay if the house was not fully staffed before leaving. Upon interview on 8/25/25 at 1:22 p.m. PCA-A stated she arrived at the house on 8/8/25 at 7:45 p.m. and the only nurse she saw was RN-B. She stated she was instructed to listen for P1's alarm because her nurses had not arrived. She stated she heard the alarm after a few minutes after she was instructed to listen for it and immediate notified RN-B who was in the room in the back of the house. Upon interview on 8/25/25 at 4:47 p.m. P1's medical provider stated eight minutes for a ventilator sounding was poor practice for a totally helpless patient who was ordered to have one-to-one nursing twenty-four hours a day. Leaving her unattended for that amount of time "is a problem." Upon interview on 8/26/25 at 2:10 p.m. RN-B stated on 8/8/25 P1's scheduled nurse was not onsite. She needed to care for P4, she instructed PCA-A to listen for P1's alarm. She stated she was not certain of the time, "a little before 8:00 a.m." PCA notified her, and she responded immediately to P1's alarm. Upon observation and interview on 8/26/25 at 2:38 p.m. P1's Respiratory Therapist (RT) ran the ventilator report from P1's ventilator. The report revealed on 8/8/25 P1 was not hooked up to her ventilator for eight minutes and three seconds. Upon interview on 8/26/25 at 3:45 p.m. the director of nursing (DON) stated she aware that on 8/8/25 P1's nurse was not in the home and the incident was investigated. She stated the reason they only staff three nurses from 7:00 p.m. until 7:00 a.m. was because up until 4/2025 P2 was not ordered to have twenty yet.	G0580		

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G0580	Continued from page 12 The facilities Combined Federal and State Home Care Bills of Rights undated indicated the client had the right to receive all services outline in the plan of care.	G0580		
G0960	Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is NOT MET as evidenced by: Based on observations, interview, and document review the agency failed to provide oversight of patient assignments for four complex patients for 4 of 4 (P1, P2, P3, & P4) reviewed for staffing. Nursing staff were providing care and services up to and more than twenty-four continuous hours for patients who were at risk for respiratory failure due to tracheostomy and ventilator dependence as well as quadriplegic patients requiring total assistance Based on observations, interview, and document review the agency failed to provide oversight of patient assignments for four complex patients for 4 of 4 patients (P1, P2, P3, & P4) reviewed. Nursing staff were providing care and services up to and more than twenty-four continuous hours for patients who were at risk for respiratory failure due to tracheostomy and ventilator dependence as well as quadriplegic patients requiring total assistance. Findings: The Office of the Revisor of Statutes dated 2024 reviewed 8/26/25 https.//www.revisor.mn.gov/statutes/cite/181.275 Sec. 181.275 MN Statutes indicated: Subdivision 1. Definitions. For purposes of this section, the following terms have the meanings given them: (1) "emergency" means a period when replacement staff are not able to report for duty for the next shift or increased patient need, because of unusual, unpredictable, or unforeseen circumstances such as, but not limited to, an act of terrorism, a disease	G0960		

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G0960	Continued from page 13 outbreak, adverse weather conditions, or natural disasters which impact continuity of patient care; (2) "normal work period" means 12 or fewer consecutive hours consistent with a predetermined work shift. P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days.	G0960		

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G0960	Continued from page 14 Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental status was oriented and forgetful. The agency staffing schedule reviewed for dates 7/20/25 to 8/9/25 for the Oakdale house where P1, P2, P3, and P4 reside indicated RN-A, RN-B, and RN-C were consistently scheduled more than 12-hours in 24-hour period. On 7/20/25, RN-B was scheduled 7:00 a.m. through 7/22/25, 7:00 p.m. (60 total hours) On 7/22/25, RN- C was scheduled 7:00 p.m. through 7/24/25, 7:00 a.m. (36 total hours) On 7/28/25, RN-C was scheduled 7:00 a.m. through 7/31/25, 7:00 a.m. (60 total hours) On 7/28/25, RN-B was scheduled 7:00 a.m. through 7/29/25, 7:00 a.m. (36 total hours)	G0960		

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G0960	Continued from page 15 On 8/3/25, RN-B was scheduled 7:00 a.m. through 8/5/25, 7:00 p.m. (60 total hours) On 8/8/25, RN-A was scheduled 7:00 a.m. through 8/10/25, 7:00 a.m. (60 total hours) Upon interview on 8/25/25 at 3:58 p.m. RN-C stated he is often scheduled for multiple shifts in a row. He stated he can take two hours in breaks every 12-hours. He stated at if he is working 36 hours he will save-up his break time and take 6 hours at once. He will go in the basement of the house and sleep or go to his car. He stated there was a schedule on to take breaks when multiple shifts were being worked at once. Upon interview on 8/26/25 at 2:10 p.m. RN-A verified the July and August schedules were correct and she is often scheduled for multiple shifts at time. She stated she will a two-hour break for every 12-hours she worked. She stated her breaks were not documented on the staff time sheet and breaks were not taken at any specific times. Upon interview on 8/26/25 at 3:30 p.m. the clinical manager stated she did not schedule the employees and was not certain of the regulatory requirements. The director of nursing (DON), the co-owner completed the schedules and handled all the payroll. The agency did not have a policy on staffing that the clinical manager was aware of. Upon interview on 8/26/25 at 3:45 p.m. the DON stated she was not aware that she could not schedule the staff for multiple shifts if they did not have a problem with it as long as they were taking ample breaks. A policy on staffing was requested however none was provided.	G0960		

