

Protecting, Maintaining and Improving the Health of All Minnesotans

# State Rapid Response Investigative Public Report

Office of Health Facility Complaints

Maltreatment Report #: HL358335106M Date Concluded: May 31, 2023

**Compliance #:** HL358338729C

Name, Address, and County of Licensee

Investigated:

Comforting Angels 202 Highway 10 Hawley, MN 56549 Clay County

Facility Type: Home Care Provider Evaluator's Name: Barbara Axness, RN

Special Investigator

Finding: Substantiated, facility and individual responsibility

### **Nature of Investigation:**

The Minnesota Department of Health investigated an allegation of maltreatment, in accordance with the Minnesota Reporting of Maltreatment of Vulnerable Adults Act, Minn. Stat. 626.557, and to evaluate compliance with applicable licensing standards for the provider type.

### Initial Investigation Allegation(s):

The owner/alleged perpetrator (AP) financially exploited the client when the AP made several unauthorized withdrawals from the client's bank account.

### **Investigative Findings and Conclusion:**

The Minnesota Department of Health determined financial exploitation was substantiated. The AP and the facility were responsible for the maltreatment. The AP withdrew \$246,726.70 from the client's bank accounts over a period of nine months. The AP made as many as five withdrawals per month from the client's bank accounts and did not provide billing statements indicating the reasons for the withdrawals. In addition, the client's debit card was used to make unauthorized purchases. Multiple unlicensed personnel (ULP) and the client's responsible party reported concerns of misuse of the client's debit card to the AP, however, the AP failed to investigate the allegations.

The investigator conducted interviews with facility staff members, including administrative staff, nursing staff, and unlicensed staff. The investigator also contacted law enforcement. The investigation included review of medical records, bank statements, and billing statements.

The client received comprehensive home care services from the provider in the client's home. The home care agency did not have documentation of the client's diagnoses. The client did not have a signed service plan. The client's most recent assessment contained information on COVID-19 screenings, vital signs, and a medication list. The client was receiving 24-hour services from agency unlicensed personnel (ULP).

The client's bank statements identified approximately 28 automated clearing house (ACH) withdrawals from the AP's home care agency over a nine-month period. The individual transactions ranged from \$286.27 to \$13,964.27 with anywhere from two to five transactions made each month on various dates. Some transactions were completed the same day and some a few days apart. In total \$246,726.70 was withdrawn via ACH by the agency. The client's bank statements included several transactions the client did not make, including charges to an online language coach and a computer game company.

The investigator requested copies of the billing statements the AP had sent to the client. The client's responsible party had not seen the statements the client was sent and requested the AP send her (responsible party) copies of the statements. The AP emailed the responsible party a total of 22 statements, covering six months of services. The statements the AP sent the investigator did not match the statements sent to the client's responsible party. The statements provided to the investigator included 82 pages covering ten months of services. The statements included discrepancies in the totals for monthly services when compared to the statements sent to the client's responsible party.

The amounts listed on the statements did not line up with amounts withdrawn from the client's bank accounts via the ACH withdrawal. The dates the ACH withdrawals occurred also did not line up with the billing cycle dates.

During an interview, the client's responsible party stated she had not received any billing statements for the client's care but was told it would cost \$25,000 per month. The responsible party had agreed to ACH withdrawals but hadn't checked the client's bank account for several months. When she did, she noticed a lot of money had been taken out, so she asked the AP for billing statements and was sent nine months of statements. The email she received was sent from the accounting department of the home care agency by a person with the AP's first name and first letter of last name. The responsible party indicated the statements included hours ULP worked, but the hours didn't add up to the 24 hours charged to the client. The responsible party questioned the AP about the bill, as she was billed for hours that staff were not present in the home and the amounts did not line up to what was withdrawn from the client's bank account but did not get any real answers. The responsible party provided the AP with a debit card for staff to use if they took the client out for the client to buy food, snacks, or other items. The

responsible party had noticed suspicious charges on the debit card and reported those concerns to the AP. The responsible party deactivated the client's debit card since it was apparent not all the charges were from the client. After the debit card was canceled, the AP put any expenses related to the client on invoices, but the invoices lacked details and sometimes receipts, and the responsible party had concerns about some of the expenses.

During investigative interviews, multiple staff members stated there were many times there was not a caregiver in the home, even though the client was supposed to be receiving 24-hour care. Staff reported that sometimes staff just didn't show up. They would come to the client's home and sleep for the duration of their shift; or come to the client's home to clock in, leave, and come back later to clock out. Multiple staff members reported these concerns to the AP. In addition, multiple staff reported voicing concerns about debit card misuse to the AP. One staff member stated the AP was "well aware of what was going on" and had been notified by herself and other staff about the client's personal items being taken by caregivers and staff using the debit card for things for themselves. Another staff member reported she told the AP staff members used the client's debit card for purchases for themselves at places like restaurants, gas stations, fast food places, and Apple. The staff member stated there were times she bought groceries for the client with her own money, since the client was out of certain things and the next time she worked, the items would be missing. The staff member added there was one time staff said they bought things for the client at Sam's Club, but she didn't see evidence of anything in the client's home. Multiple staff members reported there were many times where ULP came into the client's home, clocked in, and left, then came back at the end of their shift to clock out, and the client was billed for the full visit time. A staff member stated the AP was aware of the potentially fraudulent charges on the client's debit card and the missing personal items, and she had assumed the AP was taking care of it since "we're mandated reporters."

During further investigative interviews, multiple current and former administrative assistants stated they were not permitted access to anything regarding client billing as part of their office job duties. The administrative assistants stated the only person who was allowed to do billing was the owner. The administrative assistants frequently received calls from various clients and family members with concerns and questions on bills and charges, but they were directed to not address the concerns and have them speak with the owner.

During an interview, the AP stated she billed monthly, or on the 1<sup>st</sup> and 15<sup>th</sup> of the month, and recently started billing weekly for services provided. The AP didn't know why the client's bank account was showing withdrawals from the agency that fell outside of her stated billing cycles and for amounts more than what the statements reflected. The AP said she had some issues with her billing software, but never received any disputes from the client or the family about the amounts taken out, so she was not aware money above and beyond the cost of services was being withdrawn. The AP had not noticed concerning transactions in her bank account and had not noticed the additional deposits to her bank account. When asked about specific transactions, the AP stated she would have to see the client's bank statements to be able to better explain why there were multiple ACH transactions for amounts that did not line up with

the billing statements. The AP stated the client "was an easy client" and she had not received any concerns related to billing, concerns with staff conduct, or misappropriation of funds. The AP stated there were no gaps in the client's care and a caregiver was present 24/7, except for when family came to visit and sent some caregivers home. The AP confirmed staff slept on the overnight shifts but she directed them to set an alarm for every hour so they can get up and check on the client. The AP stated the client's responsible party brought concerns over one month's charges to her attention and "she was right, so it was credited back." The AP stated she did now know of any concerns involving staff using the client's debit card for personal use.

In conclusion, the Minnesota Department of Health determined financial exploitation was substantiated.

# Substantiated: Minnesota Statutes, section 626.5572, Subdivision 19.

"Substantiated" means a preponderance of evidence shows that an act that meets the definition of maltreatment occurred.

## Financial exploitation: Minnesota Statutes, section 626.5572, subdivision 9

"Financial exploitation" means: ...

- (a) In breach of a fiduciary obligation recognized elsewhere in law, including pertinent regulations, contractual obligations, documented consent by a competent person, or the obligations of a responsible party under section 144.6501, a person:
- (1) engages in unauthorized expenditure of funds entrusted to the actor by the vulnerable adult which results or is likely to result in detriment to the vulnerable adult; or
- (2) fails to use the financial resources of the vulnerable adult to provide food, clothing, shelter, health care, therapeutic conduct or supervision for the vulnerable adult, and the failure results or is likely to result in detriment to the vulnerable adult.
- (b) In the absence of legal authority a person:
- (1) willfully uses, withholds, or disposes of funds or property of a vulnerable adult;
- (2) obtains for the actor or another the performance of services by a third person for the wrongful profit or advantage of the actor or another to the detriment of the vulnerable adult;
- (3) acquires possession or control of, or an interest in, funds or property of a vulnerable adult through the use of undue influence, harassment, duress, deception, or fraud; or
- (4) forces, compels, coerces, or entices a vulnerable adult against the vulnerable adult's will to perform services for the profit or advantage of another.

Vulnerable Adult interviewed: No, unable Family/Responsible Party interviewed: Yes Alleged Perpetrator interviewed: Yes

Action taken by facility:

No action taken.

**Action taken by the Minnesota Department of Health:** 

The facility was found to be in noncompliance. To view a copy of the Statement of Deficiencies and/or correction orders, please visit:

https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html

If you are viewing this report on the MDH website, please see the attached Statement of Deficiencies.

You may also call 651-201-4890 to receive a copy via mail or email

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

CC:

The Office of Ombudsman for Long Term Care
The Office of Ombudsman for Mental Health and Developmental Disabilities
Clay County Attorney
Moorhead City Attorney
Moorhead Police Department

(X6) DATE

Minnesota Department of Health

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| HOME CARE PROCORRECTION OR  In accordance with 144A.43 to 144A.48 issued pursuant to a provided at the stat When a Minnesota items, failure to combe considered lack  INITIAL COMMENT HL358335105M/ HI HL358335106M/ HI HL358335684M/ HI On April 4-12, 2023 Health conducted a above provider, and orders are issued. A investigation, there services under the license.  The following imme | Minnesota Statutes, section 32, these correction orders are a complaint investigation.  The section is corrected with all requirements are number indicated below. Statute contains several apply with any of the items will of compliance.  TS:  1358338727C 1358338728C 1358338729C 1358338728C 1358338728C 1358338728C 1358338728C 1358338728C 1358338728C 1358338728C 1358338728C |                     | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota State Statutes for Hom Providers. The assigned tag num appears in the far-left column entit Prefix Tag." The state Statute num the corresponding text of the state out of compliance is listed in the "Summary Statement of Deficience column. This column also includes findings which are in violation of the requirement after the statement, "Minnesota requirement is not met evidenced by." Following the surve findings is the Time Period for Corrections of the Fourth Column which States, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE SUBMIT A PLAN OF CORRECTION." THIS APPLIES THE SUBMIT A PLAN OF CORRECTION." THIS APPLIES THE SUBMIT A PLAN OF CORRECTION THE LEFT COLUMN WHICH SUBDITIONS OF MINNESOTA STATUTES.  THE LETTER IN THE LEFT COLUMN USED FOR TRACKING PURPOS REFLECTS THE SCOPE AND LE ISSUED PURSUANT TO 144A.47 SUBDIVISION 11 (b)(1)(2). | oftware. to e Care ber iled "ID iber and statute ies" is the ie state This as eyors' rection. DING OF THIS ON FOR TATE  JMN IS ES AND IVEL |  |
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Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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SS=I

financial exploitation occurred, and that an

maltreatment, in addition to the licensee, in

evidence that maltreatment occurred.

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individual staff person was responsible for the

connection with incidents which occurred. The

MDH concluded there was a preponderance of

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Minnesota Department of Health

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Minnesota Department of Health

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|                          | the office and direct   | ted O-A to remit payment.  |                     |   |       |                          |
|                          | investigator that she the mail today. The send the check with O-A wrote back, "go investigator advised license online and process.      | at 2:45 p.m., O-A emailed the would be putting a check in investigator advised O-A to tracking or via certified mail. and idea, thanks." The O-A she could renew her bay online to expedite the  |                     |   |       |                          |
|                          | •   | at 10:21 a.m., MDH staff<br>k from O-A had not yet arrived   |                     |   |       |                          |
|                          | mailed her check or<br>send with tracking of<br>investigator advised<br>the online payment<br>license is renewed.<br>has been operating | at 12:30 p.m., O-A stated she hapril 10, 2023, but did not or via certified mail. The O-A again to consider using option to ensure her expired O-A was reminded again she with an expired license since 3, and has been aware of the se April 4, 2023. |                     |   |       |                          |
|                          | •   | , O-A had not submitted<br>he comprehensive license.   |                     |   |       |                          |
|                          | No further informati  | on provided.   |                     |   |       |                          |
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Minnesota Department of Health

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|                          | address, and mailing of the county in which has a principal place (2) the initial license in subdivision 7; (3) the email address address, and teleph administrative office (4) the email address address, and teleph office, if any; (5) the names, email telephone numbers officials;   | e fee in the amount specified ss, physical address, mailing none number of the principal ss, physical address, mailing none number of each branch sil and mailing addresses, and of all owners and managerial  |                     |  |       |                          |
|                          | background study r<br>144A.476 for all per<br>management, opera-<br>care provider;<br>(7) documentation of<br>required by section<br>seeking employment<br>home care provider<br>(8) evidence of wor-<br>as required by section<br>(9) documentation of<br>is seeking;<br>(10) identification of<br>is seeking;<br>(11) documentation<br>official who is in char<br>and attestation that<br>understands the ho-<br>(12) documentation<br>designated one or re-<br>officials, or employed<br>which shall not affer | of compliance with the equirements of section roons involved in the ation, or control of the home of a background study as 144.057 for any individual at, paid or volunteer, with the roots, with the roots and 176.181 and 176.182; of liability coverage, if the roots the license level the provider that identifies the managerial arge of day-to-day operations the person has reviewed and me care provider regulations; that the applicant has more owners, managerial res as an agent or agents, of the legal responsibility of managerial official under this |                     |  |       |                          |

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|                          | agent on behalf of a association, or unit (14) verification that following policies ari if a license is issued the policies and procurrent: (i) requirements in complete maltreatment of mirreporting of maltreatment of home evaluations of home evaluations of home evaluations of home evaluations and intia and the providers and assin a client's condition and communicated providers as appropicated providers and providers are appropicated providers and providers and providers are appropicated providers and providers are approvided providers and providers are approvided providers and provi | f the officer or managing in entity, corporation, of government; it the applicant has the ind procedures in place so that it, the applicant will implement cedures and keep them chapter 260E, reporting of nors, and section 626.557, tment of vulnerable adults; nandling background studies ing, and competency is care staff, and a process for formance; aints from clients, family representatives regarding evided by staff; I evaluation of clients' needs ibility to provide those in and ongoing client is essments and how changes in are identified, managed, to staff and other health care oriate; ind implementation of the I of rights; of practices; redications, treatments, or ed; and opriate screenings, to show that erculosis, consistent with its Centers for Disease Control indards; and | 0 465               |  |       |                          |

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| NAME OF PROVIDER   |  | 202 HIGH   |                     | STATE, ZIP CODE  |      |                          |
|  | CH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| by: Based license require compre the ma day-to- and im proced regulat  This pr violatio safety l client's cause s was iss probler failure a large  The fin  The lice Compr Manag applica comple which of the lice care la followir below.'  The foll read ar | nent.  N Requirement on interview e failed to show that of lice the portion or all the po | ent is not met as evidenced and record review, the now they had met the ensure when applying for a me care license, by attesting cials who were in charge of the ns, had reviewed, understood, urrent policies and uired, by home care provider cords reviewed.  ed in a level two violation (a t harm a client's health or cotential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when lisive or represent a systemic cted or has potential to affect ll of the clients). |                     |  |      |                          |

Minnesota Department of Health

| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 465  Continued From page 8  Sections 144A.43 through 144A.484, Housing with Services Establishment, Chapter 144D, Assisted Living Services, Chapter 144D, Reporting of Maltreatment of Minors, MN Statute Section 626.556, and Reporting of Maltreatment of Vulnerable Adults, MN Statute Section 626.557." This page was dated, February 15, 2022, and signed by owner (O)-A.  The licensee had a comprehensive home care license issued on March 5, 2022. The license expired on March 4, 2023. As of April 24, 2023, the licensee had not renewed the comprehensive license, despite outreach from MDH staff to assist with renewing the license.   |        | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′          | E CONSTRUCTION  | COMP | SURVEY                   |
|--|--------|--|---|--------------|---|------|--------------------------|
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 465  Continued From page 8  Sections 144A.43 through 144A.484, Housing with Services Establishment, Chapter 144D, Assisted Living Services, Chapter 144G, Reporting of Maltreatment of Minors, MN Statute Section 626.556, and Reporting of Maltreatment of Vulnerable Adults, MN Statute Section 626.557." This page was dated, February 15, 2022, and signed by owner (O)-A.  The licensee had a comprehensive home care license issued on March 5, 2022. The license expired on March 4, 2023. As of April 24, 2023, the licensee had not renewed the comprehensive license, despite outreach from MDH staff to assist with renewing the license. |        |  | H35833  | B. WING      |   |      |                          |
| (X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)   DATE OF THE APPROPRIATE DEFICIENCY)   DATE OF THE APPROPRIATE DEFICIENCY   |        |  | 202 HIGH  | WAY 10       | STATE, ZIP CODE   |      |                          |
| Sections 144A.43 through 144A.484, Housing with Services Establishment, Chapter 144D, Assisted Living Services, Chapter 144G, Reporting of Maltreatment of Minors, MN Statute Section 626.556, and Reporting of Maltreatment of Vulnerable Adults, MN Statute Section 626.557." This page was dated, February 15, 2022, and signed by owner (O)-A.  The licensee had a comprehensive home care license issued on March 5, 2022. The license expired on March 4, 2023. As of April 24, 2023, the licensee had not renewed the comprehensive license, despite outreach from MDH staff to assist with renewing the license.   | PREFIX | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL  | ID<br>PREFIX | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE | (X5)<br>COMPLETE<br>DATE |
| On April 4, 2023, at 12:15 p.m., owner (O)-A stated she was familiar with the Minnesota Home Care Laws and Regulations, and understood the regulations.  The licensee failed to implement the following required policies and procedures:  - conducting and handling background studies on employees;  - orientation, training, and competency evaluations of home care staff;  - conducting initial and ongoing client evaluations and assessments; and  - orientation to and implementation of the home care bill of rights;  Refer to licensing order at 144A.44 Subd. 1(a) (14). The licensee failed to obtain home care licensure while providing services to clients in their home and advertising as a home care  | 0 465  | Sections 144A.43 the with Services Estable Assisted Living Serre Reporting of Maltre Section 626.556, and of Vulnerable Adults 626.557." This page 2022, and signed by The licensee had a license issued on Mexpired on March 4 the licensee had no license, despite out with renewing the licensee had no license, despite out with renewing the licensee failed required policies and care Laws and Regregulations.  The licensee failed required policies and employees;  - orientation, training evaluations of home and assessments;  - orientation to and care bill of rights;  Refer to licensing of (14). The licensee for licensure while provided the pr | hrough 144A.484, Housing blishment, Chapter 144D, vices, Chapter 144G, atment of Minors, MN Statute and Reporting of Maltreatment is, MN Statute Section he was dated, February 15, yowner (O)-A.  comprehensive home care larch 5, 2022. The license 1, 2023. As of April 24, 2023, at renewed the comprehensive reach from MDH staff to assist cense.  12:15 p.m., owner (O)-A complete in the following and understood the standard implement the following and procedures:  and inglement the following and procedures:  and ongoing client evaluations and implementation of the home care viding services to clients in |              |   |      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--|---|---------------------|--|-------------------|--------------------------|
|  |   |                     |  |                   | ;                        |
|  | H35833  | B. WING             |  | 04/1              | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| COMFORTING ANGELS  | 202 HIGH  | WAY 10<br>MN 56549  |  |                   |                          |
|  |   |                     |  | ONI               | ()/(5)                   |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 0 465 Continued From p   | age 9   | 0 465               |  |                   |                          |
| provider.  |   |                     |  |                   |                          |
| The licensee failed from financial expl (C1, C2) when the account for the commade unauthorized clients' bank accounts and accounts are licensed failed records contained include a background 12 of 12 employee (ULP)-K, ULP-L, ULP-R, ULP-S, ULUP-W).  Refer to licensing | order a 144A.471, Subd. 1. It to ensure protection from oitation for two of two clients licensee failed to accurately at of services rendered and dACH withdrawals from the unts.  order at 144A.476, Subd. 2. It to ensure current employee all the required content to und study clearance letter for s, (unlicensed personnel JLP-M, ULP-O, ULP-P, ULP-Q, LP-T, ULP-U, ULP-V, and order at 144A.479 Subd. 2. The ensure the provider's website |                     |  |                   |                          |
|  | vices accurately depicted the sive level services the agency  |                     |  |                   |                          |
| The licensee failed from financial explosion (C1, C2) when the account for the cost  | order at 144A.479, Subd. 5. I to ensure protection from oitation for two of two clients licensee failed to accurately st of services rendered and ACH withdrawals from the unts.  |                     |  |                   |                          |
| The licensee failed Minnesota Adult A (MAARC) suspect  | order at 144A.479, Subd. 6(a). It to immediately report to the buse Reporting Center ed maltreatment of financial r of four clients (C1, C2, C3, viewed.  |                     |  |                   |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                  | CONSTRUCTION  | ` '       | E SURVEY<br>PLETED       |
|--------------------------|--|---|----------------------|---|-----------|--------------------------|
|                          |  | H35833  | B. WING              |   |           | C<br><b>12/2023</b>      |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S       | TATE, ZIP CODE  |           |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH<br>HAWLEY,   | WAY 10<br>, MN 56549 |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 0 465                    | The licensee failed prevention plan (IAI the required content C2, C3, C4).  Refer to licensing of The licensee failed record contained all four of four employed and unlicensed persulter. With record Refer to licensing of The licensee failed Minnesota Home Cato the client or client initiation of services C2, C3, C4) with record Refer to licensing of The licensee failed (RN) completed a cafter a change in cato (C4) as required.  Refer to licensing of Services plans included the refour clients (C1, C2). Refer to licensing of The licensee failed included a signature the provider to document of the provider of the provider to document of the provider of the provi | rder at 144A.479, Subd. 6(b). to ensure an individual abuse PP) was developed to include t for four of four clients (C1, rder at 144A.479, Subd. 7. to ensure the employee of the required content for ees (registered nurse (RN)-C sonnel (ULP)-K, ULP-L, s reviewed.  rder at 144A.4791, Subd. 1. to ensure the current are Bill of Rights was provided t's representative prior to for four of four clients (C1, cords reviewed.  rder at 144A.4791, Subd. 8. to ensure the registered nurse comprehensive reassessment andition for one of one clients or failed to ensure service required content for four of the clients are serviced to the required content for four of four |                      |   |           |                          |
|                          |  | rder at 144A.4791, Subd. 11.<br>to maintain a record of all   |                      |   |           |                          |

