

STATE LICENSING COMPLIANCE REPORT

Report #: HL379947089C

Date Concluded: December 20, 2023

Name, Address, and County of Facility

Investigated:

CaringHands Home Health Care
6714 92nd Bay
Cottage Grove, MN 55016
Washington County

Facility Type: Assisted Living Facility (ALF)

Evaluator's Name: Rhylee Gilb, RN
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 37994	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/27/2023
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NAME OF PROVIDER OR SUPPLIER CARINGHANDS HOME HEALTH CARE INC	STREET ADDRESS, CITY, STATE, ZIP CODE 6714 92ND BAY COTTAGE GROVE, MN 55016
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
0 000	<p>Initial Comments</p> <p>On November 27, 2023, the Minnesota Department of Health initiated an investigation of complaint HL379947089C. During the investigation, it was identified that the allegation was regarding a different, similarly-named facility. No correction orders are issued.</p>	0 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____