Protecting, Maintaining and Improving the Health of All Minnesotans

Delivered Via Email

September 17, 2025

Administrator
SEFERTT HEALTH CARE LLC
3621 85TH AVENUE NORTH STE 103
BROOKLYN PARK, MN 55443

Re: Enclosed State Licensing Orders
Event ID: 1D4453-H1

Dear Administrator:

A survey of the Home Care Provider named above was completed on August 26, 2025, 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 one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.482.

In accordance with Minnesota Statute section 144A.477, for home care providers that are licensed to provide home care services and are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, with survey and enforcement by the Minnesota Department of Health as an agent for the United States Department of Health and Human Services, the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) are considered equivalent to the federal requirements. Because your facility is a certified home health agency, violations of the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) may lead to enforcement actions under Minnesota Statute section 144A.474. If your facility fails to comply with all the federal deficiencies issued as a result of this Department's survey completed on August 26, 2025, the findings supporting the federal violations shall be considered violations of the applicable licensure requirements. The notice of termination from the Medicare program by the Centers for Medicare and Medicaid Services (CMS) or the failure to attain compliance with the federal regulations within the time periods approved by CMS may constitute grounds for the revocation, suspension or nonrenewal of the license.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for home care providers.

The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN requirement is not met as evidenced by."

We urge you to review these orders carefully. If you have questions, please contact the supervisor listed below. When all orders are corrected, the order form should be signed and returned to this office at:

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

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

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(s) assessed.

The written request for reconsideration and all supporting documents must be received by the Commissioner within 15 calendar days of the correction order receipt date.

The Commissioner shall respond in writing to the request within 60 days of the date the provider requests a reconsideration. Any documentation received after the 15 calendar days will not be

considered. You are required to send your written request and all supporting documents to Health.Homecare@state.mn.us; or, if you prefer you can mail it to:

Home Care Correction Order Reconsideration Process
Minnesota Department of Health
Health Regulation Division
625 Robert St. N
St. Paul, MN 55164-0975
Telephone 651-201-4200
Health.CM-Cert@state.mn.us

Failure to correct state licensing correction orders may result in enforcement actions in accordance with the provisions of Minnesota Statutes, sections 144A.43 to 144A.482.

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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00000	Initial Comments On 8/21/25 & 8/25/25 - 8/26/25 an abbreviated complaint was conducted. The following licensing orders are being issued as a result of the survey. *****ATTENTION***** HOME CARE PROVIDER LICENSING CORRECTION ORDER In accordance with Minnesota Statutes, section 144A.43 to 144A.482, this correction order(s) has been issued pursuant to a survey. Determination of whether a violation has been corrected requires compliance with all requirements provided at the Statute number indicated below. When Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.	00000		
00265	Up-To-Date Plan/Accepted Standards Practice CFR(s): 144A.44, Subd. 1(a)(2) receive care and services according to a suitable and up-to-date plan, and subject to accepted health care, medical or nursing standards, to take an active part in developing, modifying, and evaluating the plan and services This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observations, interview, and document review the agency failed to provide oversight of patient assignments for four complex patients for 4 of 4 patients (P1, P2, P3, & P4) reviewed. Nursing staff were providing care and services up to and more than twenty-four continuous hours for patients who were at risk for respiratory failure due to tracheostomy and ventilator dependence as well as quadriplegic patients requiring total assistance.	00265		

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

Minnesota State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 28096	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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00265	Continued from page 1 This practice resulted in a level two violation (a violation that did not harm a client's health or safety, but was not likely to cause serious injury, impairment or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a larger portion or all of the clients). Findings: The Office of the Revisor of Statutes dated 2024 reviewed 8/26/25 https.//www.revisor.mn.gov/statutes/cite/181.275 Sec. 181.275 MN Statutes indicated: Subdivision 1. Definitions. For purposes of this section, the following terms have the meanings given them: (1) "emergency" means a period when replacement staff are not able to report for duty for the next shift or increased patient need, because of unusual, unpredictable, or unforeseen circumstances such as, but not limited to, an act of terrorism, a disease outbreak, adverse weather conditions, or natural disasters which impact continuity of patient care; (2) "normal work period" means 12 or fewer consecutive hours consistent with a predetermined work shift. P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was	00265		

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00265	Continued from page 2 oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days. Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's	00265		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEFERTT HEALTH CARE LLC	3621 85TH AVENUE NORTH STE 103 , BROOKLYN PARK, Minnesota, 55443