Minnesota Department of Health

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ,                 | E CONSTRUCTION   | (X3) DATE :<br>COMPI |                          |
|--------------------------|--|--|---------------------|--|----------------------|--------------------------|
|                          |  | H35833   | B. WING             |  | 04/1                 | ;<br>2/2023              |
| NAME OF F                | PROVIDER OR SUPPLIER   |  | DESS CITY S         | TATE ZID CODE  | 1 0471               | 2/2020                   |
| NAIVIE OF F              | ROVIDER OR SUPPLIER  | 202 HIGH\  |                     | STATE, ZIP CODE  |                      |                          |
| COMFOR                   | RTING ANGELS   |  | MN 56549            |  |                      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE                 | (X5)<br>COMPLETE<br>DATE |
| 0 465                    | Continued From pa  | ge 11  | 0 465               |  |                      |                          |
|                          | the date the compla-<br>home care provider   | complaints received, including int was received, and the 's investigation and resolution en it failed to document any d.   |                     |  |                      |                          |
|                          | licensee failed to im<br>Minnesota Adult Ab<br>(MAARC) suspecte  | rder at 626.557, Subd. 3. The mediately report to the use Reporting Center d maltreatment of financial of four clients (C1, C2, C3, ewed.  |                     |  |                      |                          |
|                          | which indicated the the Minnesota statu  | ection orders were issued,<br>licensee's understanding of<br>ites were limited, and not<br>nce with sections 144A.43 to  |                     |  |                      |                          |
|                          | No further informati   | on was provided.   |                     |  |                      |                          |
|                          | Time period for cor  | rection: Seven (7) Days  |                     |  |                      |                          |
| 0 715<br>SS=I            |  | Employees, Contractors, and  | 0 715               |  |                      |                          |
|                          | home care provider background study read may be disqual Nothing in this section prohibit a home care self-disclosure of crediance on information of a reliance on information or succonfirmed conviction | equired by section 144.057, ified under chapter 245C. on shall be construed to e provider from requiring siminal conviction information. In employee in good faith tion or records obtained under bdivision 1, regarding a n does not subject the home if liability or liability for |                     |  |                      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | ` ′  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |                              |                          |
|---|--|--|--|---|------------------------------|--------------------------|
|   |  | H35833   | B. WING                                  |   | C<br><b>12/2023</b>          |                          |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AL  | DDRESS, CITY, S                          | TATE, ZIP CODE  |                              |                          |
| COMFO   | RTING ANGELS   | 202 HIGH<br>HAWLEY   | IWAY 10<br>', MN 56549                   |   |                              |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTIO<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | N SHOULD BE<br>E APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| 0 715   | Continued From pa  | ge 12  | 0 715                                    |   |                              |                          |
|   | Based on interview licensee failed to en records contained a include a background 12 of 12 employees (ULP)-K, ULP-L, ULULP-R, ULP-S, ULF ULP-W).  This practice result violation that harmed not including serious or a violation that has serious injury, impairs are pervasive or repare the serious or repare the serious injury. | and record review, the sure current employee all the required content to nd study clearance letter for s, (unlicensed personnel P-M, ULP-O, ULP-P, ULP-Q, P-T, ULP-U, ULP-V, and ed in a level three violation (a ed a client's health or safety, as injury, impairment, or death, as the potential to lead to a sirment, or death), and was read scope (when problems present a systemic failure that potential to affect a large clients). |  |   |                              |                          |
|   | This resulted in an April 12, 2023, at 8:  | immediate correction order on :30 a.m.   |  |   |                              |                          |
|   | The findings include   | e:   |  |   |                              |                          |
|   |  | eptember 19, 2021, to provide<br>to the licensee's clients and<br>April 1, 2023.   |  |   |                              |                          |
|   | ULP-K's record lack  | ked documentation of a clearance letter.   |  |   |                              |                          |
|   | provided to the inverse record included a NULP-K from a differ   | P-K's employee record was stigator on April 4, 2023. The IETStudy submission form for ent HFID, dated July 3, 2019, years before ULP-K was hired   |  |   |                              |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |  | ` ′  | E CONSTRUCTION      | COMPLETED   |      |                          |
|--|--|--|---------------------|---|------|--------------------------|
|  |  | H35833   | B. WING             |   | 04/1 | )<br>2/2023              |
|  | PROVIDER OR SUPPLIER   | STREET AD  202 HIGH  | , ,                 | STATE, ZIP CODE   |      |                          |
| COMPO  | TING ANGLES  | HAWLEY,  | MN 56549            |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 /15  | O-A resent ULP-K's requested by the involution background study wis submission sent on A search of NETStudies added to the lice 13, 2023, and remould be removed. When the search of Net Search of Net Search of Net Study of A search of Net Study of Net Stud | April 10, 2023, at 10:34 a.m., background study as vestigator. ULP-K's vas the same NETStudy April 4, 2023.  Idy indicated the employee censee's roster on February ved on February 28, 2023. Ided to the roster again on removed on March 24, 2023. In a recent date entered for ints.  Exptember 3, 2022, to provide to the licensee's clients and February 18, 2023.  Indeed documentation of a learance letter.  Indeed indicated the employee | 0 715               |   |      |                          |
|  | was added to the lice 2021, and removed did not have a record completed.  ULP-M ULP-M was hired Jadirect care services was terminated on lice background study of A search of NETStudy as added to the lice  | censee's roster on June 1, on March 16, 2022. ULP-L of of fingerprints being anuary 18, 2023, to provide to the licensee's clients and March 23, 2023.   |                     |   |      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | (X3) DATE S |                          |
|---|--|---------------------|---|-------------|--------------------------|
|   |  | A. BUILDING:        | A. BUILDING:  |             |                          |
|   | H35833   | B. WING             |   | 04/1        | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE   |             |                          |
| COMFORTING ANGELS   | 202 HIGH   | WAY 10              |   |             |                          |
| COMPORTING ANGLES   | HAWLEY,  | MN 56549            |   |             |                          |
| PREFIX (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE        | (X5)<br>COMPLETE<br>DATE |
| 0 715 Continued From pa   | ge 1 <b>4</b>  | 0 715               |   |             |                          |
| On April 4, 2023, at she was aware ULF getting a DUI some stated around that the altercation between home. O-A stated L mouth off" at ULP-F shifts and the police wanted to press chance to problem and that cance temper issues" In a identified ULP-L as regarding theft of not around January or she had contacted see if she could be narcotics but they we stated she had been handguns from C1' was working with the not done any kind of guns or brought and investigator request ULP-M's employee study clearance letted the employees were his would be at the office would have to have partial copy of ULP-provided before the | 1:20 p.m., owner (O)-A stated P-L was on probation after time in the fall of 2022. O-A time, there was a physical ULP-L and ULP-K at C2's JLP-L had been "shooting her K when they were changing e came and asked if either arges. O-A stated ULP-L rges against ULP-K and she ething like an assault charge. In not sure if the case had been to the twas told by a lawyer that en formally convicted of continue to work unsupervised A stated ULP-L had a drinking aused her to have "a bit of ddition, O-A stated she had a likely alleged perpetrator arcotics from C3's apartment February of 2023. O-A stated ULP-L's probation officer to tested for the missing were not able to do so. O-A in made aware of two missing is home during the time ULP-M are client. O-A stated she had of investigation into the missing of concerns to the police. The ted copies of ULP-K and files to include background ters. O-A stated since the red in North Dakota, their files be in West Fargo and she them fax the records over. A c-K's employee file was investigator exited and O-A quested information would be |                     |   |             |                          |

Minnesota Department of Health

STATE FORM JRM011 If continuation sheet 15 of 131

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ´  | CONSTRUCTION        | ` '  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|--|---------------------|--|-------------------------------|--------------------------|
|   |   | H35833   | B. WING             |  |                               | C<br><b>12/2023</b>      |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, ST     | TATE, ZIP CODE   |                               |                          |
| COMEO   | RTING ANGELS  | 202 HIGH   | WAY 10              |  |                               |                          |
| COMIC   | INTINO ANOLLO   | HAWLEY,  | MN 56549            |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE                     | (X5)<br>COMPLETE<br>DATE |
| 0 715   | to get an update on studies. O-A stated yesterday (April 4, 2 out the study was fr years before startin company and there included. O-A stated responsible for inte studies, and general was asked if she was asked if she was asked if she was an hour away. aware, all employed On April 10, 2023, a investigator partial of file and ULP-K's ba from before she be licensee. ULP-M's participated to a shad agreed it was likely and agreed it was likely and agreed it was likely and taken her probation office breathalyzer installed therapy. O-A stated January and resum | 2:50 p.m., O-A was contacted the request for background ULP-K's study was sent 2023). The investigator pointed form a different HFID several gemployment with her was also no clearance letter doffice manager (OM)-J was rviews, doing background all employee file upkeep. O-A as aware the above mentioned at reflected on her NETStudy here was a period of time keep submitting the employee use the place they used to get sed and the closest location O-A stated as far as she was as had a background letter.  at 10:34 a.m., O-A emailed the copies of ULP-M's employee ckground check submission gan employment with the partial employee file did not and study clearance letter. On 1:57 a.m., O-A emailed the of ULP-L's background study ted a date of June 1, 2021.  at 4:00 p.m., O-A confirmed P-L got a DUI shortly after she hift and left a client's house kely ULP-L had been drinking pervised with a client. O-A en her off the schedule until |                     |  |                               |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | ` ´   | E CONSTRUCTION      | COMPLETED  |      |                          |
|--|---|---|---------------------|--|------|--------------------------|
|  |   | H35833  | B. WING             |  | 04/1 | 2/ <b>2023</b>           |
|  | PROVIDER OR SUPPLIER  | 202 HIGH  | WAY 10              | TATE, ZIP CODE   |      |                          |
|  | ANOLLO  | HAWLEY,   | MN 56549            |  |      | _                        |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 715  | confirmed they did background study we September 2021 are unsupervised direct terminated for a not O-A confirmed ULP even after charges altercation with anothome. O-A confirmed his fingerprints and study completed. Of to complete fingerprints and study complete fingerprints are study complete fingerprints and study complete fingerprints and study complete fingerprints and study complete fingerprints are study complete fingerprints. | quit in October 2019. O-A not complete a new when she was hired back in ad that ULP-K worked the with clients until she was call no show on April 1, 2023. P-K worked unsupervised, were pressed after an ther staff member at a client's red ULP-M never completed did not have a background p-A stated they had asked him rints many times but he never red to work unsupervised ckground study they did to work. O-A stated they had perprints done as the local site and it would take upwards of a nee letter back and some not get clearance letters back | 0 715               |  |      |                          |
|  | (RN)-C stated she was between ULP-L and the client's home affincident. RN-C stated pressing charges as but was not aware a background study of not have knowledge office members who RN-C stated she fe working with the lice incident because "the everyone has an ophave to put general would be fine, anoth so do you want a di  | at 1:55 p.m., registered nurse was aware of the fight d ULP-K and had responded to ter she was called about the ed she was aware ULP-L was gainst ULP-K after the incident neither had a current completed. RN-C stated, "I do e of that I can't keep track of aren't doing their jobs." It both ULP could continue ensee's clients after the his is where my opinion is, like pinion so I'm gonna sayI'd public opinion is one person it her person not going to be fine rect answer, what do you see [they can continue to                                    |                     |  |      |                          |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549    CAN TO BE ADDRESS ADDRE | AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | A. BUILDING:   |         |   | COMPLETED |          |
|--|--|---|--|---------|---|-----------|----------|
| COMFORTING ANGELS    X,4   ID   PREFIX   (EACH EDEFICIENCES   (EACH EDEFICIENCES   EACH EDEFICIENCES   (EACH EDEFICIENCE)   (EACH EDEFI |  |   | H35833   | B. WING |   |           |          |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  0 715 Continued From page 17  work unsupervised with clients], as long as those two caregivers are not in contact with each other. They do a good job just because they don't get alongIt's all about personalities and what personalities that get along, I can't make that judgment call, they did a good job when they worked. Just because they had an argument doesn't mean they're bad people."  On April 11, 2023, at 8:36 a.m., the investigator requested additional background study clearance letters from the following employees listed as current employees as identified by the licensee on April 4, 2023, ULP-Q, ULP-P, ULP-Q, ULP-R, ULP-S, ULP-T, ULP-U, ULP-V, and ULP-W.  ULP-O  ULP-O was hired August 30, 2022, to provide customer service and support to the licensee's clients.  ULP-O's record lacked documentation of a background study clearance letter.  A search of NETStudy indicated the employee was not added to the licensee's roster.  On April 11, 2023, at 8:50 a.m., O-A stated ULP-O only worked in the office and she did not realize office staff needed to complete background studies.  ULP-P  ULP-P was hired August 28, 2021, to provide direct care services to the licensee's clients.   |  |   | 202 HIGH   | WAY 10  | STATE, ZIP CODE   |           |          |
| work unsupervised with clients], as long as those two caregivers are not in contact with each other. They do a good job just because they don't get alongit's all about personalities and what personalities that get along. I can't make that judgment call, they did a good job when they worked. Just because they had an argument doesn't mean they're bad people."  On April 11, 2023, at 8:36 a.m., the investigator requested additional background study clearance letters from the following employees listed as current employees as identified by the licensee on April 4, 2023, ULP-O, ULP-P, ULP-Q, ULP-R, ULP-S, ULP-T, ULP-U, ULP-V, and ULP-W.  ULP-O  ULP-O was hired August 30, 2022, to provide customer service and support to the licensee's clients.  ULP-O's record lacked documentation of a background study clearance letter.  A search of NETStudy indicated the employee was not added to the licensee's roster.  On April 11, 2023, at 8:50 a.m., O-A stated ULP-O only worked in the office and she did not realize office staff needed to complete background studies.  ULP-P  ULP-P was hired August 28, 2021, to provide direct care services to the licensee's clients.  | PREFIX   | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL   | PREFIX  | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE      | COMPLETE |
| background study clearance letter.   | 0 715  | work unsupervised two caregivers are in They do a good job alongit's all about personalities that go judgment call, they worked. Just becaudoesn't mean they're On April 11, 2023, a requested additional letters from the follocurrent employees on April 4, 2023, ULULP-S, ULP-T, ULF ULP-O  ULP-O was hired Accustomer service and clients.  ULP-O's record lack background study of the Accustomer service and clients.  ULP-O only worked realize office staff in background studies.  ULP-P was hired Accustomer services.  ULP-P secord lack the Content of the Content | with clients], as long as those not in contact with each other. just because they don't get personalities and what et along, I can't make that did a good job when they se they had an argument the bad people."  It 8:36 a.m., the investigator all background study clearance owing employees listed as as identified by the licensee LP-O, ULP-P, ULP-Q, ULP-R, P-U, ULP-V, and ULP-W.  The did a good job when they see they had an argument the bad people."  It 8:36 a.m., the investigator all background study clearance owing employees listed as as identified by the licensee LP-O, ULP-P, ULP-Q, ULP-R, P-U, ULP-V, and ULP-W.  In gust 30, 2022, to provide the licensee's roster.  It 8:50 a.m., O-A stated in the office and she did not seeded to complete it.  It 8:50 a.m., O-A stated in the office and she did not seeded to complete it.  In gust 28, 2021, to provide to the licensee's clients. | 0 715   |   |           |          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | E CONSTRUCTION  | COMPLETED |                          |
|--------------------------|---|--|---------------------|---|-----------|--------------------------|
|                          |   | 1125022  | B WING              |   | 04/4      |                          |
|                          |   | H35833   | B. WII 10           |   | 04/1      | 2/2023                   |
| NAME OF F                | PROVIDER OR SUPPLIER                      | STREET AD  202 HIGH  | ,                   | STATE, ZIP CODE   |           |                          |
| COMFOR                   | RTING ANGELS                              |  | MN 56549            |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY                          | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                        | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | _D BE     | (X5)<br>COMPLETE<br>DATE |
| 0 715                    | Continued From page                       | ge 18  | 0 715               |   |           |                          |
|                          | A search of NETStu<br>was not added to th | idy indicated the employee<br>le licensee's roster.  |                     |   |           |                          |
|                          | is a family member                        | t 8:50 a.m., O-A stated ULP-P who helps her with payroll e did not realize they needed ground study. |                     |   |           |                          |
|                          | ULP-Q                                     |  |                     |   |           |                          |
|                          |   | larch 23, 2023, to provide to the licensee's clients.  |                     |   |           |                          |
|                          | ULP-Q's record lack<br>background study c | ked documentation of a learance letter.  |                     |   |           |                          |
|                          | A search of NETStu<br>was not added to th | idy indicated the employee<br>le licensee's roster.  |                     |   |           |                          |
|                          | •   | it 8:50 a.m., O-A stated the started and not yet completed   |                     |   |           |                          |
|                          | ULP-R                                     |  |                     |   |           |                          |
|                          |   | arch 3, 2023, to provide direct the licensee's clients.  |                     |   |           |                          |
|                          | ULP-R's record lack<br>background study c | ked documentation of a learance letter.  |                     |   |           |                          |
|                          | A search of NETStu<br>was not added to th | idy indicated the employee<br>le licensee's roster.  |                     |   |           |                          |
|                          | •   | nt 8:50 a.m., O-A stated ULP-R o start yet so they have not round study yet.                         |                     |   |           |                          |
|                          |   |  |                     |   |           |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | , ,  | E CONSTRUCTION      | COMPLETED   |                 |                          |
|--|---|--|---------------------|---|-----------------|--------------------------|
|  |   | H35833   | B. WING             |   | C<br>04/12/2023 |                          |
| NAME OF I  | PROVIDER OR SUPPLIER  | STREET AD  |                     | STATE, ZIP CODE   |                 |                          |
| COMFOR   | RTING ANGELS  |  | MN 56549            |   |                 |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (PROVIDENCY) | D BE            | (X5)<br>COMPLETE<br>DATE |
| 0 715  | Care services to the ULP-S' record lacked background study of the A search of NETStudy as not added to the On April 11, 2023, a investigator the folloclearance letter but supervision."  ULP-T  ULP-T was hired Dedirect care services  ULP-T's record lacked background study of the A search of NETStudy as not added to the On April 11, 2023, a attempted to get find was closed due to the had been experience do fingerprints in the since December to ULP-U | ay 13, 2022, to provide direct licensee's clients.  ed documentation of a learance letter.  dy indicated the employee le licensee's roster.  et 1:20 p.m., O-A emailed the owing: "I can't provide the she was done 5/2022 with no ecember 20, 2022, to provide to the licensee's clients.  ed documentation of a learance letter.  dy indicated the employee le licensee's roster.  et 8:50 a.m., O-A stated ULP-T gerprints last week but the site he blizzard. O-A stated they sing trouble locating a site to e area and they've been trying find a fingerprinting location. | 0 715               |   |                 |                          |
|  | ULP-U's record lack   | ked documentation of a learance letter.  |                     |   |                 |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |  | ` ′  | E CONSTRUCTION       | COMPLETED   |      |                          |
|--|--|--|----------------------|---|------|--------------------------|
|  |  | H35833   | B. WING              |   | 04/1 | )<br>2/2023              |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S       | STATE, ZIP CODE   |      |                          |
| COMFO  | RTING ANGELS   | 202 HIGH<br>HAWLEY   | WAY 10<br>, MN 56549 |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 715  | Continued From pa  | ge 20  | 0 715                |   |      |                          |
|  | A search of NETStu<br>was not added to th  | idy indicated the employee<br>le licensee's roster.  |                      |   |      |                          |
|  | investigator the following fingerprints 5/2022 called netstudy toda her status and was due to no consent for the following fingerprints for the following financial financial fingerprints for the following financial finan | at 1:20 p.m., O-A emailed the owing: "she completed her and under no supervision""I ay [April 11, 2023] regarding informed she was removed or out of state check was strative staff] will put her back |                      |   |      |                          |
|  | ULP-V  |  |                      |   |      |                          |
|  |  | ctober 6, 2022, to provide to the licensee's clients.  |                      |   |      |                          |
|  | A search of NETStu<br>was not added to th  | idy indicated the employee<br>le licensee's roster.  |                      |   |      |                          |
|  | investigator a copy  | at 1:20 p.m., O-A emailed the of the employee's background er dated October 31, 2022.  |                      |   |      |                          |
|  | ULP-W  |  |                      |   |      |                          |
|  |  | December 19, 2022, to provide to the licensee's clients, and March 24, 2023.   |                      |   |      |                          |
|  | ULP-W's record lack  | ked documentation of a learance letter.  |                      |   |      |                          |
|  | A search of NETStu<br>was not added to th  | idy indicated the employee<br>le licensee's roster.  |                      |   |      |                          |
|  | ULP-W was no long  | at 8:50 a.m., O-A stated ger with the licensee and they aground clearance letter for   |                      |   |      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | ` ´  | E CONSTRUCTION      | (X3) DATE SURVEY<br>COMPLETED  |                 |                          |
|---|---|--|---------------------|--|-----------------|--------------------------|
|   |   | H35833   |                     |  | C<br>04/12/2023 |                          |
|   | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  | U4/1            | 212023                   |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE           | (X5)<br>COMPLETE<br>DATE |
| 0 715   | if she was aware the employees were were clients without a background studies RN-C stated, background study of prior to providing caunder the direction RN-C stated, "We're certain degree as a their job. What you responsible for their am not responsible cant do everything."  No further information in the supervision of the supervision | at 2:20 p.m., RN-C was asked e above mentioned orking unsupervised with ekground study clearance. "I have nothing to do with that's human resources." she should be verifying the learance letter was completed are to clients since ULP work and supervision of the RN. e all individuals I can only do a nurse and everybody does made it sound like is I'm a background studies which I for any background study, I |                     |  |                 |                          |
| 0 785<br>SS=C   | three, widespread ( TIME PERIOD FOR  144A.479, Subd. 2  Home care provided fraudulent, or misled marketing of services section, advertising or electronic means potential clients about terms of home care  | CORRECTION: Immediate Advertising  s shall not use false, ading advertising in the es. For purposes of this includes any verbal, written, of communicating to out the availability, nature, or   | 0 785               |  |                 |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE<br>A. BUILDING: _   | ` '                 | (X3) DATE SURVEY<br>COMPLETED   |          |                          |
|---|--|---|---------------------|---|----------|--------------------------|
|   |  | H35833  | B. WING             |   |          | C<br><b>12/2023</b>      |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, ST     | ΓΑΤΕ, ZIP CODE  |          |                          |
| COMFO   | RTING ANGELS   | 202 HIGH\<br>HΔWLEY   | WAY 10<br>MN 56549  |   |          |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORR<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETE<br>DATE |
| 0 785   | licensee failed to enfor home care servicurrent comprehens provided.  This practice result violation that has not a minimal impact of health or safety), a widespread scope or represent a syste or has potential to a the clients).  Findings Include:  On April 4, 2023, and Comforting Angels website for the licenthy://www.comfortwebpage indicated current, operational would "bring quality clients' needs to the Area, and Beyond." following information "Comforting Angels services to the patient Locations: MN and Personal Care, Compreparation, And more than the licensee's Complicense expired on the license expired on the licensee's Complicense expired on the licensee's Complicense expired on the license expired on the licensee's Complicense expired on the license expired on the licensee's Complicense expired on the licensee's Complicensee's Complicense | and record review, the insure the provider's website ices accurately depicted the sive level services the agency ed in a level one violation (a potential to cause more than in the client and does not affect and was issued at a (when problems are pervasive emic failure that has affected affect a large portion or all of internet search for resulted in the following insee, tingangels.care/about. The Comforting Angels was a I home care provider that it Home Care that meets is Red River Valley, Lakes it The website included the en about their services; it Homecare provides these ent at home: Service ND. Skilled Nursing Care, inpanionship Cares, Meal any other services." | 0 785               |   |          |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING:  |                      | ` '  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|----------------------|--|-------------------------------|--------------------------|
|   |   |   |                      |  |                               | <b>)</b>                 |
|   |   | H35833  | B. WING              |  | 04/1                          | 2/2023                   |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S       | TATE, ZIP CODE   |                               |                          |
| COMFOR  | RTING ANGELS  | 202 HIGHV<br>HAWLEY,  | WAY 10<br>, MN 56549 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 0 785   | Continued From pa   | ge 23   | 0 785                |  |                               |                          |
|   | confirmed she was   | nsed home care provider. O-A not a Medicare certified refore not be able to provide e.  |                      |  |                               |                          |
|   | No further informati  | ion was provided.   |                      |  |                               |                          |
|   | TIME PERIOD FOR<br>(21) days  | R CORRECTION: Twenty-one  |                      |  |                               |                          |
|   | 144A.479, Subd. 5<br>Finances/Property  |   | 0 800                |  |                               |                          |
|   | household budgeting purchasing household otherwise manage a care provider must for all transactions a client's funds. When the transaction or prodocumented. A home maintain records of (b) A home care provider's or provider or staff from a client's funds or provider or staff from value, or precludes or bequests made that are exempt from incomplete of the Internal Reversity. | ne care provider must fall such transactions. ovider or staff may not borrow personal or real property, nor in client's property to the home staff's possession. Section precludes a home care in accepting gifts of minimal the acceptance of donations to a home care provider that come tax under section 501(c) |                      |  |                               |                          |
|   | licensee failed to er   | and record review the nsure protection from financial of four clients (C1, C2) when   |                      |  |                               |                          |