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00265	Continued from page 3 pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental status was oriented and forgetful. The agency staffing schedule reviewed for dates 7/20/25 to 8/9/25 for the Oakdale house where P1, P2, P3, and P4 reside indicated RN-A, RN-B, and RN-C were consistently scheduled more than 12-hours in 24-hour period. On 7/20/25, RN-B was scheduled 7:00 a.m. through 7/22/25, 7:00 p.m. (60 total hours) On 7/22/25, RN- C was scheduled 7:00 p.m. through 7/24/25, 7:00 a.m. (36 total hours) On 7/28/25, RN-C was scheduled 7:00 a.m. through 7/31/25, 7:00 a.m. (60 total hours) On 7/28/25, RN-B was scheduled 7:00 a.m. through 7/29/25, 7:00 a.m. (36 total hours) On 8/3/25, RN-B was scheduled 7:00 a.m. through 8/5/25, 7:00 p.m. (60 total hours) On 8/8/25, RN-A was scheduled 7:00 a.m. through 8/10/25, 7:00 a.m. (60 total hours) Upon interview on 8/25/25 at 3:58 p.m. RN-C stated he is often scheduled for multiple shifts in a row. He stated he can take two hours in breaks every 12-hours. He stated at if he is working 36 hours he will save-up his break time and take 6 hours at once. He will go in the basement of the house and sleep or go to his car. He stated there was a schedule on to take breaks when multiple shifts were being worked at once. Upon interview on 8/26/25 at 2:10 p.m. RN-A verified the July and August schedules were correct and she is often scheduled for multiple shifts at time. She stated she will a two-hour break for every 12-hours she worked. She stated her breaks were not documented on the staff time sheet and breaks were not taken at any specific times. Upon interview on 8/26/25 at 3:30 p.m. the clinical	00265		

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00265	Continued from page 4 manager stated she did not schedule the employees and was not certain of the regulatory requirements. The director of nursing (DON), the co-owner completed the schedules and handled all the payroll. The agency did not have a policy on staffing that the clinical manager was aware of. Upon interview on 8/26/25 at 3:45 p.m. the DON stated she was not aware that she could not schedule the staff for multiple shifts if they did not have a problem with it as long as they were taking ample breaks. A policy on staffing was requested however none was provided.	00265		

admin <admin@sefertt.com> 9/22/2025 1:46 PM

FW: ACTION REQUIRED: MDH Survey Results - Sefertt Health Care 8-26-25

To lois@sefertt.com

Sent from my Galaxy

-------- Original message --------
From: Poepping, Melissa (MDH)
Date: 9/17/25 9:23 AM (GMT-06:00)
To: admin@sefertt.com
Cc: Winters, Annette.M (MDH)
Subject: ACTION REQUIRED: MDH Survey Results - Sefertt Health Care 8-26-25

Hello,

Attached are the Certification Letter, License Letter, Health Survey 2567, and State Form for the recent survey conducted at Sefertt Health Care on 8-26-25. Please note that I have included a read receipt request for this email and that will serve as the start of the 10-day timeframe for receiving a plan of correction.

Failure to submit an acceptable written plan of correction for all deficiencies within ten calendar days may result in additional remedies and/or decertification including a loss of federal reimbursement.

Thank you.

Melissa Poepping
Compliance Analyst | Federal Enforcement
Health Regulation Division

Minnesota Department of Health
Office: 651-201-4117

DEPARTMENT OF HEALTH

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G0000	INITIAL COMMENTS On 8/21/25 & 8/25/25 - 8/26/25 a complaint survey was conducted. This resulted in a partial extended survey at Sefertt Health Care LLC. The agency was found to have not met)the requirements at 42 CFR. Part 484 for Home Health Agencies. The cumulative eû ects of these û ndings resulted in the Home Health Agency's inability to ensure provision of quality of care. The following complaints were reviewed: H81472247C / Intake 2589097	G0000		
G0486	Protect patient during investigation CFR(s): 484.50(e)(1)(iii) (iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated. This ELEMENT is NOT MET as evidenced by: Based on interview and record review the home health agency (HHA) failed to conduct a thorough investigation for 1 of 1 patient (P1) reviewed. The agencies investigation did not provide a resolution of the complaint. P1's was ventilator dependent and ordered to have skilled nursing 24-hours a day. On 8/8/25 7:46 a.m. P1's ventilator alarm sounded for eight minutes and three seconds because her tubing fell out leaving her without oxygen. Findings include: P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube	G0486	G0486 This deficiency occurred when Sefertt Health Care failed to document the resolution to the investigation conducted. DON received P1 email on 8/8/25. P1 was called immediately to ensure P1 is ok and safe. P1 states "am Ok but upset that the nurse did not report the incident to the other nurses." P1 demanded for Camera footage but DON could not transmit footage from her location but summarize what she saw on the camera when RN B ran into the room to connect the tubing. Investigation was conducted after talking with P1. RN B states she was getting P4 medication ready and as soon as she heard the alarm and the PCA notified her, she ran into the room; noticed the tubing fell off, quickly put it back, suctioned P1, stayed with P1 and asked if P1 was ok and P1 responded she was ok before leaving the room. P1 was not in distress.	9/15/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lois Arneson.	DON	9/29/2025

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G0486	Continued from page 1 through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1'sa functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. An incident note dated 8/8/25 by registered nurse (RN)-B indicated she arrived at 7:00 a.m. and received report from the night nurse who stated P1 had been suctioned more than usual. P1's alarm triggered at 7:30 a.m. and RN-B suctioned her and got a small amount of clear secretions. A personal care attendant (PCA)-A arrived at 7:45 a.m. when RN-B was preparing medications for P1. RN-B asked PCA-A to listen for P1's alarm and notify her of concerns. Before RN-B finished the medications with P1, PCA-A informed RN-B that P1's alarm was sounding. RN-B immediately connected the tubing back in place and suctioned P1. P1 was then breathing o.k. and not in any distress. By the time she finished the other two members had arrived. RN-B did not indicate the time the alarm sounded or the time she reconnected. In later interview RN-B stated RN-C had been in the house, just using the bathroom in the basement. A facility schedule dated 8/8/25 indicated RN-B, RN-C and RN-D were scheduled to work at the home from 7:00 a.m. to 7:00 p.m. The schedule did not indicate which nurse was assigned to which client. P1's timesheet dated 8/8/25 indicated RN-D arrived at 8:10 on 8/8/25. P1 sent an email message on 8/8/25 indicating she needed camera footage for the morning of 8/8/25 because took the nurse ten minutes to respond to her ventilator alarm. P1 was responded to immediately via email, but unable to send the camera footage due to the writers location. Writer explained what the footage covered at the time and investigation conducted immediately. Staff explained how the P1's alarm went off and PCA-A called RN-B from another client's room and responded	G0486	During investigation. DON found out there were 2 out of 3 nurses in the house plus the PCA making 3 staff in the house. On 8/8/25 only 3 clients were in the house P2 was in the hospital. DON sent Memo to the house platform that No staff should leave before the staff relieving each staff shows up unless ok by DON. All employee is sent this memo to sign for acknowledgement. DON will monitor to ensure proper documentation of investigation and resolution is completed by 9/15/25 DON and Clinical manager is responsible for maintenance of proper documentation of investigation and resolution.	9/15/25

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G0486	Continued from page 2 immediately. RN-B was instructed to write an incident report. P1's Patient Communication Log dated 8/8/25 indicated at 10:30 a.m. the DON called P1 to ask if she felt safe in the home until the writer returned from vacation P1 stated she was but was upset that the nurse did not tell other staff what took place. P1's nurse (uncertain which nurse) explained that she had been having issues with her tracheostomy and the respiratory therapist (RT) had been called to check all the ventilator settings. P1 was encouraged to have the staff change her tracheostomy tubing which she agreed to allow staff to change later in the afternoon. Writer would follow-up later. P1's Patient Communication Log dated 8/8/25 indicated the DON called P1 back at 4:00 p.m. Staff stated the tracheostomy change was successful and P1 was doing o.k. P1 also sent a text message at 4:08 p.m. indicated tracheostomy had been changed and everything was o.k. now. The DON instructed the nurse in question to make sure the report was filled out and in P1's chart until the writer got back from vacation. An email from P1 to the clinical manager, her county case worker and the DON dated 8/8/25 at 1:28 p.m. Indicated R1 was inquiring if the staff notified the HHA leadership about the incident. The body of the email indicated P1 was in dire need of help. There was only one nurse in the home the time of the incident (RN)-B. A couple of minutes before 8:00 a.m. at 7:58, P1's ventilator popped off. She had thick secretions blocking the top of the airway. RN-B was in P4's room, passing meds. P1 was off the vent, airway blocked, barely able to breathe, for almost ten minutes. At 8:07 before RN-B arrived. P1 indicated, nothing was even passed on to the other staff when they arrived. No incident report, nothing. When RN-D asked RN-B about it, she only minimized it." Arguing that there is no way it was as long, I might be off by 1 minute. Nobody had bothered to ask me how I am feeling, if I am OK, or even taken my vitals! Acting like it is no big deal when it is a life-threatening situation, says it all. If my trach cuff had not been leaking enough for me to get the tiny bit of air I got, I would not be typing this & there would be one hell of a lawsuit from my grieving family. It was all caught on camera. Will need a copy of that video footage & a copy of the formal incident report right away. Three to five business days should	G0486		

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G0486	Continued from page 3 be more than adequate." Upon interview on 8/21/25 at 9:59 a.m. P1 stated on 8/8/25 her ventilator tubing popped off, so she was not able to get much air, and it took eight minutes before the staff responded to her ventilator alarm sounding. P1 stated her cares were ordered to be twenty-four hours of skilled nursing every day. On 8/8/25 the nurse assigned to her had not shown up until 8:10 a.m. There was only one nurse in the house for three residents. P1 was later told that there was another nurse who was in the basement in the bathroom when her alarm was sounding. P1 stated she felt angry, depressed, and unheard because staff was telling she could not have been off the ventilator for eight minutes, that it was only about one minute. P1 stated she had her eyes on a clock the entire time she was fighting for air. Upon interview on 8/25/25 at 12:34 p.m. RN-D stated he was scheduled to work with P1 on 8/8/25 and did clock in at between 8:10 and 8:15 a.m. He stated RN-B reported the incident to him when he arrived. RN-E called the house and spoke with all the staff to obtain information about the incident. The DON instructed the staff the fill out an incident report. RN-D was not certain how long P1 was off the ventilator and had not heard from the agencies leadership since 8/8/25 about the investigation. Upon interview on 8/26/25 at 2:10 p.m. RN-B stated on 8/8/25 P1's nurse was not onsite. She needed to care for P1, so she asked PCA-A to listen for P1's are. She stated she was not certain of the time, "a little before 8:00 a.m." PCA got her, and she responded immediately to P1's alarm. She denied hearing the alarm from P4's room. RN-B stated the DON reached out the staff a few times on 8/8/25 about P1's staff. RN-B denied ever hearing how long P1 was off the ventilator or if there were any changes to staffing to ensure all client have the staff at the home. Upon interview on 8/26/25 at 3:26 p.m. the DON stated she conducted the investigation and made sure P1 was safe. She instructed staff to fill out an incident report and to change P1's ventilator tubing. She denied finding out how long P1's ventilator was alarming or how many staff were in the home. She denied following up with P1's request to see the video monitoring taken in her room and denied finding a root cause why it took	G0486		