Minnesota Department of Health

STATE FORM JRM011 If continuation sheet 24 of 131

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | ` '  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|---|---------------------|--|-------------------------------|--------------------------|
|   |  | H35833  | B. WING             |  |                               | C<br><b>12/2023</b>      |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S      | TATE, ZIP CODE   |                               |                          |
| COMFO   | RTING ANGELS   | 202 HIGH\   | NAY 10<br>MN 56549  |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUTH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCED) | ULD BE                        | (X5)<br>COMPLETE<br>DATE |
| 0 800   | Cost of services ren ACH withdrawals from the property of the pr | o accurately account for the dered and made unauthorized om the clients' bank accounts.  ed in a level three violation (and a client's health or safety, as injury, impairment, or death, as the potential to lead to irment, or death), was issued to when one or a limited are affected or one or a laff are involved or the red only occasionally).  ACH TRANSACTIONS  The care services on May 19, and on March 28, 2023.  The service plan had a may 20, 2022, under O-A's ice plan indicated the client of care per day for "basic & ers," but did not specify what provided were. The service ost for unlicensed personnel of per hour during the week | 0 800               |  |                               |                          |

Minnesota Department of Health

| ` '                      |   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|--|---|-------------------------------|--------------------------|
|                          |   | H35833   | B. WING                                  |   | C<br>04/12/2023               |                          |
|                          | PROVIDER OR SUPPLIER  | 202 HIGH   | , ,                                      | TATE, ZIP CODE  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECT) | ULD BE                        | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | provided to the und have 48 hours to ache needed when there processed after 48 invoiced amount, where the client state of the client's care but \$25,000 per month withdrawals but did account for several it, she noticed a lot and so she asked Costatements from Jumonth which were a March 3, 2023. The accounting departments of the last name. Fillisted the hours ULF to 24 hours, which the Client's bank accounts did not line the client's bank accounts did not accounts did not line the client's bank accounts did not accounts did not line the client's bank accounts did not line the client's bank accounts did not accounts did not line the client's bank accounts did not line the client's bank accounts did not accounts did not line the client's bank accounts did not accounts did not line the client's bank accounts did not line the client's bank accounts did not accounts did not line the client's bank accounts did not line the client's bank accounts did not line the client's bank accounts did not accounts did not line the client's bank accoun | il invoice for its services ersigned client. Clients will ddress any disputes, no action is no disputes for ach will be hours of email, for the full hich may vary by invoice."  ndicated D&G Angels LLC 70 from the client's account actions from June 2022 | 0 800                                    |   |                               |                          |

Minnesota Department of Health

|                          | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BUILDING:        |  | COMPLETED |                          |
|--------------------------|--|---|---------------------|--|-----------|--------------------------|
|                          |  | H35833  | B. WING             |  | 04/1      | )<br>2/2023              |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  | •         |                          |
| COMFOR                   | RTING ANGELS   | 202 HIGH  |                     |  |           |                          |
|                          |  |   | MN 56549            |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE     | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa  | ge 26   | 0 800               |  |           |                          |
|                          | FM-D about C1's st   | atements.   |                     |  |           |                          |
|                          | on April 16, 2023, demailed to FM-D or up until March 3, 20 statements. A review   | d from O-A to the investigator id not match statements O-A March 3, 2023. FM-D stated 23, she had not received any w of the client's statements ons contained the following |                     |  |           |                          |
|                          | responsible party, F<br>balances due:<br>February 1 through<br>\$11,041.07 due by I<br>February 16 through<br>\$10,390.26 due by         | h February 28, 2023, reflected  |                     |  |           |                          |
|                          | investigator indicate<br>February 1 through<br>\$11,041.07 due by I<br>February 16 through<br>\$10,390.26 due by                         | h February 28, 2023, reflected  |                     |  |           |                          |
|                          | contained the follow \$13,870.00 was with by D&G Angels LLC \$11,041.07 was with by D&G Angels LLC \$286.27 was withdr D&G Angels LLC vi | hdrawn on February 1, 2023, via ACH hdrawn on February 14, 2023, via ACH awn on February 22, 2023, by a ACH hdrawn on February 22, 2023,                                    |                     |  |           |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|---|---|---|---------------------|--|-------|--------------------------|
|   |   | H35833  | B. WING             |  | 04/1  | )<br>2/2023              |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE  | -     |                          |
| 0014501   |   | 202 HIGH  | ,                   |  |       |                          |
| COMFO   | RTING ANGELS  | HAWLEY,   | MN 56549            |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| 0 800   | Continued From pa   | ge 27   | 0 800               |  |       |                          |
|   | In total, \$36,147.34 withdrawals by D&G  | was withdrawn over four ACH<br>Angels LLC   |                     |  |       |                          |
|   | responsible party, For balances due: January 1 through 3 \$11,581.56 due by 3 Billing statements p  | rovided by O-A to the   |                     |  |       |                          |
|   | January 1 through 3<br>\$11.299.52 due by 3<br>January 16 through<br>\$11.848.56 due by 3   | January 31, 2023, reflected   |                     |  |       |                          |
|   | contained the follow \$3,401.54 was with D&G Angels LLC vi \$11,611.56 was with D&G Angels LLC vi \$11,311.56 was with by D&G Angels LLC vi \$688.72 was withdr D&G Angels LLC vi | drawn on January 3, 2023, by a ACH adrawn on January 9, 2023, by a ACH adrawn on January 18, 2023, by a ACH awn on January 25, 2023, by a ACH was withdrawn over five ACH |                     |  |       |                          |
|   | indicated the follow December 1 throug reflected \$10,220.0 December 1 throug   | rovided by O-A to FM-D<br>ing balances due:<br>h December 14, 2022,<br>0 due by December 15, 2022<br>h December 15, 2022,<br>s of care, December 1,                       |                     |  |       |                          |

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|--|--|-------------------------------|--------------------------|
|                          |  | H35833  | B. WING                                  |  | 04/1                          | )<br>2/2023              |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S                           | STATE, ZIP CODE  |                               |                          |
| COMFOR                   | RTING ANGELS   | 202 HIGH\<br>HAWLEY,  | NAY 10<br>MN 56549                       |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa  | ge 28   | 0 800                                    |  |                               |                          |
|                          | for a total due of \$2<br>December 16 throu<br>reflected \$15,754.3  | ecember 15th at \$730 per day<br>,190.00<br>gh December 31, 2022,<br>8 due by December 31, 2022<br>rvices for December was  |  |  |                               |                          |
|                          | investigator indicated December 1 through reflected \$10,220.0 December 16 through reflected \$12,936.0  | rovided by O-A to the ed the following balances due: h December 15, 2022, 0 due by December 15, 2022 gh December 31, 2022, 2 due by December 31, 2022 rvices for December was                             |  |  |                               |                          |
|                          | contained the follow \$11,102.62 was with \$10,950.00 was with 2022, by D&G Angels LLC \$1,514.97 was with by D&G Angels LLC \$12,410.00 was with 2022, by D&G Angels LLC \$12,410.00 was with 2022, by D&G Angels LC \$12,410.00 was with 2022, by D& | hdrawn on December 1, 2022,<br>via ACH<br>hdrawn on December 12,<br>els LLC via ACH<br>drawn on December 19, 2022,<br>via ACH<br>hdrawn on December 22,<br>els LLC via ACH<br>was withdrawn over four ACH |  |  |                               |                          |
|                          | indicated the follow<br>November 1 throug<br>reflected \$29,914.2<br>November 12 throu<br>reflected \$22,052.6<br>The total cost of set<br>\$51,966.89   | h November 15, 2022,<br>7 due by November 15, 2022<br>gh November 30, 2022,<br>2 due by November 30, 2022<br>rvices for November was  |  |  |                               |                          |
|                          | Billing statements p   | rovided by O-A to the   |  |  |                               |                          |

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|---|--|--|--|-------------------------------|--------------------------|
|                          |   | H35833   | B. WING                                  |  | 04/1                          | 2/ <b>2023</b>           |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS. CITY. S                           | STATE, ZIP CODE  | -                             |                          |
|                          |   | 202 HIGH   | , ,                                      |  |                               |                          |
| COMFOR                   | RTING ANGELS  | HAWLEY,  | MN 56549                                 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 29  | 0 800                                    |  |                               |                          |
|                          | investigator indicated November 1 through reflected \$11,117.20 November 16 through reflected \$11,285.19   | ed the following balances due:<br>h November 15, 2022,<br>O due by November 15, 2022<br>gh November 30, 2022,<br>9 due by November 30, 2022<br>rvices for November was               |  |  |                               |                          |
|                          | contained the follow<br>\$746.88 was withdred<br>by D&G Angels LLC<br>\$10,950.00 was with<br>2022 by D&G Angel<br>\$13,964.27 was with<br>2022 by D&G Angel<br>\$10,950.00 was with<br>2022 by D&G Angel         | awn on November 14, 2022, C via ACH hdrawn on November 14, els LLC via ACH hdrawn on November 17, els LLC via ACH hdrawn on November 28, els LLC via ACH was withdrawn over four ACH |  |  |                               |                          |
|                          | indicated the follow<br>October 1 through 0<br>\$12,067.80 due by<br>October 16 through<br>services on Octobe<br>on October 17 for \$<br>October 28 for \$1,6<br>for \$4,428.69, and \$<br>\$4,489.50 for a total | October 15, 2022, reflected  |  |  |                               |                          |
|                          | investigator indicate October 1 through (\$11,159.30 due by (\$11,159.30)   | rovided by O-A to the ed the following balances due: October 15, 2022, reflected October 15, 2022, reflected   |  |  |                               |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | COMPLETED |                          |
|--------------------------|---|---|--|---|-----------|--------------------------|
|                          |   | H35833  | B. WING                                  |   | 04/1      | 2/2023                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S                           | STATE, ZIP CODE   | -         |                          |
| COMFOR                   | RTING ANGELS  | 202 HIGH<br>HAWLEY  | WAY 10<br>, MN 56549                     |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 30   | 0 800                                    |   |           |                          |
|                          | \$11,680.00 due by 6<br>The total cost of ser<br>\$22,839.30  | October 31, 2022.<br>rvices for October was   |  |   |           |                          |
|                          | contained the follow \$11,108.95 was with by D&G Angels LLC \$12,067.80 was with by D&G Angels LLC \$11,680.00 was with by D&G Angels LLC | hdrawn on October 7, 2022,<br>c via ACH<br>hdrawn on October 19, 2022,<br>c via ACH<br>hdrawn on October 31, 2022,<br>c via ACH<br>was withdrawn over three   |  |   |           |                          |
|                          | indicated the following September 1 through reflected \$9,683.64 September 16 through reflected \$11,108.95                               | rovided by O-A to FM-D<br>ing balances due:<br>gh September 15, 2022,<br>due by September 15, 2022.<br>ugh September 30, 2022,<br>5 due by September 30, 2022<br>rvices for September was                       |  |   |           |                          |
|                          | investigator indicate September 1 through reflected \$9,718.84 September 16 through reflected \$10,949.3                                  | rovided by O-A to the ed the following balances due: the following balances due: the september 15, 2022, due by September 15, 2022 and September 30, 2022, 6 due by September 30, 2022 rvices for September was |  |   |           |                          |
|                          | contained the follow<br>\$9,066.58 was with<br>by D&G Angels LLC  | drawn on September 2, 2022,<br>via ACH<br>drawn on September 19,  |  |   |           |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | l ` ´               | E CONSTRUCTION   | COMP     | LETED                    |
|--------------------------|--|--|---------------------|--|----------|--------------------------|
|                          |  | H35833   | B. WING             |  | 04/1     | )<br>2/2023              |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | DRESS CITY S        | STATE, ZIP CODE  | 1 0 17 1 |                          |
|                          | RTING ANGELS   | 202 HIGH   | , ,                 |  |          |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE    | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | August 2022 Billing statements prindicated the following August 1 through August 30 through August 30 through August 30 through August 30 through August 1 through July \$7,590.34 was with D&G Angels LLC viril In total, \$16,603.84 withdrawals by D&G July 2022 Billing statements prindicated the following July 1 through July \$15,906.25 due by August 1 through July \$15,906.25 due by August 30 through \$15,906.25 due by August 3 | was withdrawn over two ACH angels LLC  rovided by O-A to FM-D ang balances due: ugust 31, 2022, reflected September 1, 2022. August 31, 2022, reflected otember 1, 2022 rovices for August was  rovided by O-A to the ed the following balances due: ugust 31, 2022 reflected August 31, 2022  om C1's investment account ring transactions: drawn on August 3, 2022 by a ACH drawn on August 19, 2023 by a ACH was withdrawn over two ACH angels LLC  rovided by O-A to FM-D ang balances due: 31, 2022, reflected August 10, 2022  rovided by O-A to the ed the following balances due: 31, 2022, reflected and angels LCC  rovided by O-A to the ed the following balances due: 31, 2022, reflected | 0 800               | BEHOLINOT  |          |                          |
|                          | Bank statements fro  | om C1's investment account ving transactions:  |                     |  |          |                          |

| STATEMEN                 | ota Department of Health of Department of Health of Deficiencies   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE       | CONSTRUCTION  | (X3) DATE |                          |
|--------------------------|--|--|---------------------|---|-----------|--------------------------|
| AND PLAN                 | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING: _      |   | COMF      | PLETED                   |
|                          |  | H35833   | B. WING             |   |           | 2/ <b>2023</b>           |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET A   | DDRESS, CITY, S     | TATE, ZIP CODE  |           |                          |
| 0011501                  |  | 202 HIG  | HWAY 10             |   |           |                          |
| COMFOR                   | RTING ANGELS   | HAWLE  | Y, MN 56549         |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETI<br>DATE |
| 0 800                    | Continued From pa  | age 32   | 0 800               |   |           |                          |
|                          | D&G Angels LLC v \$9,115.28 was with D&G Angels LLC v \$6,895.75 was with D&G Angels LLC v In total, \$18,400.63 ACH withdrawals b June 2022 Billing statements p indicated the follow June 1 through June \$9,026.20 due by J June 16 through Ju \$8,955.36 due by J  | idrawn on July 7, 2022, by ia ACH adrawn on July 19, 2022, by ia ACH was withdrawn over three by D&G Angels LLC crovided by O-A to FM-D ving balances due: ne 15, 2022, reflected lune 25, 2022 ane 30, 2022 reflected |                     |   |           |                          |
|                          | investigator indicated June 1 through June \$9,026.20 due by June 16 through June \$8,968.92 due by June 19 through June 19 thro | ine 30, 2022, reflected  |                     |   |           |                          |

Minnesota Department of Health

May 2022

\$17,995.12

Bank statements from C1's investment account

\$2,389.60 was withdrawn on June 9, 2022, by

\$9,026.20 was withdrawn on June 17, 2022, by

In total, \$11,415.80 was withdrawn over two ACH

Billing statements for May were not sent to FM-D.

contained the following transactions:

D&G Angels LLC via ACH

D&G Angels LLC via ACH

withdrawals by D&G Angels LLC

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ,                  | E CONSTRUCTION  | (X3) DATE | SURVEY<br>LETED  |
|--------------------------|--|--|--------------------|---|-----------|------------------|
|                          |  |  |                    |   |           | <b>;</b>         |
|                          |  | H35833   | B. WING            |   |           | 2/2023           |
| NAME OF PR               | OVIDER OR SUPPLIER   | STREET ADD   | DRESS, CITY, S     | STATE, ZIP CODE   |           |                  |
| COMFORT                  | ING ANGELS   | 202 HIGH\<br>HΔWLEY  | NAY 10<br>MN 56549 |   |           |                  |
| (Y4) ID                  | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID                 | PROVIDER'S PLAN OF CORRECTI   | ON        | (X5)             |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG      | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE     | COMPLETE<br>DATE |
| 0 800                    | Continued From pa  | ge 33  | 0 800              |   |           |                  |
| i                        | nvestigator indicate   | rovided by O-A to the ed the following balances due: y 31, 2022 reflected \$2,408.39   |                    |   |           |                  |
| 1                        |  | ad not yet been set up with the<br>drawals were made in May  |                    |   |           |                  |
|                          | previously billed moduling on the 1st and currently now billing O-A stated she did account was showing Angels LLC that felloycles and were for statements reflected some with her billing any disputes from the amounts being the am | at 11:15 a.m., O-A stated she onthly then recently went to d 15th of the month, and is weekly for services provided. Not know why C1's investmenting withdrawals from D&G outside of her stated billing amounts more than what d. O-A stated she had some ng software and she never got he client or his family about taken out so was not aware beyond the cost of services t. O-A confirmed she had not ning transactions in her bank of noticed the additional k account. |                    |   |           |                  |
| t<br>t<br>t              | would have to see one one one what the date of explain why there we statements and date of the control of the c | at 12:20 p.m., O-A stated she C1's bank account statements es were to be able to better ere multiple ACH transactions tes that did not line up with d to FM-D or the investigator. It is able to explain every as able to see the bank   |                    |   |           |                  |
| E                        | JNAUTHORIZED F  Bank statements for a cluded the following the statements of the following the statements of the following the statements of the statements  | r the client's debit card  |                    |   |           |                  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--|--|---------------------|--|-------------------|--------------------------|
|  |  |                     |  |                   |                          |
|  | H35833   | B. WING             |  | 04/1              | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIE  | R STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| COMFORTING ANGELS  | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |                   |                          |
| PREFIX (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 0 800 Continued From   | age 34   | 0 800               |  |                   |                          |
| Lobster January 11, 2023 was charged to B coach January 12, 2023 was charged to B coach January 14, 2023 games, a game of like Fortnite January 15, 2023 WalMart January 16, 2023 WalMart January 20, 2023 a web based flast January 22, 2023 McDonald's January 24, 2023 was charged to A | \$50.38 was charged to two charges totaling \$21.73  |                     |  |                   |                          |
| she had provided use if they took Cobe able to buy for stated she notice card and reported stated she deactive since it was apparance it was apparanceled, O-A would the client on involved details and some   | 23, at 2:15 p.m., FM-D stated O-A with a debit card for staff to 1 anywhere so the client would d, snacks, or other items. FM-D suspicious charges on the those concerns to O-A. FM-D vated the client's debit card rent not all the charges were M-D stated after the card was uld put any expenses related to ces but the invoices lacked imes receipts and she still had ome of the expenses. |                     |  |                   |                          |
| •  | at 8:20 a.m., administrative ated AA-I stated O-A was "well  |                     |  |                   |                          |

Minnesota Department of Health

|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | (X3) DATE | SURVEY<br>LETED          |
|--------------------------|--|--|---------------------|---|-----------|--------------------------|
|                          |  | H35833   | B. WING             |   | 04/1      | )<br>2/2023              |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |           |                          |
| COMFOR                   | RTING ANGELS   | 202 HIGH   | WAY 10              |   |           |                          |
| OOWII OI                 | TING ANGLES  | HAWLEY,  | MN 56549            |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)                    | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa  | ge 35  | 0 800               |   |           |                          |
|                          | notified by herself a  | going on" and had been and other staff about his g taken by caregivers and t card for things for |                     |   |           |                          |
|                          | was aware other UL personal credit card at places like restaud places, and Apple. It she bought grocerishe was out of certain worked, the items was onthings for the client see evidence of any ULP-B stated there came in to the client then came back at fout and the client was out and the client was out and the client was onthings for the potentially fractionally fracti |  |                     |   |           |                          |
|                          | •  | 1:15 p.m., O-A stated she did ncerns involving staff using ersonal use.                          |                     |   |           |                          |
|                          | UNAUTHORIZED A   | ACH TRANSACTIONS   |                     |   |           |                          |
|                          | 12, 2020, and disch  | ne care services on November narged on March 3, 2023.  |                     |   |           |                          |
|                          | C2's record did not  | contain a service plan.  |                     |   |           |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ´               | E CONSTRUCTION   | (X3) DATE<br>COMP | IPLETED                  |  |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|--|
|                          |  | H35833  | B. WING             |  | 04/1              | )<br>2/2023              |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |  |
| COMFOR                   | RTING ANGELS   | 202 HIGH<br>HAWLEY,   | WAY 10<br>MN 56549  |  |                   |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)                                       | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE             | (X5)<br>COMPLETE<br>DATE |  |
| 0 800                    | Continued From pa  | ge 36   | 0 800               |  |                   |                          |  |
|                          | automatic withdraw by C2 on November authorized D&G Angwhere such withdray scheduled payment applicable taxes or at the time of such authorization signed 2021, and O-A on FD&G Angels to "chacard on the date Cocreates its invoice for undersigned client." by C2 and O-A on CD&G Angels "to chacard. Comforting Arinvoice for its service undersigned client. address any dispute there is no dispute there is no dispute the service of the service o | Client will have 48 hours to es, no action needed when for ach will be processed after or the full invoiced amount, |                     |  |                   |                          |  |
|                          | transactions to colle  |   |                     |  |                   |                          |  |
|                          | D&G Angles LLC ov  | 6 was withdrawn via ACH by ver a 16 month period from ough February 2023.   |                     |  |                   |                          |  |
|                          | November 2021<br>Billing statements for<br>sent to FM-H.   | or November 2021 were not   |                     |  |                   |                          |  |
|                          |  | rovided by O-A to the ed \$8,169.81 was due for care  |                     |  |                   |                          |  |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` ′               | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|---|--|---------------------|---|-------------------|--------------------------|
|                          |   |  |                     |   |                   |                          |
|                          |   | H35833   | B. WING             |   | 04/1              | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |                   |                          |
| COMFO                    | RTING ANGELS  | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |   |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 37  | 0 800               |   |                   |                          |
|                          |   | November 1 through  The statement indicated a 81 was made.   |                     |   |                   |                          |
|                          | transactions: \$13,000 was withdr D&G Angels LLC vi \$3,090.96 was withdray D&G Angels LLC \$3,000 was withdray D&G Angels LLC vi \$5,277.81 was withd by D&G Angels LLC \$5,230.86 was withd by D&G Angels LLC In total, \$29,599.63 withdrawals by D&G December 2021    | drawn on November 12, 2021 via ACH wn on November 16, 2021 by a ACH drawn on November 19, 2021 via ACH drawn on November 26, 2021 via ACH was withdrawn over five ACH  |                     |   |                   |                          |
|                          | investigator include credit memo. December 1 throug indicated \$3,965.06 was paid. December 6 throug indicated \$5,373.54 was paid. December 20 throu indicated \$7,300.03 was paid. A statement including 25, 27, 28, 29,30, and was due and the back a statement from D | provided by O-A to the d six statements and one h December 5, 2021, was due and the balance h December 12, 2021, was due and the balance gh December 26, 2021, was due and the balance and services on December 14, and 31 indicated \$4,439.08 alance was paid. ecember 31, 2021 for added after 04, 12, 2023 |                     |   |                   |                          |

Minnesota Department of Health

|               | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′           | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED  |
|---------------|--|--|---------------|--|-------------------|------------------|
|               |  | H35833   | B. WING       |  | 04/1              | )<br>2/2023      |
| NAME OF       | PROVIDER OR SUPPLIER   | STREET AD  | DRESS CITY S  | STATE, ZIP CODE  | -                 |                  |
|               |  | 202 HIGH   | ,             | , , , , , , , , , , , , , , , , , , ,  |                   |                  |
| COMFO         | RTING ANGELS   |  | MN 56549      |  |                   |                  |
| (X4) ID       | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID            | PROVIDER'S PLAN OF CORRECT   | ON                | (X5)             |
| PRÉFIX<br>TAG | ,  | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                   | COMPLETE<br>DATE |
| 0 800         | Continued From pa  | ge 38  | 0 800         |  |                   |                  |
|               | A statement for sup<br>December 31, 2021<br>invoice credited 04.<br>charged duplicate"<br>\$69.16 was due and<br>A credit memo indic<br>issued on April 12, 2<br>The total of the stat<br>\$21,158.44<br>Bank statements for | client owed \$80.73. plies and expenses dated I, included a line item of, "This 12.2023 due to above The statement indicated d the balance was paid. cated a credit of \$69.16 was 2023, for an "overcharge." ements added up to |               |  |                   |                  |
|               | by D&G Angels LLC \$3,965.05 was with by D&G Angels LLC \$5,373.54 was with by D&G Angels LLC \$5,100.47 was with by D&G Angels LLC \$7,300.03 was with by D&G Angels LLC In total, \$30,088.27 withdrawals by D&G           | drawn on December 10, 2021 C via ACH drawn on December 20, 2021 C via ACH drawn on December 22, 2021 C via ACH drawn on December 30, 2021 C via ACH was withdrawn over five ACH  |               |  |                   |                  |
|               | the following balance January 10-16, 202 and \$112.87 for me receipts were not in of \$5,815.62 for a w A second statement sent to FM-H which and \$258.68 in grow with no receipts atta of \$13,013.85. The amount due on   | 2 included \$5,702.75 for care als and supplies, however cluded, resulting in a total due  |               |  |                   |                  |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | <b>`</b>            | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
|                          |   | H35833   | B. WING             |  | 04/1              | 2/ <b>2023</b>           |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE   |                   |                          |
| COMEO                    | RTING ANGELS  | 202 HIGH   | WAY 10              |  |                   |                          |
| COMPOR                   | TING ANGELS   | HAWLEY,  | MN 56549            |  |                   | _                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 39  | 0 800               |  |                   |                          |
| 0 800                    | \$330,982.86 for a to<br>due by January 31,<br>from January 1-9 we<br>explanation was off<br>was overlapping bill<br>Billing statements per<br>investigator include<br>the month.<br>The first set of docu-<br>January 10 through<br>indicated \$5,815.62<br>was paid.<br>The second statem<br>and one credit ment<br>A statement including<br>January 17 through<br>\$12,253.78 was due<br>A statement for January 17 through<br>\$12,253.78 was due<br>A statement for January 16, 2022, indicated \$5,<br>\$5,714.29 paid and<br>A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and<br>A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and<br>A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and<br>A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and<br>A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and<br>A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and A statement for service January 16, 2022, indicated \$5,<br>\$1,714.29 paid and A statement for service January 16, 2022, indicated \$5, | otal of \$341,288.19 that was 2022. Statements for care ere not sent to FM-H and notered by O-A as to why there ling dates.  Frovided by O-A to the did two separate documents for aments included services from January 16, 2022, and was due and the balance ent included three statements no.  Ing services on January 9, and January 31, 2022, indicated e and the balance was paid.  Frovided by O-A to the did two separate documents for aments included services and the balance was paid.  Frovided by O-A to the did two separate documents for aments included services on January 9, and January 31, 2022, indicated e and the balance was paid.  Frovided by O-A to the did two separate documents for aments included services on January 9, and January 3 through January 9, and January 3 through January 1 through indicated \$5,702.75 was due | 0 800               |  |                   |                          |
|                          | \$23,783.69   | ements added up to   |                     |  |                   |                          |
|                          | transactions:<br>\$4,439.08 was with<br>D&G Angels LLC vi<br>charged on January<br>overdrafted.<br>\$6,505.61 was attendanced.<br>January 12, 2022 b  | r C2 contained the following drawn on January 7, 2022 by a ACH. A \$35 fee was 10, 2022, after the account on D&G Angels LLC via ACH, sharged when the account   |                     |  |                   |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | COMP  | LETED                    |
|--------------------------|---|--|---------------------|--|-------|--------------------------|
|                          |   | 1125022  | B WING              |  | 04/4  |                          |
|                          |   | H35833   | D. WIINO            |  | 04/1  | 2/2023                   |
| NAME OF I                | PROVIDER OR SUPPLIER  |  | ,                   | STATE, ZIP CODE  |       |                          |
| COMFOR                   | RTING ANGELS  | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 40  | 0 800               |  |       |                          |
|                          | January 19, 2022 D<br>a \$35 fee was charg<br>overdrafted.  | mpted to be withdrawn on &G Angels LLC via ACH, but ged when the account was withdrawn by D&G Angels mpts.   |                     |  |       |                          |
|                          | statement for service with \$284.96 due by statement for care for February 28, 2022 in charges, \$435 for stotal of \$23,550.44. indicated \$2,300 was outstanding balance. | ent by O-A to FM-H included a ces on February, 28, 2022, March 1, 2022. A second from February 1, 2022 through ncluded \$188.72 in mileage upplies, and \$23,115.44 for a Page 7 of the statement as due, combined with an e of \$338,998.19 for a total of February 28, 2022. |                     |  |       |                          |
|                          | investigator included<br>credit memo.<br>A February 1 through<br>statement indicated  | rovided by O-A to the d two statements and one the statements and one statements and one statements and section and statement standing. The total cost of the section as \$23,823.24.  |                     |  |       |                          |
|                          |   | 2, statement indicated or services on February 28,   |                     |  |       |                          |
|                          |   | 022, credit memo indicated,<br>ision to credit invoice<br>96   |                     |  |       |                          |
|                          | transactions:   | r C2 contained the following awn on February 24, 2022 by a ACH   |                     |  |       |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | E CONSTRUCTION  | COMP   | LETED                    |
|--------------------------|--|--|--------------------|---|--------|--------------------------|
|                          |  | H35833   | B. WING            |   | 04/1   | )<br>2/2023              |
|                          |  |  |                    |   | 1 04/1 | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |  | , ,                | STATE, ZIP CODE   |        |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH\  | WAY 10<br>MN 56549 |   |        |                          |
| (V 4) ID                 | SI IMMARY STA  | TEMENT OF DEFICIENCIES   | ID ID              | PROVIDER'S PLAN OF CORRECTI   | ON     | (V5)                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG      | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE  | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa  | ge <b>4</b> 1  | 0 800              |   |        |                          |
|                          | statement for March<br>The statement inclu-<br>charges, \$430 in su-<br>provided, \$346.58 in<br>provided, \$1,233.08<br>no receipts provided<br>bugs" with no receipt<br>with no receipt provided<br>care for a total bala<br>the statement indicated | ent by O-A to FM-H included an 1 through March 31, 2022. Ided \$693.72 in mileage applies with no receipts in groceries with no receipts in unspecified expenses with d, \$341.07 for "motel-bed of provided, \$322 for a bed wided and \$27,216.57 due for nce of \$30,583.02. Page 10 of ated \$28,999.14 was due, utstanding balance of otal of \$341,288.19 due by |                    |   |        |                          |
|                          | investigator indicate March 1 through March 1 through March 1 through March 1 \$4,629.80 was still cost of the month's \$31,107.74. The state  | arch 31, 2022 indicated a 7.94 had been made and outstanding, resulting in the care and services of atement included more detail ome receipts. Expenses  |                    |   |        |                          |
|                          | transactions: \$24,947.42 was wit D&G Angels LLC vi charged March 4, 2 enough funds in the \$21,405.82 was left \$21,000 was withdr D&G Angels LLC vi balance of \$405.82 \$259.14 was withdr D&G Angels LLC vi  | awn on March 8, 2022, by a ACH, leaving the account . awn on March 8, 2022 by  |                    |   |        |                          |

Minnesota Department of Health

| H35833 B. WING 04/12/2  | 2023                     |
|---|--------------------------|
| <u> </u>  |                          |
| NAME OF PROVIDER OR SUPPLIER  COMFORTING ANGELS  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10  HAWLEY, MN 56549  |                          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  | (X5)<br>COMPLETE<br>DATE |
| D&G Angels LLC via ACH. In total, D&G Angels LLC attempted to withdraw \$47,706.56 and successfully withdrew \$22,759.14  April 2022  Billing statements sent by O-A to FM-H included a statement for April 30, 2022 with \$33.55 due for one hour of care and mileage. An additional statement sent for April 1 through April 30, 2022, included \$179.15 for groceries, \$998.11 in unspecified expenses with no receipts provided, \$17.50 for wipes, \$431.36 in mileage, and \$28,125.99 due for care for a total balance of \$29,752.11. Page 9 of the statement indicated \$29,752.11 was due, combined with an outstanding balance of \$311,356.08, for a total of \$341,288.19 due by April 30, 2022.  Billing statements provided by O-A to the investigator indicated the following: April 1 through April 30, 2022, indicated a total due of \$30,033.18. The statement included some receipts, including a \$657.34 expense for "remove debris for [C2] @ [address] HAZARD PAY/BED BUGS."  Bank statements for C2 contained the following transactions: \$1,000 was withdrawn on April 11, 2022 by D&G Angels LLC via ACH In total, \$2,000 was withdrawn by D&G Angels LLC via ACH In 1014, \$2,000 was withdrawn by D&G Angels LLC via ACH In 1014, \$2,000 was withdrawn by D&G Angels LLC via ACH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In total, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 was withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdrawn by D&G Angels LLC via CH In 1014, \$2,000 mas withdr |                          |

Minnesota Department of Health

|                          | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | COMPLETED |                          |
|--------------------------|--|---|---------------------|--|-----------|--------------------------|
|                          |  | H35833  | B. WING             |  | 04/1      | ;<br>2/2023              |
|                          |  |   | <u>l</u>            |  | 04/1      | ZIZUZJ                   |
| NAME OF                  | PROVIDER OR SUPPLIER   |   | , ,                 | STATE, ZIP CODE  |           |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH'<br>HAWLEY,  | WAY 10<br>MN 56549  |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE     | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa  | ge <b>4</b> 3   | 0 800               |  |           |                          |
|                          | \$269.64 in mileage, products and \$29,1 balance of \$30,232 indicated \$30,232.0 outstanding balance \$341,288.19 due by Billing statements prinvestigator indicated May 1 through May balance due of \$30.0 Bank statements for transactions:                          | rovided by O-A to the ed the following: 31, 2022, indicated a total, 268.60.  r C2 contained the following awn on May 16, 2022 by D&G |                     |  |           |                          |
|                          | statement for June included \$180 for more wheelchair rental, \$75 for wipes and go with no receipts processes with no remileage, and \$27,95 halance of \$29,755 houtstanding balance \$341,288.19 due by Billing statements processing the statements of transactions: | rovided by O-A to the ed the following:<br>e 30, 2022, indicated a total  |                     |  |           |                          |

Minnesota Department of Health

|                          | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ,                 | E CONSTRUCTION  | COMPLETED |                          |
|--------------------------|---|---|---------------------|---|-----------|--------------------------|
|                          |   |   |                     |   | c         | ;                        |
|                          |   | H35833  | B. WING             |   | 04/1      | 2/2023                   |
| NAME OF F                | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE   |           |                          |
| COMFOR                   | RTING ANGELS  | 202 HIGH\<br>HAWLEY,  | NAY 10<br>MN 56549  |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 44   | 0 800               |   |           |                          |
|                          | Angels LLC via ACH  | ┥.  |                     |   |           |                          |
|                          | statement for July 1 included \$300 for in monthly commode a gloves and wipes, \$ expenses with no revisit expenses, \$35 \$30,147.20 for care \$31,723.26. Page 9 \$31,723.26 was due outstanding balance \$341,288.19 due by Billing statements prinvestigator indicated July 1 through July balance due of \$30. | rovided by O-A to the ed the following:<br>31, 2022, indicated a total<br>,743.80. The statement                      |                     |   |           |                          |
|                          |   | that indicated, "error no air, commode rental and no 3 review"  |                     |   |           |                          |
|                          | transactions:<br>\$1,000 was withdray<br>Angels LLC via ACH<br>\$2,300 was deposit<br>2022, at a branch in<br>\$2,300 was withdray<br>Angels LLC via ACH  | ed to C2's account on July 20,<br>n Fargo, North Dakota<br>wn on July 26, 2022 by D&G<br>H<br>withdrawn by D&G Angels |                     |   |           |                          |
|                          | statement for Augus<br>and included \$180 to  | ent by O-A to FM-H included a st 1 through August 30, 2022 for monthly commode and 82.50 for gloves and wipes,        |                     |   |           |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | ` '  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|---------------------|--|-------------------------------|--------------------------|
|   |   | H35833  | B. WING             |  | 04/1                          | )<br>2/2023              |
| NAME OF F   | PROVIDER OR SUPPLIER  | STREET ADD  | DRESS, CITY, S      | STATE, ZIP CODE  |                               |                          |
| COMFOR  | RTING ANGELS  | 202 HIGH\<br>HAWLEY,  | NAY 10<br>MN 56549  |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE                          | (X5)<br>COMPLETE<br>DATE |
| 0 800   | groceries with no remileage, \$314.15 in receipts provided, a total balance of \$30 statement indicated combined with an orange statement of total balance due of included a line item charge for wheelch supplies 04.12.2023  Bank statements for transactions: \$1,200 was withdray Angels LLC via ACH September 2022  Billing statements so statement for September 30, 2022 and included commode and where and wipes, \$540 for \$88.93 for groceries \$107.84 in mileage, a total balance of \$25 statement indicated combined with an orange \$312,615.33, for a total balance of \$25 statement of \$2 | ce products, \$93.52 for receipts provided, \$279.48 in a unspecified expenses with no and \$28,949.83 for care, for a 1,348.48. Page 8 of the \$30,348.48 was due, utstanding balance of otal of \$341,288.19 due by a rovided by O-A to the red the following: ugust 31, 2022, indicated a f \$29,587.14. The statement that indicated, "error no air, commode rental and a review"  The C2 contained the following with August 19, 2022 by D&G and \$180 for monthly relichair rental, \$80 for gloves incontinence products, with no receipt provided, and \$27,676.09 for care, for 28,672.86. Page 7 of the \$28,672.86 was due, utstanding balance of otal of \$341,288.19 due by 2.  The covided by O-A to the statement of the continence of the substanding balance of otal of \$341,288.19 due by 2. | 0 800               |  |                               |                          |
|   | investigator indicate September 1 throug  | ed the following:<br>gh September 30, 2022,   |                     |  |                               |                          |