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G0486	Continued from page 4 staff eight minutes and three seconds to respond. A facility policy titled Client; Family Complaint/Grievance Policy dated 2014 indicated clients of the agency are provided with written information and how to address their concerns related to their cares. The agency must maintain documentation of its efforts and demonstrate compliance with state requirement.	G0486		
G0572	Plan of care CFR(s): 484.60(a)(1) 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. This STANDARD is NOT MET as evidenced by: Based on observation, interview, and record review the home health agency (HHA) failed to provide a reasonable expectation for use of call lights for 4 of 4 patient (P1, P2, P3, P4) reviewed for assistance. P2 had to knock on her wall to call for assistance, P3 yelled out for assistance and P4 had no way of calling for assistance. P1 recently received a touch call button on her own following an incident at the home. Findings include: P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of	G0572	G0572 This deficiency occurred when Sefertt Health Care fail to provide a reasonable expectation for use of call lights. P1 has a call light connected to her bedroom ventilator that she independently triggers to call for help. And that is what she has been using effectively for years but she added another call light when this incident happened that she can push with her leg. P2 has a call light but don't remember to use it due to history of stroke. She used to have one attached to her bed railings but don't remember its there, then it was put around her neck but was removed after she had bypass surgery done to right IJ. P2 MD has ordered Occupational therapy consult on 9/11 to look into getting her a different type of call button. Earliest appointment is 10/23/25.	10/23/25

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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G0572	Continued from page 5 daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. Upon observation and interview on 8/21/25 at 9:59 a.m. P1 was seated in her specialized wheelchair in the commons area of the home. She was breathing through her ventilator using her Dynavox (a speech generating device in which P1 used her eyes to generate the device to speak). She stated she had an incident at the agency where her tracheostomy tube fell out and it took several minutes for the staff to respond. Following the incident P1 met with a speech therapist and got assistance with getting a touch call button that she can slightly move with her feet to call for staff assistance. She asked for the call button because of her anxiety from the incident when tracheostomy tube falling out and she was "tired" of using her Dynavox to reach out to staff as they could not always hear it from her room. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. Upon observation and interview on 8/21/25 at 2:45 p.m. P2 was in bed. P2 could not speak, however could make her needs met by mouthing the words. P2 stated to call for help she knocked on her wall when she required staff assistance. P2 stated staff could not hear her knocking on the wall, but during the day when P1 was in	G0572	All staff have been instructed to continue to encourage P2 to use the call light she has now pending recommendations from PT. P3 has a baby monitor that his nurse keeps close by for him to call. Occupational therapy is working with his case manager to get him a customized call light. P4 is working with Allina Speech therapist to get a customized call light in place. DON will ensure all clients have a call light device as soon as possible before the end of October, 2025 DON will monitor and maintain the use of call light by all clients	10/23/25

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G0572	Continued from page 6 the living room P1 would use her Dynavox machine to notify staff when P2 required assistance. P2 had never been offered a call bell of any kind. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days. Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. Upon observation and interview on 8/25/25 at 1:12 p.m. P3 was lying flat in his bed, he had his cell phone attached to a bar above his head. He used his tongue to scroll on his phone. He stated when he required assistance he would yell. He would yell loud enough to get staffs attention, however sometimes it took a "while." He stated If he needed, he could use phone to call the home and ask for staff. P3 denied ever being asked for another way to notify staff of when he required assistance. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental	G0572		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 248147	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 08/26/2025

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G0572	Continued from page 7 status was oriented and forgetful. Upon observation and interview on 8/21/25 at 9:00 a.m. P4 was laying in his bed, his arms were contracture and bent at the elbows with his hands by his face. He could move his eyes and make small gestures with his mouth. R4's family member (FM)-A was with him at his bedside. She stated his arms were also in the contracture position and he would not be able to call for assistance. FM-A stated that was one of the reasons she spent most of her days with him. Upon interview on 8/21/25 at 12:45 p.m. registered nurse (RN)-A stated P1 now has a way to call for staff since she has the touch alarm she used with her foot. P2 used the wall to knock and verified P1 often will notify staff when P2 is knocking on her wall. P3 yells out of his room, and he was close to the kitchen, allowing staff hears him. P4 was unable to call for help, staff needed to check on him often. Upon interview on 8/26/25 at 3:30 p.m. the clinical manager (CM) stated she was aware P1 got herself a touch alarm. The agency had given P2 a call light in the past and P2 did not use the light, so the agency removed it. P3 yelled for help and P4 was able to use a call light. A policy regarding client communication notification was requested however none was received.	G0572		
G0580	Only as ordered by a physician CFR(s): 484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. This ELEMENT is NOT MET as evidenced by: Based on observation, interview, and record review the home health agency (HHA) failed to conform with practitioner orders for the services for 4 of 4 (P1, P2, P3 and P4). P1, P2, P3, and P4 were all ordered to receive 24-hour extended skilled nursing services and the agency only staffed three nurses daily from 7:00 p.m. to 7:00 a.m. In addition, on 8/8/25 P1's ventilator tubing fell out and it took staff eight minutes and three seconds to tend to her because her assigned nurse was not in the home.	G0580		

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G0580	Continued from page 8 Based on observation, interview, and record review the home health agency (HHA) failed to conform with practitioner orders for the services for 4 of 4 patients (P1, P2, P3 and P4) reviewed. P1, P2, P3, and P4 were all ordered to receive 24-hour extended skilled nursing services and the agency only staffed three nurses daily from 7:00 p.m. to 7:00 a.m. In addition, on 8/8/25 P1's ventilator tubing fell out and it took staff eight minutes and three seconds to tend to her because her assigned nurse was not in the home. Findings include: The agency staffing schedules reviewed for dates 7/1/25 to 8/31/25 for the Oakdale house where P1, P2, P3, and P4 reside indicated from daily from 7:00 a.m. to 7:00 p.m. four nursing staff were scheduled. From 7:00 p.m. to 7:00 a.m. only three nurses were scheduled. P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing	G0580	G0580 This deficiency occurred when Sefertt Health Care only staffed three nurses daily for 7pm to 7am shift. This happened because Sefertt health Care did not get authorization for 24 hours nursing care for P2 from 5/1/25 – 8/31/25. As of 8/29/25 four Nurses are scheduled for every shift (7am to 7pm and 7pm to 7am.) when ever all four clients are in the house. As of 8/29/25, Sefertt health Care now have authorization for 24-hour nursing for P2 and staff clients accordingly. Sefertt Health Care has requested for shared hours for P1, and P3 which is in process per the case Manager. DON will monitor and ensure one on one staffing is implemented on every shift and when there is shortage of staff, efforts will be made to find respite homes available or clients will be sent to hospital of choice for safety by 8/29/25 DON will ensure compliance with clients' plan of care and service agreement by 9/5/2025	9/5/25

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G0580	Continued from page 9 assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days. Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental status was oriented and forgetful. An incident note dated 8/8/25 by registered nurse (RN)-B indicated she arrived at 7:00 a.m. and received report from the night nurse who stated P1 had been	G0580		

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G0580	Continued from page 10 suctioned more than usual. P1's alarm triggered at 7:30 a.m. and RN-B suctioned her and got a small amount of clear secretions. A personal care attendant (PCA)-A arrived at 7:45 a.m. when RN-B was preparing medications for P4. RN-B instructed PCA-A to listen for P1's alarm and notify her of concerns. Before RN-B finished the medications with P4, PCA-A informed RN-B that P1's alarm was sounding. RN-B immediately connected the tubing back in place and suctioned P1. P1 was then breathing o.k. and not in any distress. By the time she finished connecting tubing the other twos staff members had arrived. An email from P1 to the clinical manager, her county case worker, and the director of nursing (DON) dated 8/8/25 at 1:28 p.m. Indicated R1 was inquiring if the staff notified the agencies leadership. The body of the email indicated: P1 was in dire need of help. There was only one nurse in the home the time of the incident (RN)-B. A couple of minutes before 8:00 a.m. at 7:58, P1's ventilator popped off. She had thick secretions blocking the top of the airway. RN-B was in P4's room, passing meds. P1 was off the vent, airway blocked, barely able to breathe, for almost ten minutes. At 8:07 before RN-B arrived. Upon interview on 8/21/25 at 9:59 a.m. P1 stated on 8/8/25 her ventilator tubing popped off, so she was not able to get much air, and it took eight minutes before the staff responded to her ventilator alarm sounding. P1 stated her cares were ordered to be twenty-four hours of skilled nursing every day. On 8/8/25 the nurse assigned to her had not shown up until 8:10 a.m. There was only one nurse in the house for three residents. Upon interview on 8/25/25 at 10:18 a.m. P1's county case manager stated P1 to be receiving one-to-one skilled nursing care twenty-fours a day. There was no shared nursing services ordered. P1 was very dependent and required constant supervision. Upon interview on 8/25/25 at 12:34 p.m. RN-D stated he was scheduled to work with P1 on 8/8/25 arrived at the house between 8:10 and 8:15 a.m. He stated RN-B reported the incident to him when he arrived. Upon interview on 8/25/25 at 3:58 p.m. RN-C stated he was in the house on 8/18/25 at 7:00 a.m., however he was using the bathroom in the basement of the home for	G0580		