Minnesota Department of Health

STATE FORM JRM011 If continuation sheet 46 of 131

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>F CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|--|--|-------------------------------|--------------------------|
|                          |  | H35833  | B. WING                                  |  | 04/1                          | )<br>2/2023              |
| NAME OF PE               | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S                           | STATE, ZIP CODE  | •                             |                          |
|                          |  | 202 HIGH  | , ,                                      | 717 (1 L, L  |                               |                          |
| COMFORT                  | TING ANGELS  | HAWLEY,   | MN 56549                                 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From page  | ge 46   | 0 800                                    |  |                               |                          |
|                          | A second statement due. A credit memorattached to the state was credited back to double invoiced04 Sank statements for transactions: \$1,200 was withdray D&G Angels LLC visions.  | r C2 contained the following<br>wn on September 2, 2022 by<br>a ACH<br>wn on September 15, 2022 by  |  |  |                               |                          |
|                          | \$2,500 was withdra<br>D&G Angels LLC vi   | wn on September 19, 2022 by   |  |  |                               |                          |
|                          | statement for October 2022, and included and wheelchair rent products, \$155.15 for mileage, and \$25 for mileage, a | ent by O-A to FM-H included a per 1 through October 31, \$180 for monthly commode al, \$510 for incontinence or groceries with no receipts or gloves and wipes, \$134.80 28,329.78 for care, for a total 23. Page 8 of the statement as was due, combined with an e of \$311,865.96, for a total of October 31, 2022. |  |  |                               |                          |
| i                        | nvestigator indicate   | October 31, 2022, indicated a   |  |  |                               |                          |
| t                        | ransactions:   | r C2 contained the following wn on October 18, 2022 by a ACH.   |  |  |                               |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` '                 | E CONSTRUCTION   | COMP | LETED                    |
|--------------------------|---|--|---------------------|--|------|--------------------------|
|                          |   | H35833   | B. WING             |  | 04/1 | )<br>2/2023              |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |      |                          |
| COMFOR                   | RTING ANGELS  | 202 HIGH\<br>HAWLEY,   | NAY 10<br>MN 56549  |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 800                    | Continued From pa   | ge 47  | 0 800               |  |      |                          |
|                          | November 2022 Billing statements s statement for Nove 2022 and included 3 and wheelchair rent products, \$107.50 f for groceries with no in mileage, and \$29 balance of \$30,644 indicated \$30,644 outstanding balance \$341,288.19 due by additional billing statements  Billing statements p investigator indicated November 1 throug indicated a total bal Bank statements  Bank statements for transactions: \$1,200.00 was wither by D&G Angels LLC On November 15, 2 made at a Wells Fast,800 was withdray D&G Angels LLC views and the statements of the statements for transactions: \$1,800 was withdray D&G Angels LLC views and the statements for transactions: | ent by O-A to FM-H included a mber 1 through November 31, \$180 for monthly commode al, \$300 for incontinence or gloves and wipes, \$188.06 or receipts provided, \$134.80 or 733.73 for care, for a total .09. Page 8 of the statement of 9 was due, combined with an erof \$310,644.10, for a total of 7 November 30, 2022. An other included \$188.14 for eccipts provided. The total of 1 was \$30,832.23 or ovided by O-A to the end the following:  In November 30, 2022, ance due of \$30,551.39  In C2 contained the following drawn on November 7, 2022 or via ACH 2022, a deposit of \$1,800 was argo in Bullhead City, Arizona. We on November 15, 2022 by a series of \$1,800 was argo in Bullhead City, Arizona. |                     |  |      |                          |
|                          | statement for Dece<br>2022 and included S<br>Page 7 of the stater<br>was due, combined  | ent by O-A to FM-H included a mber 1 through December 31, \$28,383.12 for care provided. ment indicated \$28,383.12 with an outstanding balance a total of \$341,288.19 due by   |                     |  |      |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | A. BUILDING:  |                     | COMPLETED  |       |                          |
|--|---|---|---------------------|--|-------|--------------------------|
|  |   | H35833  | B. WING             |  | 04/1  | 2/2023                   |
|  | PROVIDER OR SUPPLIER  | 202 HIGH  | , ,                 | STATE, ZIP CODE  |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |
| 0 800  | investigator indicated December 1 through indicated a total ball statement included "error no charge for and no supplies 04.  January 2023 Billing statements for statement was for \$\$\$180 for monthly corrental, \$59 for glove incontinence produce with no receipts proceed services for 15, 2023 and totale third statement reflected services for 15, 2023 and totale third statement reflected \$13,943.1 for care indicated \$13,943.1 outstanding balance \$341,288.19 due by of the three statements produced by the statements of the three statements for the three statements for the three statements for the statement statement statement statements for the statement statement statement statements for the statement statemen | provided by O-A to the ed the following: h December 31, 2022, ance due of \$26,699.02. The a line item that indicated, wheelchair, commode rental 12.2023 review"  ent by O-A to FM-H included r January 2023. One 6924.21 for supplies, including ommode and wheelchair es and wipes, \$450 for cets, and \$235.21 for groceries, vided. A second statement or January 1 through January d \$14,086.01 for care. The ected services for January 16, 2023, which totaled. Page 4 of the statement 1 was due, combined with an expectation of \$327,345.08, for a total of a January 31, 2023. The total ents was \$28,953.33.  Provided by O-A to the ed the following: January 15, 2023, indicated a f \$14,137.18 January 31, 2023, indicated a f \$14,005.35, resulting in a for the month.  The C2 contained the following with on January 3, 2023 by |                     |  |       |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |   | ` ´   | CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---|--|-------------------------------|--------------------------|
|   |   |   |  | С                             | ,                        |
|   | H35833  | B. WING   |  | 04/1                          | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER COMFORTING ANGELS  | 202 HIGH  | DRESS, CITY, S <sup>-</sup><br>WAY 10<br>MN 56549 | TATE, ZIP CODE   |                               |                          |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                               | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 800 Continued From pa   | age 49  | 0 800   |  |                               |                          |
| two statements for statement was for \$180 for monthly crental, \$300 for incomplete gloves and wipes, no receipts provide for \$605.00 for supmonthly commode for incontinence provides. Page 2 of the was due, combined of \$340,683.19, for February 28, 2023 statements was \$1 |   |   |  |                               |                          |
| investigator indicate February 1 through a total balance due second statement groceries, wipes, g   | February 28, 2023, indicated of \$24,545.94 for care and a indicated \$696.88 was due for loves, incontenence products, d commode rental. The total |   |  |                               |                          |
| transactions:<br>\$1,200 was withdra<br>D&G Angels LLC v<br>\$1,200 was withdra<br>D&G Angels LLC v   | awn on February 6, 2023 by<br>ia ACH<br>awn on February 28, 2023 by   |   |  |                               |                          |
| statement dated M<br>for a "non-complia   | ovided the investigator with a arch 6, 2023, for \$12,684.00 nt notice 14 day termination." FM-H confirmed O-A had not                              |   |  |                               |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ` ′          | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                      |
|--|---|----------------|---|-------------------------------|----------------------|
|  |   | A. BOILDING.   |   |                               |                      |
|  | H35833  | B. WING        |   |                               | C<br>1 <b>2/2023</b> |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S | STATE, ZIP CODE   |                               |                      |
|  | 202 HIGH  |                | , —, —, —, —, —, —, —, —, —, —, —, —, —,                                  |                               |                      |
| COMFORTING ANGELS  |   | , MN 56549     |   |                               |                      |
| (X4) ID SUMMARY STA  | TEMENT OF DEFICIENCIES  | ID             | PROVIDER'S PLAN OF CORREC   | CTION                         | (X5)                 |
| PREFIX (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE                       | COMPLETE<br>DATE     |
| 0 800 Continued From pa  | ge 50   | 0 800          |   |                               |                      |
| sent the March 6, 2  | 023, statement to her.  |                |   |                               |                      |
| manager (PM)-F standard didn't leave her caregivers. PM-F stated he had isolated, being final struggling to make stated he was able member of C2's who care of the situation.  |   |                |   |                               |                      |
| (FM)-H stated she is previously been vershe obtained power ago. FM-H stated significantly manager to that's when she statements and every person to see what she tried talking to ahold of. FM-H stated for C2 and noticed taken from one ban was missing from a stated after she specific she was told C2 still requested a bill as she could not located C2. FM-H stated the about \$341,000, or | , at 9:50 a.m., family member ives out of state and had not by involved with C2's care until of attorney a few months he was notified by C2's hat bills had not been paid so rted looking at C2's bank entually came to visit C2 in was going on. FM-H stated O-A but she was difficult to get ed she obtained bank records about \$100,000 had been ak account and almost \$50,000 as avings account. FM-H oke with O-A about the billing, I owed about \$100,000 so she she had not been sent any and e any bills that were sent to be bills O-A sent her totaled about \$30,000 per month, ocking considering the poor |                |   |                               |                      |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | 1 ` '  |                     |   | ATE SURVEY<br>OMPLETED |                          |
|---|---|--|---------------------|---|------------------------|--------------------------|
|   |   | H35833   | B. WING             | _   |                        | C<br><b>12/2023</b>      |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE  |                        |                          |
| COMEO   | OTINIO ANIOELO  | 202 HIGH   | WAY 10              |   |                        |                          |
| COMFOR  | RTING ANGELS  | HAWLEY   | , MN <b>5654</b> 9  |   |                        |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORF<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE AI<br>DEFICIENCY) | HOULD BE               | (X5)<br>COMPLETE<br>DATE |
| 0 800   | \$100,000 she still of stated she finally go through February 2d first requested them informed her if she which was estimate "cut her a deal" for never came back would work. FM-H scash in C2's CD's (investments) to covor On March 28, 2023 she had served as almost a year. ULP-allowed to open C2 check her mailbox of the office and let the there and either O-apartment and pick not allowed to open what happened to it office staff. ULP-G stated there ran out of groceries even after telling O-ULP-G stated there ran out of groceries even after telling O-ULP-G stated she smoney the last few incontinence production of the paychecks were latter final paycheck of stated she has asked stated she has asked stated she has asked stated she stated stated she has asked stated she stated s | lien on C2's condo if the wed was not paid. FM-H of bills for January 2022 023 several weeks after she in FM-H stated O-A had paid the outstanding bill, and to be \$100,000, she would the remained of the year but with a proposal on how that stated O-A had suggested she certificate of deposit |                     |   |                        |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | ` '     | (X3) DATE SURVEY<br>COMPLETED |  |
|---|--|---------------------|---|---------|-------------------------------|--|
|   |  | A. BOILDING.        |   |         |                               |  |
|   | H35833   | B. WING             |   |         | C<br>1 <b>2/2023</b>          |  |
| NAME OF PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |         |                               |  |
|   | 202 HIGH   | , ,                 |   |         |                               |  |
| COMFORTING ANGELS   |  | MN 56549            |   |         |                               |  |
| (VA) ID SLIMMARV STA  | TEMENT OF DEFICIENCIES   |                     | PROVIDER'S PLAN OF CORREC   | NOIT    | (V5)                          |  |
| PREFIX (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APP<br>DEFICIENCY) | OULD BE | (X5)<br>COMPLETE<br>DATE      |  |
| 0 800 Continued From pa   | ige 52   | 0 800               |   |         |                               |  |
| worried since she's they had not gotten bounced. ULP-G st where caregivers d scheduled shifts an could but wasn't ab ULP-G stated O-A schedule but didn't.  On March 30, 2023 the investigator a sout C2's finances. In January 2023 and the end of the monall of C2's mail. FM with text messages which read, "Just to on January 16 and her bill and at this process that she summary that she sound statements and couple of them and which she never dispretty good filing sy almost all the state wrote she kept ask statements from O-over January and Fithen towards the end O-A had been asking security number but provide it to O-A. Fither towards the condition of the condition | heard from other former staff paid or their paychecks stated there were often times idn't show up for their id she'd stay whenever she let to stay more than 16 hours. was aware of the holes in the really do anything about it.  3, at 1:57 p.m., FM-H emailed ummary of her work figuring FM-H wrote she contacted O-A d told her she'd be coming up th and would need access to left provided the investigator is between her and O-A, one of the forewarn you, I will be back I'm going to talk to [C2] about point I probably will have no the in a nursing home her bill is the it's over \$100,000 which I hagainst her condo any and any the has" FM-H wrote in her sent O-A a text asking for C2's and O-A had told her she had a least would email them to FM-H, do FM-H stated "[C2] had a least were missing." FM-H ing for copies of the payches of the payche |                     |   |         |                               |  |
| .   | 2 and she had asked her to she could buy C2 food and   |                     |   |         |                               |  |
|   | cts as O-A was not providing   |                     |   |         |                               |  |

Minnesota Department of Health

|  | OF DEFICIENCIES CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ´            | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                  |
|--|--|--|----------------|--|-------------------------------|------------------|
|  |  |  | A. BUILDING:   |  |                               |                  |
|  |  | H35833   | B. WING        |  | 04/1                          | 2/2023           |
| NAME OF PRO  | VIDER OR SUPPLIER  | STREET ADI   | DRESS, CITY, S | STATE, ZIP CODE  |                               |                  |
|  |  | 202 HIGH   | , ,            | ,  |                               |                  |
| COMFORTI   | NG ANGELS  |  | MN 56549       |  |                               |                  |
| (X4) ID  | SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID             | PROVIDER'S PLAN OF CORRECT   | ION                           | (X5)             |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE                        | COMPLETE<br>DATE |
| 0 800 C  | ontinued From pa   | ge 53  | 0 800          |  |                               |                  |
| ui<br>oi<br>w<br>if<br>C   | nlicensed personn<br>nlicensed personn<br>ut of her own pock<br>anted her to conta<br>she wanted acces<br>2, she had to go th  |  |                |  |                               |                  |
| eventh gewind shows the state of the state o | verything for C2 sineir hands clean of etting 24 hour care ould always be a content of the has been working the has not been participated she had sent witched to billing of the harmonth. O-A stated something of the harmonth of the harmont | 1:25 p.m., O-A stated they did nce her family had "wiped her." O-A stated C2 was from the agency and there caregiver there. O-A stated ng with an attorney because aid by C2 for over a year. O-A FM-H monthly invoices and nonthly until recently when she in the 1st and 15th of each she knew C2 would get money retirement account of about each month that is what she'd from C2's accounts when C2 her bill in full "just so I'd be A stated C2's care usually ran I7 000 per month. O-A was |                |  |                               |                  |
| as as state as   | sked about the trace counts that totale ated she didn't not een pulled from Cate 5 withdrawals wated for ACH with ne done monthly unonth, then there selected on the bar ould take and ope ould "scream if we not had no interest ated they scanned emputer. O-A confirmation.   | 17,000 per month. O-A was insactions shown on C2's bank of close to \$30,000 and O-A tice those large amounts had 2's account or that upwards of were made in a month. O-A drawals, there would only be intil she began billing twice a hould be two ACH withdrawals in K statement. O-A stated she in C2's mail because she e opened anything for her," in seeing her own mail. O-A all of C2's mail in to their firmed she sent the text thing C2 in a nursing home to                           |                |  |                               |                  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                     | (X3) DATE SURVEY<br>COMPLETED  |                 |                          |
|--|--|--|---------------------|--|-----------------|--------------------------|
|  |  | H35833   | B. WING             |  | C<br>04/12/2023 |                          |
|  | PROVIDER OR SUPPLIER   | 202 HIGH   | ,                   | STATE, ZIP CODE  | •               |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE           | (X5)<br>COMPLETE<br>DATE |
| 0 800  | billing system had so behind on her billing was upgraded. O-A checks they got out confirmed she had O-A stated C2 had client authorized he withdrawls to catch she told FM-H she'd a lawyer because so she did not recall the 2021 and 2022 and statements to know On April 20, 2023, a had not been notified issued and after chedid not see any cree FM-H confirmed she any of the invoices investigator.  The facility provided | at 11:55 a.m., O-A stated her ome issues and she got of for a while when the system confirmed she would deposit of the client's mail and deposited a check in Arizona. It is past due balance and the rest to make additional ACH up on the balance owed. O-A deposited to turn the case over to the was past due. O-A stated to larger withdrawals made in would have to see bank what they were for.  In 1:45 p.m., FM-H stated she deposited by O-A of any credit memos the ecking C2's bank accounts, dits made back to her account. The had not seen or been sent O-A had provided to the deposite of the | 0 800               |  |                 |                          |
| 0 805<br>SS=F  | (a) All home care properties of the minors in chapter 2 the reporting of malin section 626.557.  | a) Reporting Maltrx of linors  roviders must comply with e reporting of maltreatment of 60E and the requirements for treatment of vulnerable adults Each home care provider implement a written  | 0 805               |  |                 |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  |   |                     |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|--------------------------|--|---|---------------------|--|-------------------------------|--------------------------|
|                          |  | H35833  | B. WING             |  | 04/1                          | 2/ <b>2023</b>           |
|                          | PROVIDER OR SUPPLIER   | 202 HIGH  | , ,                 | TATE, ZIP CODE   |                               |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE                        | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | This MN Requirement by: Based on interview licensee failed to im Minnesota Adult Ab (MAARC) suspecte exploitation for four C4) with records result violation that did no safety but had the problems are pervariallure that has affer a large portion or all The findings include C1 The licensee failed investigate allegation after unlicensed perconcerns with ULP their own use, using use, and concerns services.  C1 admitted to hom 2022 and discharge C1's service plan who wer of attorney a signed by owner (O | e that all cases of suspected eported.  ent is not met as evidenced and record review, the mediately report to the use Reporting Center d maltreatment of financial of four clients (C1, C2, C3, viewed.  ed in a level two violation (at harm a client's health or otential to have harmed a fety, but was not likely to y, impairment, or death), and espread scope (when sive or represent a systemic cted or has potential to affect I of the clients). | 0 805               |  |                               |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ´                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|--|--|---------------------|--|-------------------|--------------------------|
|                          |  | H35833   | B. WING             |  | 04/1              | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | received 4.5 hours medication reminded the basic services process of the basic services provided to the basic services provi | ice plan indicated the client of care per day for "basic & ers," but did not specify what provided were.  ed a Recurring Payments was signed by family member 5, 2022 and owner (O)-A on e authorization allowed D&G doing business as] Comforting to charge the client's bank and. The agreement indicated would "email invoice for its to the undersigned client. hours to address any needed when there is no I be processed after 48 hours invoiced amount, which may actions from June 2022 |                     |  |                   |                          |
|                          | to \$626.59.  On March 24, 2023 she had not receive  | , at 2:15 p.m., FM-D stated<br>ed any billing statements for   |                     |  |                   |                          |
|                          | \$25,000 per month withdrawals but did account for several it, she noticed a lot and so she asked Castatements from Ju   | was told it would cost and she agreed to ACH n't check the client's bank months. When she checked of money had been taken out 0-A for billing statements and ne 2022 through the current emailed to her from O-A on  |                     |  |                   |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLE  IDENTIFICATION NUMBER:  A. BUILDING:  |                        |  |                                   |                          |
|--|---|------------------------|--|-----------------------------------|--------------------------|
|  | H35833  | B. WING                |  |                                   | C<br><b>12/2023</b>      |
| NAME OF PROVIDER OR SUPPLIER   | STREET A  | DDRESS, CITY, S        | TATE, ZIP CODE   |                                   |                          |
| COMFORTING ANGELS  | 202 HIGH<br>HAWLEY  | HWAY 10<br>', MN 56549 |  |                                   |                          |
| PREFIX (EACH DEFICIENCY  | EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| accounting departments by a person with O-A of her last name. FM listed the hours ULP to 24 hours, which the FM-D stated she had bill because she was staff were not present amounts did not line the client's bank account as a credit card for staff anywhere so the client snacks, or other items suspicious charges reported those concount deactivated the client apparent not all the FM-D stated after the O-A would put any exponentimes receipts about some of the exponentially missing the replied back to her the might have taken the On April 10, 2023, as assistant (AA)-I stated have 24 hour care be or they would be slesstated "she'll bill like" | email was sent from the ent of the home care agency. A's first name and first letter M-D stated the statements worked and it didn't add up ney were being charged for. It dasked O-A questions on the being billed for hours that in the home and the up to what was taken from count but did not get any real ed she had provided O-A with for use if they took C1 ent would be able to buy food, ins. FM-D stated she noticed on the debit card and erns to O-A. FM-D stated she it's debit card since it was charges were from the client e debit card was canceled, expenses related to the client invoices lacked details and and she still had concerns expenses.  at 9:15 a.m., FM-D stated O-A that the client was wo guns and that O-A had hat she suspected ULP-M |                        |  |                                   |                          |