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G0580	Continued from page 11 15-20 minutes when P1's alarm sounded. He stated he heard the alarm for a minute and figured she had relieved assistance. RN-B was giving medications to the patient RN-C was scheduled to care for on the day of 8/8/25. Upon interview on 8/26/25 at 1:10 p.m. patient care assistant (PCA)-B stated on 8/8/25 he left the home following his shift a little after 7:00 a.m. and there was only one nurse in the home, RN-B. He stated he had never been asked to stay if the house was not fully staffed before leaving. Upon interview on 8/25/25 at 1:22 p.m. PCA-A stated she arrived at the house on 8/8/25 at 7:45 p.m. and the only nurse she saw was RN-B. She stated she was instructed to listen for P1's alarm because her nurses had not arrived. She stated she heard the alarm after a few minutes after she was instructed to listen for it and immediate notified RN-B who was in the room in the back of the house. Upon interview on 8/25/25 at 4:47 p.m. P1's medical provider stated eight minutes for a ventilator sounding was poor practice for a totally helpless patient who was ordered to have one-to-one nursing twenty-four hours a day. Leaving her unattended for that amount of time "is a problem." Upon interview on 8/26/25 at 2:10 p.m. RN-B stated on 8/8/25 P1's scheduled nurse was not onsite. She needed to care for P4, she instructed PCA-A to listen for P1's alarm. She stated she was not certain of the time, "a little before 8:00 a.m." PCA notified her, and she responded immediately to P1's alarm. Upon observation and interview on 8/26/25 at 2:38 p.m. P1's Respiratory Therapist (RT) ran the ventilator report from P1's ventilator. The report revealed on 8/8/25 P1 was not hooked up to her ventilator for eight minutes and three seconds. Upon interview on 8/26/25 at 3:45 p.m. the director of nursing (DON) stated she aware that on 8/8/25 P1's nurse was not in the home and the incident was investigated. She stated the reason they only staff three nurses from 7:00 p.m. until 7:00 a.m. was because up until 4/2025 P2 was not ordered to have twenty yet.	G0580		

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G0580	Continued from page 12 The facilities Combined Federal and State Home Care Bills of Rights undated indicated the client had the right to receive all services outline in the plan of care. G0960 Make patient and personnel assignments, CFR(s): 484.105(c)(1) Making patient and personnel assignments, This ELEMENT is NOT MET as evidenced by: Based on observations, interview, and document review the agency failed to provide oversight of patient assignments for four complex patients for 4 of 4 (P1, P2, P3, & P4) reviewed for staffing. Nursing staff were providing care and services up to and more than twenty-four continuous hours for patients who were at risk for respiratory failure due to tracheostomy and ventilator dependence as well as quadriplegic patients requiring total assistance Based on observations, interview, and document review the agency failed to provide oversight of patient assignments for four complex patients for 4 of 4 patients (P1, P2, P3, & P4) reviewed. Nursing staff were providing care and services up to and more than twenty-four continuous hours for patients who were at risk for respiratory failure due to tracheostomy and ventilator dependence as well as quadriplegic patients requiring total assistance. Findings: The Office of the Revisor of Statutes dated 2024 reviewed 8/26/25 https.//www.revisor.mn.gov/statutes/cite/181.275 Sec. 181.275 MN Statutes indicated: Subdivision 1. Definitions. For purposes of this section, the following terms have the meanings given them: (1) "emergency" means a period when replacement staff are not able to report for duty for the next shift or increased patient need, because of unusual, unpredictable, or unforeseen circumstances such as, but not limited to, an act of terrorism, a disease	G0580 G0960	G0960 This deficiency occurred when Sefertt Health Care scheduled staff for multiple shifts. This was due to shortage of nursing staff. Agency has requested for shared hours for P1, P3, and P4. As of 9/1/2025, Agency has been scheduling staff for only 12 hours. Many of the staff picked up the open shifts due to shortage of staff. The service agreement for P1, P2, P3 and P4 states "clients will go to hospital of choice when there is shortage of staff. But hospitals no longer take Clients unless such client is acutely sick due to shortage of staff from their end also. We have been looking for respite place for P1 for over six months now in collaboration with her case Manager with no result. We will continue to work with P1 Case Manager for respite option. DON will continue to work with Client's case Managers to get shared hours or respite in place when there is shortage of staff. DON will ensure and maintain scheduling staff for 8 or 12 hours shifts by 10/1/2025	10/1/25