Minnesota Department of Health

| STATEMENT OF D<br>AND PLAN OF CO   |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | l ` ´               | E CONSTRUCTION   | ` '   | ATE SURVEY<br>OMPLETED   |  |
|--|--|---|---------------------|--|-------|--------------------------|--|
|  |  |   |                     |  |       | }                        |  |
|  |  | H35833  | B. WING             |  |       | 2/2023                   |  |
| NAME OF PROVID   | ER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE  |       |                          |  |
| COMFORTING   | ANGFLS   | 202 HIGH  | WAY 10              |  |       |                          |  |
|  | ANOLLO   | HAWLEY,   | MN 56549            |  |       |                          |  |
|  | EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |  |
| 0 805 <b>Cont</b>  | inued From pa  | ge 58   | 0 805               |  |       |                          |  |
| persestaff them alleg did nallow.  On A was perse at place she like work state thing see e ULP-came then out a time, miss upda | onal items being using his creditions the client of know any of certain aces like restantional credit card as out of certains out of certains out of certains of the client evidence of any ed there was on a for the client evidence of any ed there was on a for the client evidence of any ed there was on a for the client evidence of any ed there was on a for the client ed the client was and the client was an according to the client was an according to the client was an according to the client was a client was | ig taken by caregivers and it card for things for taked she was aware of it was being charged a lot but the details as the only person  |                     |  |       |                          |  |
| clien  | t's credit card a  | and the missing personal items<br>ned O-A was taking care of it   |                     |  |       |                          |  |
|  |  | ited reporters."  |                     |  |       |                          |  |
| an eacond cond state care, when care, on the   | erns on his bill uct or misappred there were no giver was alway always always always always home. Consider the covernight shappred to the covernight of the  | 1:15 p.m. O-A stated C1 "was she had not received any s or concerns with staff opriation of his funds. O-A o gaps in C1's care and a ys present 24/7, except for o visit and sent some 0-A confirmed staff will sleep ifts but she directed them to ery hour so they can get up |                     |  |       |                          |  |

Minnesota Department of Health

|                          | MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE  |  | E SURVEY<br>PLETED  |   |           |                          |
|--------------------------|--|--|---------------------|---|-----------|--------------------------|
|                          |  | H35833   | B. WING             |   |           | C<br><b>12/2023</b>      |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, ST     | TATE, ZIP CODE  |           |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH   |                     |   |           |                          |
|                          |  | HAWLEY,  | MN 56549            |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | Continued From pa  | ge 59  | 0 805               |   |           |                          |
|                          | and check on the clashe had been updated O-A stated FM-D had month's charges to right so it was credi  | ient. O-A was asked again if ted of any concerns with C1. ad brought concerns over one her attention and "she was ted back." O-A stated she did oncerns involving staff using  |                     |   |           |                          |
|                          | investigate allegation after the client voice her money. In addition immediately report not having food and  | to immediately report and ons of financial exploitation ed concerns O-A was stealing ion, the licensee failed to and investigate allegations of I supplies that were to be usee and gaps in the client's care.   |                     |   |           |                          |
|                          |  | ne care services on November<br>narged on March 3, 2023.   |                     |   |           |                          |
|                          | C2's record did not  | contain a service plan.  |                     |   |           |                          |
|                          | automatic withdraw by C2 on November authorized D&G And where such withdray scheduled payment applicable taxes or at the time of such authorization signed 2021, and O-A on Final D&G Angels to "character on the date Concreates its invoice for undersigned client." by C2 and O-A on Card O-A on Ca | ed three authorizations for als. One authorization signed r 14, 2020, indicated the client gels to initiate "withdrawals wals shall be equal to each periodically due plus any other amounts due and owing withdrawal." Another d by C2 on September 17, sebruary 22, 2022, authorized arge my bank account or credit omforting Angels Home Care or its services provided to the Another authorization signed october 4, 2021, authorized arge my bank account or credit |                     |   |           |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING: |  |  | (X3) DATE SURVEY<br>COMPLETED |   |       |                          |
|--|--|--|-------------------------------|---|-------|--------------------------|
|  |  | H35833   | B. WING                       |   | 04/1  | )<br>2/2023              |
| NAME OF  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S                | STATE, ZIP CODE   |       |                          |
| COMFO  | RTING ANGELS   | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549            |   |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE |
| 0 805  | address any dispute there is no dispute 48 hours of email, f which may vary involved. Bank statements for indicated C2 had part 2021, when the lice transactions to collect tr | des provided to the Client will have 48 hours to es, no action needed when for ach will be processed after or the full invoiced amount, pice by invoice."  The C2's checking accounts aid by check until November use began using ACH ect payment.  Where was withdrawn via ACH by yer a 16 month period from ough February 2023.  The thick the | 0 805                         |   |       |                          |

Minnesota Department of Health

|                          | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ,                   | E CONSTRUCTION   | COMP | LETED                    |
|--------------------------|--|--|---------------------|--|------|--------------------------|
|                          |  | H35833   | B. WING             |  | 04/1 | ;<br>2/2023              |
| NAME OF F                | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |      |                          |
|                          |  | 202 HIGH\  |                     | ,,,,,  |      |                          |
| COMFOR                   | RTING ANGELS   |  | MN 56549            |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.) | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | Continued From page  | ge 61  | 0 805               |  |      |                          |
| 0 805                    | on. FM-H stated she was difficult to get a obtained bank record \$100,000 had been and almost \$50,000 account. FM-H state about the billing, sh \$100,000 so she received been sent any and sthat were sent to C2 sent her totaled about the sent any and stated O-A had three condo if the \$100,000 FM-H stated she find through February 200 first requested them informed her if she which was estimate "cut her a deal" for the sent and eal for the sent and served as a lamost a year. ULP-allowed to open C2 check her mailbox of the office and let the there and either O-A apartment and pick not allowed to open callowed to open | e tried talking to O-A but she shold of. FM-H stated she rds for C2 and noticed about taken from one bank account was missing from a savings ed after she spoke with O-A e was told C2 still owed about quested a bill as she had not she could not locate any bills 2. FM-H stated the bills O-A but \$341,000, or about which "seemed shocking r care she was getting." FM-H atened to put a lien on C2's 00 she still owed was not paid. ally got bills for January 2022 023 several weeks after she in FM-H stated O-A had paid the outstanding bill, d to be \$100,000, she would the remained of the year but ith a proposal on how that stated O-A had suggested she certificate of deposit er her bills.  If at 10:15 a.m., ULP-G stated a primary caregiver for C2 for G stated caregivers were not so mail but they were to go and daily and would have to call em know if there was any mail A or BM-J would drive to her it up. ULP-G stated they were the mail and she's not sure |                     |  |      |                          |
|                          | office staff. ULP-G schecks in the mail f  | after it was taken by the stated she noticed a few rom time to time and that C2 nt to her, "[O-A] is stealing my ted she wasn't sure if that was   |                     |  |      |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | CONSTRUCTION   | ` '       | E SURVEY<br>PLETED       |
|--------------------------|---|---|---------------------|--|-----------|--------------------------|
|                          |   | H35833  | B. WING             |  |           | C<br><b>12/2023</b>      |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, ST     | TATE, ZIP CODE   |           |                          |
| COMEO                    | DTINIC ANCEL C  | 202 HIGH  | WAY 10              |  |           |                          |
| COMFO                    | RTING ANGELS  | HAWLEY,   | , MN 56549          |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | ULP-G stated there ran out of groceries even after telling O-ULP-G stated she smoney the last few incontinence product been reimbursed by quit working for the paychecks were latter final paycheck is convorried since she's they had not gotten bounced. ULP-G stated on January 16 and the read of the montal of C2's mail. FM with text messages which read, "Just to on January 16 and her bill and at this per choice but to put he astronomical with mill also put a lien are (sic) assets that she summary that she is bank statements and couple of them and | ge 62  It it "seemed pretty shady."  Were a few times where C2  or incontinence products,  A she needed to order some.  Spent about \$300 of her own months buying groceries and cts for C2 and that she has not y O-A yet. ULP-G stated she licensee after a few of her e and she is still waiting to get of approximately \$600. ULP-G ed O-A several times when her ming and has been getting heard from other former staff paid or their paychecks ated there were often times idn't show up for their d she'd stay whenever she le to stay more than 16 hours. Was aware of the holes in the really do anything about it.  , at 1:57 p.m., FM-H emailed ummary of her work figuring FM-H wrote she contacted O-A d told her she'd be coming up h and would need access to -H provided the investigator between her and O-A, one of of forewarn you, I will be back I'm going to talk to [C2] about oint I probably will have no er in a nursing home her bill is ne, it's over \$100,000 which I gainst her condo any and any e has" FM-H wrote in her sent O-A a text asking for C2's and O-A had told her she had a would email them to FM-H, d. FM-H stated "[C2] had a |                     |  |           |                          |

Minnesota Department of Health

|                          | EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:   |  | (X3) DATE SURVEY<br>COMPLETED |   |      |                          |
|--------------------------|--|--|-------------------------------|---|------|--------------------------|
|                          |  | H35833   | B. WING                       |   | 04/1 | )<br>2/2023              |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S                | STATE, ZIP CODE   |      |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549            |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | almost all the stater wrote she kept asking statements from Oover January and Fithen towards the endo-A had been asking security number but provide it to O-A. Fif friendly" with one of providing care to Casend her money so incontinence produce what she needed. Funlicensed personn unlicensed personn out of her own pock wanted her to contain if she wanted access C2, she had to go the On April 4, 2023, at from the time two U altercation at the clift ULP being arrested she was not aware care. O-A stated more emailed to the client clients have 48 hour to voice concerns we gotten any concerns they did everything "wiped their hands of was getting 24 hours there would always stated she has been because she has not year. O-A stated she invoices and payments." | stem so it was clear that ments were missing." FM-H ng for copies of the A's services multiple times ebruary 2023, and finally got do of February. FM-H wrote ag around to get C2's social theither she nor C2 would M-H wrote she "became the unlicensed personnel 2 and she had asked her to she could buy C2 food and cts as O-A was not providing FM-H wrote she sent that el \$128 via Venmo as the el was paying for food for C2 tet. FM-H wrote O-A never act the caregivers directly and as to C2 or wanted to contact | 0 805                         |   |      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE<br>COMPI | SURVEY<br>LETED          |
|---|--|---------------------|--|--------------------|--------------------------|
|   | 1125022  | B. WING             |  | C C                |                          |
|   | H35833   | D. WING             |  | 04/1               | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER  |  | ,                   | STATE, ZIP CODE  |                    |                          |
| COMFORTING ANGELS   | 202 HIGH\<br>HAWLEY,   | MN 56549            |  |                    |                          |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE              | (X5)<br>COMPLETE<br>DATE |
| would get money faccount of about \$ that is what she'd waccounts when C2 full "just so I'd be pC2's care usually reper month. O-A washown on C2's bar to \$30,000 and O-large amounts had or that upwards of in a month. O-A stawould only be one billing twice a mon ACH withdrawals restatement. O-A sta C2's mail because opened anything for seeing her own material of C2's mail in to the On April 12, 2023, would use her own supplies for C2 and O-A was taking all had 24 hour service staff were not there. On April 14, 2023, had used her own supplies for C2 wheevery time she were mattress was soak like everyone was supposed to be do | nonth. O-A stated she knew C2 rom her husband's retirement 1,200 a month so each month withdraw via ACH from C2's had stopped paying her bill in raid something." O-A stated an about \$15,000 to \$17,000 is asked about the transactions asked about the transactions ask accounts that totaled close A stated she didn't notice those been pulled from C2's account 4 to 5 withdrawals were made ated for ACH withdrawals, there done monthly until she began th, then there should be two effected on the bank ted she would take and open she would "scream if we or her," and had no interest in ail. O-A stated the scanned all |                     |  |                    |                          |
| C3  |  |                     |  |                    |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ´                 | E CONSTRUCTION   | COMPL |                          |
|--|--|---------------------|--|-------|--------------------------|
|  | H35833   | B. WING             |  | 04/1  | ;<br>2/2023              |
| NAME OF PROVIDER OR SUPPLIER  COMFORTING ANGELS  | 202 HIGH   |                     | TATE, ZIP CODE   |       |                          |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE) | .D BE | (X5)<br>COMPLETE<br>DATE |
| investigate C3's rep (anti-seizure medica pain) potentially beit the licensee as well made to C3's credit allowed the alleged continue working wi allegations were ma  C3 admitted to hom 2022.  C3's diagnoses incl injury that causes p trunk, legs, and pelv  C3's undated, unsig client had twice dail services for three h week. The service p services were proviservices, or the rate  A police report from C3 had called to rep after she noticed so taken. The report in through February 12 were taken. A bottle taken on January 12 occasions, four pills 48 pills were taken medications were n after ULP-L had pro  On March 28, 2023 nurse (CN)-N stated | to immediately report and ort of a bottle of Gabapentin ation and used to treat nerve ng taken by an employee of as an attempted charge card. In addition, the licensee perpetrator, ULP-L, to the the client after the ade.  The care services on August 23, uded quadriplegia (spinal cord aralysis in all or part of the vic organs).  The service plan indicated the y "basic and skilled nursing" ours per day, seven days per plan did not identify what ded, who would provide the efor the services.  February 15, 2023, indicated for January 12, 2023, 2, 2023, 209 Gabapentin pills of 153 pills was reported 2, 2023, then on two other were taken each time, and on February 12, 2023. The oted missing immediately | 0 805               |  |       |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | l ` ´          | E CONSTRUCTION  | (X3) DATE<br>COMPI | SURVEY<br>LETED  |
|--|---|----------------|---|--------------------|------------------|
|  |   | 71. 501251110. |   |                    |                  |
|  | H35833  | B. WING        |   | _                  | <i>2</i> /2023   |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD   | DRESS CITY S   | STATE, ZIP CODE   | -                  |                  |
| TWANE OF TROVIDER OR OUT LIER  | 202 HIGH  | , ,            | 717(1 L, 211 00DL   |                    |                  |
| COMFORTING ANGELS  |   | MN 56549       |   |                    |                  |
| (X4) ID SUMMARY STATE  | MENT OF DEFICIENCIES  | ID             | PROVIDER'S PLAN OF CORRECTI   | ON                 | (X5)             |
| PRÉFIX (EACH DEFICIENCY M  | IUST BE PRECEDED BY FULL<br>DENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                    | COMPLETE<br>DATE |
| 0 805 Continued From page  | e 66  | 0 805          |   |                    |                  |
| refilled was missing. I attempted to use C3s purchase at Walmart. with C3 again on Feb informed by C3 that a missing. CN-N stated make a police report stated she had contact 2023, and told O-A th perpetrator and shoul C3's home or provide.  On April 4, 2023, at 1: was made aware that missing after C3 called missing. O-A stated a to count her pills befor alleged perpetrator, coher scheduled shift la called her after ULP-L additional medications she advised C3 to file and she did not feel it from the home care at to file one. O-A stated probation so she had officer to see if they coweren't able to. O-A s MAARC report because aware. O-A confirmed documentation of any the theft of medication do anything." O-A stated adult because she depress charges. O-A wulnerable adult under O-A stated, "my defining uess everyone could confirmed she would | In addition, someone had a credit card for an \$800. The health guide visited or ary 14, 2023, and was about 200 pills were now I C3 was encouraged to by the health guide. CN-Noted O-A on February 16, at ULP-L was an alleged Id not go anywhere near ecare to C3.  2:50 p.m., O-A stated she to narcotic medications were ed and told her a bottle was at that time she advised C3 are ULP-L, the suspected came to her apartment for attention to the told and reported as were missing. O-A stated a police report at that time to was necessary for a report at was necessary for a report at was necessary for a report at the time to was necessary for a report at the police were already at there was now the police were already at the police were already at the police were already at the told C3 was not a vulnerable ecided she didn't want to the told C3 was not a vulnerable ecided she didn't want to the saked if C3 would be a cert the statute definition and a vulnerable adult is I |                |   |                    |                  |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549  (A) ID PREFIX (EACH DEPROJECTIVE ACTION SHOULD BE (EACH DEPROJECTIVE ACTION SHOULD BE (EACH DEPROJECTIVE ACTION SHOULD BE INVESTIGATION)  O 805 Continued From page 67 missing medications. O-A confirmed a formal investigation was not a vulnerable adult because she makes her own decision.  On April 4, 2023, at 1:00 p.m., registered nurse (RRN)-C stated C3 was not a vulnerable adult because she makes her own decision.  On April 6, 2023, at 11:33 p.m., O-A emailed the investigator a copy of the requested incident report. The partially completed incident report was electronically signed by O-A on April 6, 2023, at 10:55 p.m., and indicated: "02.12.2023 Received a call from [C3] regarding a Bottle of pills missing (Gabapentin) she received 3 bottles which are located in her island drawer (kitchen) not sure what happened to them, [ULP-L] was the one working Friday night, both shifts on Saturday and Sunday day shift. [ULP-L] was scheduled for Monday evening which we did leave her on after she left there were 45 pills missing I spoke to [C3] Tuesday morning and told her to make a police report for we would need report documentation to get a replacement for missing pills. She did report, police notied (sic) me after a visit with [C3] which I just reported what was given to me by [C3] i did call [ULP-L]'s probation ocer (sic) about the incident but he felt that he probably wouldn't be able to do anything for he is just for alcohol." | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:   |                |  | (X3) DATE SURVEY<br>COMPLETED |          |
|---|---|--|--|----------------|--|-------------------------------|----------|
| COMFORTING ANGELS    CA) ID   SUMMARY STATEMENT OF DEFICIENCY WIN 56549   DEFICIENCY WINT GENERAL TAGS   SUMMARY STATEMENT OF DEFICIENCY WINT GE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS   PROVIDER'S PLAN OF CORRECTION GENOTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS   CROSS-REFERENCEO TO THE APPROPRIATE DATE DATE  |   |  | H35833   | B. WING        |  |                               |          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 805  Continued From page 67 missing medications. O-A confirmed a formal investigation was not completed.  On April 4, 2023, at 1:00 p.m., registered nurse (RN)-C stated C3 was not a vulnerable adult because she makes her own decision.  On April 6, 2023, at 11:33 p.m., O-A emailed the investigator a copy of the requested incident report. The partially completed incident report was electronically signed by O-A on April 6, 2023, at 10:55 p.m., and indicated: "02.12.2023 Received a call from [C3] regarding a Bottle of pills missing (Babapentin) she received 3 bottles which are located in her island drawer (kitchen) not sure what happened to them, [ULP-L] was the one working Friday night, both shifts on Saturday and Sunday day shift. [ULP-L] was scheduled for Monday evening which we did leave her on after she left there were 45 pills missing I spoke to [C3] Tuesday morning and told her to make a police report for we would need report documentation to get a replacement for missing pills. She did report, police notit. ed (sic) me after a visit with [C3] which I just reported what was given to me by [C3]. I did call [ULP-L]'s probation o.cer (sic) about the incident but he felt that he probably wouldn't be able to do anything for he is just for alcohol."  | NAME OF I   | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S | TATE, ZIP CODE   |                               |          |
| PRÉFIX TAG  CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  OR SC Continued From page 67  missing medications. O-A confirmed a formal investigation was not completed.  On April 4, 2023, at 1:00 p.m., registered nurse (RN)-C stated C3 was not a vulnerable adult because she makes her own decision.  On April 6, 2023, at 11:33 p.m., O-A emailed the investigator a copy of the requested incident report. The partially completed incident report was electronically signed by O-A on April 6, 2023, at 10:55 p.m., and indicated: "02 12.2023 Received a call from [C3] regarding a Bottle of pills missing (Gabapentin) she received 3 bottles which are located in her island drawer (kitchen) not sure what happened to them, [ULP-L] was the one working Friday night, both shifts on Saturday and Sunday day shift. [ULP-L] was scheduled for Monday evening which we did leave her on after she left there were 45 pills missing I spoke to [C3] Tuesday morning and told her to make a police report for we would need report documentation to get a replacement for missing pills. She did report, police notied (sic) me after a visit with [C3] which I just reported what was given to me by [C3]. I did call [ULP-L]'s probation ocer (sic) about the incident but he felt that he probably wouldn't be able to do anything for he is just for alcohol."  | COMFOR  | RTING ANGELS   |  |                |  |                               |          |
| missing medications. O-A confirmed a formal investigation was not completed.  On April 4, 2023, at 1:00 p.m., registered nurse (RN)-C stated C3 was not a vulnerable adult because she makes her own decision.  On April 6, 2023, at 11:33 p.m., O-A emailed the investigator a copy of the requested incident report. The partially completed incident report was electronically signed by O-A on April 6, 2023, at 10:55 p.m., and indicated: "02.12.2023 Received a call from [C3] regarding a Bottle of pills missing (Gabapentin) she received 3 bottles which are located in her island drawer (kitchen) not sure what happened to them, [ULP-L] was the one working Friday night, both shifts on Saturday and Sunday day shift. [ULP-L] was scheduled for Monday evening which we did leave her on after she left there were 45 pills missing I spoke to [C3] Tuesday morning and told her to make a police report for we would need report documentation to get a replacement for missing pills. She did report, police notied (sic) me after a visit with [C3] which I just reported what was given to me by [C3]. I did call [ULP-L]'s probation ocer (sic) about the incident but he felt that he probably wouldn't be able to do anything for he is just for alcohol."  | PRÉFIX  | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | PREFIX         | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | _D BE                         | COMPLETE |
| On April 11, 2023, at 12:20 p.m., C3 stated caregivers from the licensee come every morning and evening to get her out of and back in to bed, do a bowel program, get her dressed and ready. C3 stated she had quadraplegia and is not able to get in and out of bed on her own and needs a mechanical lift and staff assistance to get in and out of bed. C3 stated there have been times where staff did not show up and one time they had six employees quit in a week. C3 stated last   | 0 805   | missing medication investigation was not on April 4, 2023, at (RN)-C stated C3 we because she makes. On April 6, 2023, at investigator a copy report. The partially was electronically sat 10:55 p.m., and in Received a call from pills missing (Gabay which are located in not sure what happen one working Friday and Sunday day she Monday evening which are located in not sure what happen one working Friday and Sunday day she left there were Tuesday morning a report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport, police noti [C3] which I just report for we would get a replacement freport | s. O-A confirmed a formal of completed.  1:00 p.m., registered nurse was not a vulnerable adult is her own decision.  11:33 p.m., O-A emailed the of the requested incident completed incident report igned by O-A on April 6, 2023, in [C3] regarding a Bottle of pentin) she received 3 bottles in her island drawer (kitchen) ened to them, [ULP-L] was the night, both shifts on Saturday iff. [ULP-L] was scheduled for nich we did leave her on after 45 pills missing I spoke to [C3] and told her to make a police need report documentation to for missing pills. She did ad (sic) me after a visit with corted what was given to me LP-L]'s probation ocer (sic) but he felt that he probably do anything for he is just for at 12:20 p.m., C3 stated licensee come every morning her out of and back in to bed, in, get her dressed and ready. Quadraplegia and is not able to d on her own and needs a staff assistance to get in and ad there have been times show up and one time they |                |  |                               |          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,            | E CONSTRUCTION  | ` '    | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|----------------|---|--------|-------------------------------|--|
| AND I LANGI CONNECTION   | IDEIVIII IO/(IIOIVIDEIX.  | A. BUILDING:   |   |        |                               |  |
|  | H35833  | B. WING        |   |        | C<br>1 <b>2/2023</b>          |  |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S | STATE, ZIP CODE   |        |                               |  |
|  | 202 HIGH  | WAY 10         |   |        |                               |  |
| COMFORTING ANGELS  | HAWLEY,   | MN 56549       |   |        |                               |  |
| (X4) ID SUMMARY STA  | ATEMENT OF DEFICIENCIES   | ID             | PROVIDER'S PLAN OF CORR   | ECTION | (X5)                          |  |
| PRÉFIX (EACH DEFICIENC)  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AF<br>DEFICIENCY) |        | COMPLETE<br>DATE              |  |
| 0 805 Continued From pa  | ige 68  | 0 805          |   |        |                               |  |
| night, "the guy who show uptwice lass the storm and care dependent on staff out of bed. I have a and water and if I k by my bed." C3 stated Gabapentin refilled 153 tablets in one land a smaller bottle 390 tablets. C3 stated missing so she mobedroom and coun again after ULP-L frequency, there were ULP-L was coming about four pills misted and if she worked to be off during the westated she discover Lexapro and Transfin her drawer one of scratched off it. C3 report her concerns probation currently police and file a report her concerns probation currently police were notified what the licensee of noted O-A came of ULP-L was schedulafter. C3 stated she with her credit card admitted for home provided it. C3 stated in February to charges on her creattempted to charge | was putting me to bed didn't to week I stayed in bed due to givers couldn't come outI'm so if no one comes, I can't get a neighbor who can bring food mow it'll storm, I keep a cooler ted she had just gotten her and the pharmacy usually did bottle, 153 tablets in another, with the rest since they send ted one whole bottle was ved the other ones to her ted them. C3 counted them inished working and "sure es some missing." C3 stated if daily, there would usually be sing each time she worked during the weekend and would eek, she'd take more. C3 red she was also missing adol and found some Tramadol day with the numbers stated she called O-A to sand was told ULP-L was on and was directed to call the bort. C3 stated ULP-L as her caregiver after the I. C3 stated she has no idea did for an investigation but ut to her apartment when led to work and left shortly e was asked to provide O-A information when she care services and she ed her bank called her some report potential fraudulent dit card when someone e \$800 at WalMart. C3 stated d towels missing, pills, |                |   |        |                               |  |