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G0960	Continued from page 13 outbreak, adverse weather conditions, or natural disasters which impact continuity of patient care; (2) "normal work period" means 12 or fewer consecutive hours consistent with a predetermined work shift. P1's Home Health Plan of Care and Certification dated 7/10/25- 9/7/25 indicated P1 received skilled nursing for a frequency and duration of 24 hour extended care daily for 60 days, 2 hours of patient care assistant (PCA) daily for 60 days. Skilled nursing was to assess and evaluate all body systems as part of her care plan, provide tracheostomy (a direct opening in the neck to allow a tube to be inserted providing an airway), gastrostomy tube (an insertion of a feeding tube through the abdominal wall directly in to the stomach)and ventilator (life support machine that helps patients breathe when they are unable to do so on their own) care along with assisting in all activities of daily living. P1's pertinent diagnoses were chronic respiratory failure, amyotrophic lateral sclerosis (Lou Gehrig's disease, a nervous system disease that weakens muscles and impacts physical function), dependent on respirator, and major depression disorder. P1's functional limitations were paralysis, endurance, ambulation, contractures, and speech. Mental status was oriented. Activities included transferring from bed to chair, prescribed exercises, and a wheelchair. P2's Home Health Plan of Care and Certification dated 5/26/25 to 7/25/25 indicated P2 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. P2's pertinent diagnoses were acute and chronic respiratory failure, hemiplegia (weakness on one side of her body) following cerebral infarct (stroke), affecting the left nondominant side, and chronic obstruction pulmonary disease. Skilled nursing assessed and evaluated the management of P2's airway, tracheostomy status, pain control, administered tube feedings through her gastrostomy tube and assess her integumentary status. P2's functional limitations were bowel and bladder incontinence, paralysis, endurance, and ambulation. P2's mental status was oriented and agitated. P2's activities permitted were complete bedrest, transfer from bed to chair, prescribed exercises, and wheelchair. P3's Home Health plan of Care and Certification dated 7/22/5 – 9/19/25 indicated P3 received skilled nursing for a frequency of 24 hours extended care daily and a patient care assistant for 4 hours daily for 60 days.	G0960		

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G0960	Continued from page 14 Nursing to assess and implement cares per plan of care, assess skin, respiratory status, neurological and mental health, pain, safety, nutrition, and elimination, maintain ventilatory and provide all nursing cares. P1's pertinent diagnoses were acute and chronic respiratory failure, quadriplegia (paralysis of all four limbs and torso), neurogenic bowel (nerve damage disrupting the bowel leading to bowel control concerns), tracheostomy status, colostomy status (opening in the abdomen allowing stool to be collected in the pouch), and dependence of respiratory status. P3's functional limitations were paralysis and ambulation. Activities permitted were prescribed exercises and wheelchair. Mental status was oriented and depressed. P4's Home Health Plan of Care and Certification dated 7/6/25 – 9/3/25 indicated P4 received skilled nursing for a frequency of 24 hours extended care daily for 60 days. Skilled nursing assessed and provided all medical cares and activities of daily living. Assessed skin integrity, respiratory, neuro, elimination, safety, and musculoskeletal, pain gastrointestinal and nutritional status. Provided Foley indwelling catheter changes monthly. Administered tube feedings daily and maintained gastrotomy tube and jejunostomy tubes. P4's pertinent diagnoses were anoxic brain damage, chronic respiratory failure, convulsions, anxiety, dysphagia (difficulty swallowing) and muscle spasms. Functional limitations were bowel and bladder incontinence, contractures, paralysis, endurance, and ambulation. Activities permitted were a wheelchair. P4's mental status was oriented and forgetful. The agency staffing schedule reviewed for dates 7/20/25 to 8/9/25 for the Oakdale house where P1, P2, P3, and P4 reside indicated RN-A, RN-B, and RN-C were consistently scheduled more than 12-hours in 24-hour period. On 7/20/25, RN-B was scheduled 7:00 a.m. through 7/22/25, 7:00 p.m. (60 total hours) On 7/22/25, RN- C was scheduled 7:00 p.m. through 7/24/25, 7:00 a.m. (36 total hours) On 7/28/25, RN-C was scheduled 7:00 a.m. through 7/31/25, 7:00 a.m. (60 total hours) On 7/28/25, RN-B was scheduled 7:00 a.m. through 7/29/25, 7:00 a.m. (36 total hours)	G0960		

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SEFERTT HEALTH CARE LLC	3621 85TH AVENUE NORTH STE 103 , BROOKLYN PARK, Minnesota, 55443

(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
G0960	Continued from page 15 On 8/3/25, RN-B was scheduled 7:00 a.m. through 8/5/25, 7:00 p.m. (60 total hours) On 8/8/25, RN-A was scheduled 7:00 a.m. through 8/10/25, 7:00 a.m. (60 total hours) Upon interview on 8/25/25 at 3:58 p.m. RN-C stated he is often scheduled for multiple shifts in a row. He stated he can take two hours in breaks every 12-hours. He stated at if he is working 36 hours he will save-up his break time and take 6 hours at once. He will go in the basement of the house and sleep or go to his car. He stated there was a schedule on to take breaks when multiple shifts were being worked at once. Upon interview on 8/26/25 at 2:10 p.m. RN-A verified the July and August schedules were correct and she is often scheduled for multiple shifts at time. She stated she will a two-hour break for every 12-hours she worked. She stated her breaks were not documented on the staff time sheet and breaks were not taken at any specific times. Upon interview on 8/26/25 at 3:30 p.m. the clinical manager stated she did not schedule the employees and was not certain of the regulatory requirements. The director of nursing (DON), the co-owner completed the schedules and handled all the payroll. The agency did not have a policy on staffing that the clinical manager was aware of. Upon interview on 8/26/25 at 3:45 p.m. the DON stated she was not aware that she could not schedule the staff for multiple shifts if they did not have a problem with it as long as they were taking ample breaks. A policy on staffing was requested however none was provided.	G0960		