Minnesota Department of Health

STATE FORM JRM011 If continuation sheet 69 of 131

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:               | ` ´            | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY               |
|--|--|----------------|--|-------------------|----------------------|
|  |  | A. BUILDING.   |  |                   |                      |
|  | H35833   | B. WING        |  |                   | C<br>1 <b>2/2023</b> |
| NAME OF PROVIDER OR SUPPLIER                     | STREET AD  | DRESS, CITY, S | STATE, ZIP CODE  |                   |                      |
|  | 202 HIGH   | WAY 10         |  |                   |                      |
| COMFORTING ANGELS                                |  | , MN 56549     |  |                   |                      |
| (X4) ID SUMMARY ST                               | ATEMENT OF DEFICIENCIES  | ID             | PROVIDER'S PLAN OF CORRECT   | TION              | (X5)                 |
| PRÉFIX (EACH DEFICIENC                           | Y MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)       | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) |                   | COMPLETE<br>DATE     |
| 0 805 Continued From page                        | age 69   | 0 805          |  |                   |                      |
| •  | sed. C3 stated O-A was made                                      |                |  |                   |                      |
|  | pt to charge \$800 at WalMart<br>thing was done about it.        |                |  |                   |                      |
| On April 11, 2023,                               | at 2:10 p.m., RN-C stated she                                    |                |  |                   |                      |
|  | dications were missing from                                      |                |  |                   |                      |
| · •  | d was only made aware when                                       |                |  |                   |                      |
| ·  | ne to O-A's office and she there. RN-C stated since she          |                |  |                   |                      |
|  | the client's medications, she                                    |                |  |                   |                      |
| did not get involve                              | d and did not know about any                                     |                |  |                   |                      |
|  | at happened to staff as that                                     |                |  |                   |                      |
|  | O-A. RN-C was asked if a ould have been made since C3            |                |  |                   |                      |
| •  | able adult. RN-C asked the                                       |                |  |                   |                      |
|  | MAARC report was. RN-C   |                |  |                   |                      |
|  | , C3 was not a vulnerable adult                                  |                |  |                   |                      |
| _  | nt] notified the proper people,"                                 |                |  |                   |                      |
|  | she didn't want to file charges.                                 |                |  |                   |                      |
|  | sked RN-C if it was possible C3                                  |                |  |                   |                      |
| •  | ges because she depended on loyees to help her get out of        |                |  |                   |                      |
|  | n't show up, she wouldn't be                                     |                |  |                   |                      |
|  | -C stated, "no because she has                                   |                |  |                   |                      |
| family and other pr                              | rivate caregivers so we're not                                   |                |  |                   |                      |
|  | 'RN-C was asked if C3 could                                      |                |  |                   |                      |
|  | ulnerable adult under  |                |  |                   |                      |
|  | definitions as opposed to her                                    |                |  |                   |                      |
| -  | nition of a vulnerable adult.  Sought it through and she's not a |                |  |                   |                      |
|  | he's very, she has no cognitive                                  |                |  |                   |                      |
|  | ke zero. She's pry smarter than                                  |                |  |                   |                      |
| · •  | out that in there. She's very                                    |                |  |                   |                      |
|  | ood support system. That's a                                     |                |  |                   |                      |
|  | on. I am a vulnerable adult right                                |                |  |                   |                      |
|  | erable adults in this era so I'm                                 |                |  |                   |                      |
|  | er that. Everyone is vulnerable                                  |                |  |                   |                      |
|  | l'm not going to deny she's a [MAARC] report to be placed,       |                |  |                   |                      |
|  | , emotional trauma, no   |                |  |                   |                      |

Minnesota Department of Health

| STATEMENT OF DEF<br>AND PLAN OF CORF  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | (X3) DATE | SURVEY<br>LETED          |
|---|--|---|---------------------|--|-----------|--------------------------|
|   |  | H35833  | B. WING             |  | 04/1      | ;<br>2/2023              |
| NAME OF PROVIDER  | R OR SUPPLIER  | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
|   | NOTIO  | 202 HIGH\   | ,                   |  |           |                          |
| COMFORTING A  | NGELS  | HAWLEY,   | MN 56549            |  |           |                          |
|   | CH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| is the toonside after Costolen. [C3] is not immedication investion ask here with the captal advice very seat that her captal advice very seat that here we have been adviced to competitive. | ability issue vocus." RN-C ered financial 3's medication RN-C stated not cognitive ation." RN-C gate [C3] and revery questa vulnerable se you're trying able adultd she would be a so since the vas no need "the bottom sed, it needs to call police at time, my questa she would we per her care." In the care would we per her care. The care would we per her care would we per her care. The care would we per her care would we per her care would we per her care. The care would we per her care would we per her care would we per her care. The care would we per her care would we per her care would we per her care. The care would we per her care would we per her care would we per her care. The care would we per her care would we per her care. The care would we per her care would we per her care would we per her care. The care would we per her care. The care would we per her care. The care would we per her care would be also would be a so where we would be a so where would be a so | with the incident that happened was asked if they had all exploitation had occurred ons were presumed to be d, "why would we do that when ely impaired, financially she's ise her insurance paid for the then stated, "You go d I hope you do it tomorrow, tion. If I get in trouble for her adult, I will get an attorneying to insinuate she's a o not put [C3] as a vulnerable every offended, it's not fair to at 12:30 p.m., O-A stated since in e C3's medications, there was the police were already notified, to make her own report. O-A line is if there's any care to be reportedI gave here to be reported she allowed ULP-L gwith C3 after it was a medications because C3 said ated she didn't think it would have the client make that think she would feel he was ok with it because she gency to provide care. | 0 805               |  |           |                          |
| The lice  | ensee failed   | to immediately report and   |                     |  | !         |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---------------------|--|-------------------------------|--------------------------|
|   | H35833  | B. WING             |  | 04/1                          | ;<br>2/2023              |
| NAME OF PROVIDER OR SUPPLIER  | STREET AD  202 HIGH   | ,                   | STATE, ZIP CODE  |                               |                          |
| COMFORTING ANGELS   | HAWLEY,   | MN 56549            |  |                               |                          |
| PREFIX (EACH DEFICIENCE)  | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 805 Continued From p  | age 71  | 0 805               |  |                               |                          |
|   | ions of financial exploitation ade aware of concerns of C4 for services.  |                     |  |                               |                          |
|   | me care services on September<br>arged on February 19, 2023.  |                     |  |                               |                          |
| hours of services basic and skilled shours of "home exservices" on Frida care per week. The what services were the services, or the service plan indicabilling Humana 80 reassessments at per visit with schedists at \$140 and \$140 | indicated the client received 2.5 to include "home exercise, services" on Mondays and 2 tercise, basic and skilled ys, for a total of 4.5 hours of e service plan did not identify e provided, who would provide e rate for the services. The ated payment would be "split % and client 20%" and nurse days 14, 30, 90 would be \$155 duled and unscheduled nurse our with split billing Humana %. The service plan listed an eptember 2, 2022, but was at's wife on February 12, 2023. Was not signed by home care |                     |  |                               |                          |
| Nursing assessment of provided.   | ents for C4 were requested, but   |                     |  |                               |                          |
| included entries for September 2, 202   | ovided to the investigator<br>or RN assessments on<br>2, September 14, 2022,<br>2, and December 27, 2022  |                     |  |                               |                          |
| assessment did n<br>a signature from t  | the September 2, 2022, RN of include any documentation or ne client indicating she was ne was listed as 9:00 a.m. to hours.   |                     |  |                               |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION  | ` '    | (X3) DATE SURVEY<br>COMPLETED |  |
|--|--|---------------------|---|--------|-------------------------------|--|
|  | H35833   | B. WING             |   | 04/1   | 2/ <b>2023</b>                |  |
| NAME OF PROVIDER OR SUPPLIER  COMFORTING ANGELS  | 202 HIGH   |                     | TATE, ZIP CODE  | •      |                               |  |
| PREFIX (EACH DEFICIENC   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (PROSS-REFERENCE) | ULD BE | (X5)<br>COMPLETE<br>DATE      |  |
| assessment did not a signature from the there. The visit tim 1:20 p.m., three hore progress notes for assessment did not beyond "covid 19 pand procedure. Cli [signs, symptoms] done." The note laindicating the RN visited as 9:00 a.m.  Progress notes for assessment did not a signature from the there. The visit tim 4:01 p.m., four how On February 27, 20 responsible party september 2, 2022 on February 19, 20 sent prior to this tir from the accountin her first name and the email. The stat \$3,721.52 was due billed at \$8.90 per reassessments we visit as identified in RN rate was billed One RN reassess hours. | the September 14, 2022, RN it include any documentation or it e client indicating she was it was listed as 10:20 a.m. to ours.  the December 8, 2022, RN it include any documentation orecautions followed per policy ent and writer afebrile. No s/s of Covid. Nurse reassessment ocked a signature from the client was there. The visit time was to 4:00 p.m., seven hours.  the December 27, 2022, RN it include any documentation or it include any documentation or it client indicating she was it was listed as 12:00 p.m. to ins.  D23, O-A emailed the client's itatements for services from itatements for services from itatements for services from itatements had been ine. O-A identified herself as itatements and used only ifirst letter of her last name in itatements indicated a total of itatements indic |                     |   |        |                               |  |
| responsible party a  | O-A emailed the client's in updated set of statements september 2, 2022, through the   |                     |   |        |                               |  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:   | ` ′  | E CONSTRUCTION   | ` ,                               | E SURVEY<br>PLETED       |
|---|--|--|-----------------------------------|--------------------------|
| H35833  | B. WING  |  |                                   | C<br><b>12/2023</b>      |
|   | ET ADDRESS, CITY, S  | TATE, ZIP CODE   |                                   |                          |
| COMFORTING ANGELS   | HIGHWAY 10<br>VLEY, MN 56549   |  |                                   |                          |
| (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF<br>(EACH CORRECTIVE AC<br>CROSS-REFERENCED TO<br>DEFICIENCE | TION SHOULD BE<br>THE APPROPRIATE | (X5)<br>COMPLETE<br>DATE |
| client's discharge on February 19, 2023. O-A identified herself as from the accounting department and used only her first name and letter of her last name in the email. The statements indicated a total of \$2,685.19 due The hourly ULP rate was billed at \$6 per hour 20% of \$30. RN reassessments were billed to the hour, not by the visit as identified in the service plan. The hourly RN rate was billed at per hour, 20% of \$155. One RN reassessme was billed for seven hours.  On April 4, 2023, at 1:25 p.m. O-A stated she was not aware of any concerns regarding the client's services or care. O-A stated the client representative was emailed statements each month but she intended to bill the client's insurance.  On April 10, 2023, at 8:20 a.m., AA-I stated she was directed to report those concerns to O-A and was not allowed to discuss anything regarding billing to clients as only O-A was allowed to dicient billing.  On April 12, 2023, at 12:25 p.m., O-A confirm she had not billed the client's insurance compy yet but had obtained an authorization number around the time the client admitted for service September. O-A stated the insurance compation to the client's care would be covered foindefinite period of time and she did not need | first  fi |  |                                   |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | ECONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|---|---------------------|--|-------------------------------|--------------------------|
| 7 HILD I EXHIT OF COTHICE OF THE I  |   | A. BUILDING:        |  |                               |                          |
|   | H35833  | B. WING             |  | 04/1                          | ;<br>2/2023              |
| NAME OF PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S      | TATE, ZIP CODE   |                               |                          |
| COMFORTING ANGELS   | 202 HIGH<br>HAWLEY,   | WAY 10<br>MN 56549  |  |                               |                          |
| PREFIX (EACH DEFICIENC  | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                         | (X5)<br>COMPLETE<br>DATE |
| she missed deadling would no longer be insurance. O-A corbilled at her highes for ULP services. On the client was billed client's cares were it would cost more able to describe he complex than stand confirmed a service admission and the before the client paracostand services processes the cost clients until a service initially stated she could be dollar amount with confirmed she sensitatements after the why the rate was he and stated she did cost for services we stated to avoid any agreed to lower he hour and ended up statements. O-A stated to lower he hour and ended up statements. O-A stated bills were now were issues with be issues with her billing several office staff.  On April 13, 2023, was one of the prince. | d. O-A confirmed it was likely nes to file insurance claims and able to bill the client's affirmed the client was initially thourly rate of \$44.50 per hour D-A stated the higher amount di was based off the fact the more complex and difficult so to provide care. O-A was not to with the client's cares were more dard home care services. O-A to plan was not executed upon service plan completed shortly assed away lacked details on rovided. O-A stated she never of care and services with the plan is completed and did not recall discussing a the client's family. O-A to out a second batch of the client's representative asked igher than initially discussed not recall talking about the hen the client admitted. O-A to difficulties with the client, she are price back down to \$30 per to sending out a second set of ated she didn't tell the client covered his care and did not nem it was being covered at a services from ULP. O-A to sent out on time and there are services from ULP. O-A to sent out on time and there are services with billing.  at 12:20 p.m., ULP-Z stated he nary caregivers for C4. ULP-Z |                     |  |                               |                          |
|   | as pretty independent and assistance of one for transfers   |                     |  |                               |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|----------------------------|--|-------------------------------|--------------------------|
| AND PLAN OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:               |  | COMP                          | LETED                    |
|   |  | D MAINIO                   |  | C                             |                          |
|   | H35833   | B. WING                    |  | 04/1                          | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIE   | R STREET AD  | DRESS, CITY, S             | STATE, ZIP CODE  |                               |                          |
| COMEODTING ANCELS   | 202 HIGH   | WAY 10                     |  |                               |                          |
| COMFORTING ANGELS   | HAWLEY,  | MN 56549                   |  |                               |                          |
| PREFIX (EACH DEFICIEN   | TATEMENT OF DEFICIENCIES<br>BY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | ILD BE                        | (X5)<br>COMPLETE<br>DATE |
| 0 805 Continued From p  | age 75   | 0 805                      |  |                               |                          |
| and go to the bath<br>did not have any of<br>and most of the v  | with a walker, eat on his own, room. ULP-Z stated the client complex cares or care needs sit he would help with exercises with the client, and   |                            |  |                               |                          |
| did not receive and bills for the client's she requested for several times from coming up with not been sent yet and sent to an address years before she worth of paperwork had to send back because the owner that an employee stated she did not and was reassure insurance was conthey'd only be resthey were told by covering 80%. Fly owner that the client paid her company was a higher among upon amount of \$ owe their 20% costs asked the owner when the insurance \$15 per hour more asked why the among they were initially answer other than reimbursed above | at 1:20 p.m., FM-X stated they y admission paperwork or any care for several months and the information to be sent of O-A. FM-X stated O-A kept ow reasons as to why it hadn't the paperwork was eventually as she had not lived at for a few was finally sent several months k and bills. FM-X stated they the paperwork more than once or kept saying she didn't get it or didn't file it properly. FM-X ever get monthly statements d more than once that wering the cost of care and consible for a 20% co pay since O-A the client's insurance was and stated they were told by the ent's insurance company had \$44.50 per hour for care, which can than the originally agreed 30 per hour, but they would still st of care. FM-X stated she had why they were still paying 20% are company was paying almost enter than the cost of care. FM-X ount changed from the \$30 per tially told but did not get an the insurance company that amount. FM-X stated she he hours listed on the bills as |                            |  |                               |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | <b>`</b> '     | ECONSTRUCTION  | (X3) DATE<br>COMP | SURVEY           |
|--|--|----------------|--|-------------------|------------------|
|  |  | , a Boilbinto. |  |                   | •                |
|  | H35833   | B. WING        |  |                   | 2/2023           |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD  | DRESS. CITY. S | TATE, ZIP CODE   |                   |                  |
|  | 202 HIGH   | , ,            |  |                   |                  |
| COMFORTING ANGELS  |  | MN 56549       |  |                   |                  |
| (X4) ID SUMMARY STA  | TEMENT OF DEFICIENCIES   | ID             | PROVIDER'S PLAN OF CORRECTI  | ON                | (X5)             |
|  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                   | COMPLETE<br>DATE |
| 0 805 Continued From pa  | ige 76   | 0 805          |  |                   |                  |
| FM-X stated shortly updated invoices the per hour they were stated the client's in record of the home claims or being paid FM-X stated the own several times to all withdrawal from the however, they declay by check. FM-X impression the own ACH than a check.   |  |                |  |                   |                  |
| •  | s, the licensee had not filed s for C1, C2, C3, and C4.  |                |  |                   |                  |
| indicated in complical Comforting Angel individually assess vulnerability to abuspecific plan to minclient. In addition, a care are mandated (including suspected vulnerable adult to services, local policor appropriate licer through the MAAR Reporting Center). following definition, years of age or old the person is living abuse or neglect wimpairment of menemotional status." care employee has | ated Vulnerable Adult policy ance with Minnesota Statutes, els employees are required to clients to determine se or neglect and develop a nimize the risk of abuse to that all employees providing home to report abuse and/or neglect ed abuse or neglect) of the the appropriate county social be department, county sheriff using or certifying organization C (Minnesota Adult Abuse The policy included the "Vulnerable Adult: Anyone 18 er, who regardless of where is unable or unlikely to report ithout assistance because of tal or physical function, or The policy directed "the home responsibility for the following: rulnerability status of each |                |  |                   |                  |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | A. BUILDING:        |  | COMPLETED |                          |
|--------------------------|--|---|---------------------|--|-----------|--------------------------|
|                          |  | H35833  | B. WING             |  | 04/1      | ;<br>2/2023              |
| NAME OF F                |  |   | DESS CITY S         | TATE ZID CODE  | 1 0 17 1  |                          |
| NAME OF F                | PROVIDER OR SUPPLIER   | 202 HIGH\   |                     | STATE, ZIP CODE  |           |                          |
| COMFOR                   | RTING ANGELS   |   | MN 56549            |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INC.) | D BE      | (X5)<br>COMPLETE<br>DATE |
| 0 805                    | Continued From page  | ge 77   | 0 805               |  |           |                          |
|                          | by other individuals, adults or minors, in Physical 2) Verbal (Sexual 4) Financial The client's risk of a adults within the rest adults within the rest adults within the rest abuse prevention pleach vulnerable adults services are provided statements of speciminimize the risk of other vulnerable addimplemented immediately visit or supervisory v | on. Susceptibility to abuse and neglect and risk of abuse including other vulnerable the following areas: 1) emotional/psychosocial) 3) Exploitation 5) Self Abuse b. abusing other vulnerable sidence shall be assessed. c. It status assessment shall be clinical record. d. An individual an shall be established for all for whom home care ed. 1) The plan shall contain fic measure to be taken to abuse to that person and allts. 2) The plan will be diately and evaluated at each more frequently, if necessary. Vill include results of the |                     |  |           |                          |
|                          | No further informati   | on was provided.  |                     |  |           |                          |
|                          | TIME PERIOD FOR days   | R CORRECTION: Seven (7)   |                     |  |           |                          |
|                          | 144A.479, Subd. 6(<br>Prevention Plan  | b) Individual Abuse   | 0 810               |  |           |                          |
|                          | implement an individual each vulnerable min care services are provider. The plan services or assessment susceptibility to abust including other vulnerable person's risk of abusticity.  | e provider must develop and dual abuse prevention plan for nor or adult for whom home rovided by a home care shall contain an individualized ent of the person's se by another individual, erable adults or minors; the sing other vulnerable adults ements of the specific   |                     |  |           |                          |

Minnesota Department of Health

| PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP   |         | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′            | E CONSTRUCTION  | COMP  | SURVEY                   |
|--|---------|---|---|----------------|---|-------|--------------------------|
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 810  Continued From page 78  measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of four clients (C1, C2, C3, C4).  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to  |         |   | H35833  | B. WING        |   |       |                          |
| (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE ACTION SHOULD BE CROSS-REFERINCED TO THE ACTION TO THE ACTION TO THE ACTION TO THE ACTION SHOULD BE CROSS-REFERINCED TO THE ACTION TO THE ACTI | NAME OF | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S | STATE, ZIP CODE   | -     |                          |
| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 810  Continued From page 78  measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of four clients (C1, C2, C3, C4).  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to  | COMFO   | RTING ANGELS  |   |                |   |       |                          |
| measures to be taken to minimize the risk of abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of four clients (C1, C2, C3, C4).  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to   | PRÉFIX  | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL  | PREFIX         | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO | LD BE | (X5)<br>COMPLETE<br>DATE |
| abuse to that person and other vulnerable adults or minors. For purposes of the abuse prevention plan, the term abuse includes self-abuse.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of four clients (C1, C2, C3, C4).  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to  | 0 810   | Continued From pa   | ge 78   | 0 810          |   |       |                          |
| by: Based on interview and record review, the licensee failed to ensure an individual abuse prevention plan (IAPP) was developed to include the required content for four of four clients (C1, C2, C3, C4).  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to  |         | abuse to that perso or minors. For purp   | n and other vulnerable adults oses of the abuse prevention  |                |   |       |                          |
| violation that did not harm a client's health or safety but had the potential to have harmed a client's health or safety, but was not likely to  |         | by: Based on interview licensee failed to en prevention plan (IAI the required contents)  | and record review, the sure an individual abuse PP) was developed to include  |                |   |       |                          |
| was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the clients).   |         | violation that did no safety but had the policent's health or saccause serious injury was issued at a wide problems are pervaluate that has affective.                  | t harm a client's health or otential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect |                |   |       |                          |
| The findings include:  |         | The findings include  | e:  |                |   |       |                          |
| C1<br>C1 admitted to home care services on May 19,<br>2022, and discharged on March 28, 2023.  |         | C1 admitted to hom  |   |                |   |       |                          |
| C1's service plan was not signed by the client's power of attorney and was not electronically signed by owner (O)-A. The service plan had a handwritten date of May 20, 2022 under O-A's signature. The service plan indicated the client received 4.5 hours of care per day for "basic & medication reminders," but did not specify what the basic services provided were.  C1's record lacked an IAPP which assessed the   |         | power of attorney a signed by owner (O handwritten date of signature. The service received 4.5 hours medication reminde the basic services parts of the services parts. | nd was not electronically )-A. The service plan had a May 20, 2022 under O-A's ice plan indicated the client of care per day for "basic & ers," but did not specify what provided were.           |                |   |       |                          |

Minnesota Department of Health

|                          | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   |      | (X3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|--|---|--|---|------|-------------------------------|--|
|                          |  | H35833  | B. WING                                  |   | 04/1 | )<br>2/2023                   |  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S                           | STATE, ZIP CODE   |      |                               |  |
| COMFOR                   | RTING ANGELS   | 202 HIGH\<br>HAWLEY,  | NAY 10<br>MN 56549                       |   |      |                               |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE      |  |
| 0 810                    | individual, including client's risk of abusing and statements of the taken to minimize the and other vulnerable C2 C2 admitted to home 12, 2020, and dische C2's record did not C2's record lacked client's susceptibility individual, including client's risk of abusing and statements of the taken to minimize the and other vulnerable C3 C3 admitted to home 2022.  | y to abuse by another other vulnerable adults; the ng other vulnerable adults; he specific measures to be ne risk of abuse to this client e adults.  The care services on November arged on March 3, 2023.  The contain a service plan.  The an IAPP which assessed the y to abuse by another other vulnerable adults; the ng other vulnerable adults; the ng other vulnerable adults; the specific measures to be the risk of abuse to this client | 0 810                                    |   |      |                               |  |
|                          | week. The service p  | ours per day, seven days per<br>plan did not identify what<br>ded, who would provide the<br>for the services.   |  |   |      |                               |  |
|                          | client's susceptibility individual, including client's risk of abusing and statements of the content of the content is a statement of the content is a statement of the content in the con | an IAPP which assessed the y to abuse by another other vulnerable adults; the ng other vulnerable adults; he specific measures to be ne risk of abuse to this client e adults.  |  |   |      |                               |  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | •                   | E CONSTRUCTION   | ` '   | TE SURVEY<br>MPLETED     |  |
|--|---|---------------------|--|-------|--------------------------|--|
|  |   | D WINC              |  | С     |                          |  |
|  | H35833  | B. WING             |  | 04/1  | 2/2023                   |  |
| NAME OF PROVIDER OR SUPPLIER  COMFORTING ANGELS  | 202 HIGH\   |                     | STATE, ZIP CODE  |       |                          |  |
| PREFIX (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |  |
| C4's service plan in hours of services pexercise, basic and plan did not identify who would provide the services. The state of September client's wife on Febplan was not signed.  C4's record lacked client's susceptibility individual, including client's risk of abust and statements of taken to minimize the and other vulnerab.  On April 17, 2023, confirmed IAPPs he above mentioned of the confirmation. | ne care services on September arged on February 19, 2023.  Indicated the client received 4.5 er week to include "home skilled services." The service what services were provided, the services, or the rate for ervice plan listed an effective 2, 2022, but was signed by the ruary 12, 2023. The service d by home care staff.  In IAPP which assessed the y to abuse by another yother vulnerable adults; the ing other vulnerable adults; the ing other vulnerable adults; the specific measures to be the risk of abuse to this client le adults.  In 12:40 p.m., owner (O)-A and not been developed for the lients. | 0 810               |  |       |                          |  |
| 0 815<br>SS=F The home care pro-<br>records of each pa-<br>scheduled voluntee<br>services, and of ea   | Employee Records  vider must maintain current d employee, regularly ers providing home care ch individual contractor re services. The records must g information:   | 0 815               |  |       |                          |  |

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| AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | , ,                 | E CONSTRUCTION   | COMPLETED |                          |
|--|--|---------------------|--|-----------|--------------------------|
|  |  |                     |  |           | ;                        |
|  | H35833   | B. WING             |  | 04/1      | 2/2023                   |
| NAME OF PROVIDER OR SUPP   | LIER STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| COMFORTING ANGELS  | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |           |                          |
| PREFIX (EACH DEFICI  | Y STATEMENT OF DEFICIENCIES<br>ENCY MUST BE PRECEDED BY FULL<br>OR LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
| 0 815 Continued From   | n page 81  | 0 815               |  |           |                          |
| (1) evidence of registration, or registration, or statute or other (2) records of cand infection of evaluations; (3) current job qualifications, restaff providing (4) documentate reviews which in needed and trace (5) for individual verification that infection controls ection 144A.4 dates of those (6) documentate required under Each employed least three years care volunteer, employed by or care provider. I operation, empfor three years.  This MN Requibes Based on intervicensee failed contained all of four employees unlicensed perswith records results. | current professional licensure, certification, if licensure, certification is required by this rules; prientation, required annual training ontrol training, and competency description, including esponsibilities, and identification of supervision; tion of annual performance dentify areas of improvement ining needs; any health screenings required by programs established under 798 have taken place and the screenings; and tion of the background study as section 144.057. The record must be retained for at resident a paid employee, home or contractor ceases to be a funder contract with the home of a home care provider ceases loyee records must be maintained the rement is not met as evidenced wiew and record review, the to ensure the employee record of the required content for four of the required for the required content for four of the required for the required for the required for t |                     |  |           |                          |
|  | d not harm a client's health or<br>the potential to have harmed a  |                     |  |           |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ,                 | E CONSTRUCTION   | COMP  | SURVEY                   |
|--------------------------|--|---|---------------------|--|-------|--------------------------|
|                          |  | H35833  | B. WING             |  | 04/1  | 2/2023                   |
|                          | PROVIDER OR SUPPLIER   | 202 HIGH\   |                     | STATE, ZIP CODE  |       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROPERTION (CROSS-REFERENCED TO THE APPR | .D BE | (X5)<br>COMPLETE<br>DATE |
| 0 815                    | cause serious injury was issued at a wid problems are perva failure that has affer a large portion or all. The findings include On April 4, 2023, at requested employed clearance letters, and orientation and train RN-C, ULP-L, and the files were kept in the employees lived over to a staff mem and requested the foffice via fax. All the provided by the time day.  On April 5, 2023, at requested via email including background application, records and job descriptions and ULP-M. Partial to the investigator.  RN-C RN-C was hired August a staff mem and under the investigator. | fety, but was not likely to y, impairment, or death), and espread scope (when sive or represent a systemic cted or has potential to affect I of the clients). | 0 815               | DEFICIENCY)  |       |                          |
|                          | RN-C's employee re required content: -evidence of curren registration, or certi  | ision to the unlicensed staff. ecord lacked the following t professional licensure, fication, if licensure, fication is required by this es;                  |                     |  |       |                          |

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| AND PLAN OF CORRECTION   | ( )  | ` ´                    | E CONSTRUCTION   | COMPLETED     |  |
|--|--|------------------------|--|---------------|--|
|  | 110500   | R WING                 |  | C             |  |
|  | H35833   | D. WING                |  | 04/12/2023    |  |
| NAME OF PROVIDER OR SUF  | PPLIER STREET A  | DDRESS, CITY, S        | STATE, ZIP CODE  |               |  |
| COMFORTING ANGELS  |  | HWAY 10<br>Y, MN 56549 |  |               |  |
| PREFIX (EACH DEF   | RY STATEMENT OF DEFICIENCIES ICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG    | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE COMPLETE |  |
| 0 815 Continued Fr   | om page 83   | 0 815                  |  |               |  |
| -records of or and infection evaluations; -current job do responsibilities providing sup-documentati which identify training need.  ULP-K ULP-K was hid direct care see was terminate.  An employee  ULP-L ULP-L was hid direct care see was terminate.  An employee  ULP-M ULP-M was hid direct care see was terminate. | rientation, required annual training control training, and competency escription, including qualifications, es, and identification of staff ervision; and on of annual performance reviews areas of improvement needed and |                        |  |               |  |
| on January 3<br>contained a c<br>"Congratulati<br>in medication  | 0, 2023. ULP-M's record also ertificate that read, ons, you are not deemed competen administration." The certificate was y 30, 2023 and signed by RN-C.  |                        |  |               |  |
| ULP-M's empred contraction of o  | loyee record lacked the following  |                        |  |               |  |

Minnesota Department of Health

|                          | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL |  |          |                          |
|--------------------------|--|--|---|--|----------|--------------------------|
|                          |  | H35833   | B. WING   |  | 04/1     | ;<br>2/2023              |
| NAME OF F                | PROVIDER OR SUPPLIER   | CTDEET AD  | DDESS CITY S  | STATE, ZIP CODE  | 1 0 17 1 |                          |
| NAIVIE OF F              | ROVIDER OR SUPPLIER  | 202 HIGH   | , ,   | STATE, ZIP CODE  |          |                          |
| COMFOR                   | RTING ANGELS   |  | MN 56549  |  |          |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE    | (X5)<br>COMPLETE<br>DATE |
| 0 815                    | Continued From pa  | ge 84  | 0 815   |  |          |                          |
|                          | evaluations; -current job descriptoresponsibilities, and providing supervision   | tion, including qualifications,<br>I identification of staff<br>on;<br>he background study as  |   |  |          |                          |
|                          | if she should be ver<br>clearance letter was<br>care to clients since<br>and supervision of to<br>not responsible for  | it 2:20 p.m., RN-C was asked rifying the background study s completed prior to providing the ULP work under the direction the RN. RN-C stated she was ULP. RN-C stated, "We're all by do a certain degree as a dy does their job"  |   |  |          |                          |
|                          |  | s of employee file was<br>of a blank checklist was<br>estigator.   |   |  |          |                          |
|                          | No further informati   | on was provided.   |   |  |          |                          |
|                          | TIME PERIOD FOR (21) days  | R CORRECTION: Twenty-One   |   |  |          |                          |
| 0 825<br>SS=C            | 144A.4791, Subd. 1   | HBOR Notification to Client  | 0 825   |  |          |                          |
|                          | client or the client's notice of the rights of the date that service client. The provider efforts to provide notice the client's represcient or client or client's represcient | provider shall provide the representative a written under section 144A.44 before es are first provided to that shall make all reasonable of the rights to the client sentative in a language the resentative can understand. Execute the text of the home care bill of 4A.44, subdivision 1, the ntain the following statement le a complaint with these |   |  |          |                          |

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Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                 | E CONSTRUCTION   | (X3) DATE :<br>COMPL |                          |
|--|---|---------------------|--|----------------------|--------------------------|
|  |   |                     |  | С                    | ;                        |
|  | H35833  | B. WING             |  | 04/1                 | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S      | TATE, ZIP CODE   |                      |                          |
| COMFORTING ANGELS  | 202 HIGH\   | WAY 10              |  |                      |                          |
| - COMI OICHING AICOLLO   | HAWLEY,   | MN 56549            |  |                      |                          |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE                 | (X5)<br>COMPLETE<br>DATE |
| 0 825 Continued From pa  | ge 85   | 0 825               |  |                      |                          |
| offices. "If you have a comperson providing you may call, write, or volume and complete and comperson providing you may call, write, or volume and also contains for Long-Term Care for Mental Health a Disabilities."  The statement shown number, website and address, and street Health Facility Compensation of the Ombudsman for Long the Ombudsman for Long the Ombudsman Developmental Disalso include the hound address, email, teles title of the person a problems or complete also include a state provider will not retain the care bill of rigacknowledgment on home care bill of rigacknowledgment more the client's representation of the client's represent | plaint about the provider or the pur home care services, you isit the Office of Health Facility tota Department of Health. Incert the Office of Ombudsman or the Office of Ombudsman and Developmental address, email address, mailing address of the Office of plaints at the Minnesota of the Office of the Ing-Term Care, and the Office for Mental Health and abilities. The statement should me care provider's name, whone number, and name or the provider to whom aints may be directed. It must ment that the home care aliate because of a complaint, provider shall obtain written of the client's receipt of the plats or shall document why an annot be obtained. The lay be obtained from the client sentative. Acknowledgment of the client is not met as evidenced and record review, the sure the current Minnesota alights was provided to the resentative prior to initiation of four clients (C1, C2, C3, C4) |                     |  |                      |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | COMP  | LETED                    |
|--------------------------|--|---|---------------------|--|-------|--------------------------|
|                          |  | 1125022   | B WING              |  | 04/4  |                          |
|                          |  | H35833  | D. WIIVO            |  | 04/1  | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE  |       |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH\<br>HAWLEY,  | WAY 10<br>MN 56549  |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE |
| 0 825                    | Continued From pa  | ge 86   | 0 825               |  |       |                          |
|                          | violation that has not a minimal impact or health or safety), and scope (when proble a systemic failure the  | ed in a level one violation (a of potential to cause more than in the client and does not affect and was issued at a widespread are pervasive or represent nat has affected or has large portion or all of the  |                     |  |       |                          |
|                          | The findings include   | e:  |                     |  |       |                          |
|                          |  | ne care services on May 19,<br>ed on March 28, 2023.  |                     |  |       |                          |
|                          | power of attorney a signed by owner (O handwritten date of signature. The serv received 4.5 hours medication reminded the basic services page 1.5. | as not signed by the client's nd was not electronically )-A. The service plan had a May 20, 2022 under O-A's ice plan indicated the client of care per day for "basic & ers," but did not specify what provided were. The service cked indicating the client Care Bill of Rights. |                     |  |       |                          |
|                          |  | evidence the client received<br>e Care Bill of Rights prior to  |                     |  |       |                          |
|                          | (FM)-D stated she  | , at 2:15 p.m., family member did not recall receiving a Home and did not recall receiving a  |                     |  |       |                          |
|                          |  | ne care services on November<br>narged on March 3, 2023.  |                     |  |       |                          |
|                          | C2's record did not  | contain a service plan.   |                     |  |       |                          |

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|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | ` '   | COMPLETED                |  |
|--------------------------|---|--|---------------------|--|-------|--------------------------|--|
|                          |   |  | D MINO              |  | C     |                          |  |
|                          |   | H35833   | B. WING             |  | 04/1  | 2/2023                   |  |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | STATE, ZIP CODE  |       |                          |  |
| COMFOR                   | RTING ANGELS  | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |       |                          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |  |
| 0 825                    | Continued From page   | ge 87  | 0 825               |  |       |                          |  |
|                          |   | evidence the client received<br>e Care Bill of Rights prior to   |                     |  |       |                          |  |
|                          | recall seeing a Hom   | FM-H stated she did not<br>ne Care Bill of Rights when C2<br>s and did not recall seeing a   |                     |  |       |                          |  |
|                          | C3<br>C3 admitted to hom<br>2022  | e care services on August 23,  |                     |  |       |                          |  |
|                          | client had twice dail services for three he week. The service provides services were provided services, or the rate | ned service plan indicated the y "basic and skilled nursing" ours per day, seven days per plan did not identify what ded, who would provide the services. The service ocked indicating the client Care Bill of Rights. |                     |  |       |                          |  |
|                          |   | evidence the client received<br>e Care Bill of Rights prior to   |                     |  |       |                          |  |
|                          | didn't remember ever<br>getting any paperwo   | er seeing a service plan or or ork upon admission. C3 stated ceiving the Home Care Bill of   |                     |  |       |                          |  |
|                          |   | e care services on September<br>rged on February 19, 2023.   |                     |  |       |                          |  |
|                          | hours of services to  | dicated the client received 2.5 include "home exercise, rvices" on Mondays and 2   |                     |  |       |                          |  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|---|--|--|--|--|-------------------------------|--------------------------|
|   |  | H35833   | B. WING                                  |  | 04/1                          | )<br>2/2023              |
| NAME OF I   | PROVIDER OR SUPPLIER   |  | DRESS CITY S                             | STATE, ZIP CODE  | 1 0 1, 1                      |                          |
|   |  | 202 HIGH   | ,  | 717(12, 211 °CODE  |                               |                          |
| COMFOR  | RTING ANGELS   | HAWLEY,  | MN 56549                                 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 825   | services" on Fridays care per week. The what services were the services, or the service plan listed a 2, 2022, but was signed by home care a box checked indice. Home Care Bill of Formal Services. FM-X statements and the Minnesota Home initiation of services. FM-X statements and the services. FM-X statements and the services. FM-X statements and services plan, additional forms with Rights.  On April 17, 2023, a everyone gets the Formal services and she received it. | ercise, basic and skilled s, for a total of 4.5 hours of service plan did not identify provided, who would provide rate for the services. The an effective date of September and by the client's wife on The service plan was not re staff. The service plan had eating the client received the Rights.  evidence the client received the Rights prior to s.  t 1:10 p.m. FM-X stated they erwork when C4 admitted for red they had asked O-A at copies of admission amber but didn't get anything ary. FM-X stated they signed including the February 12, but did not recall getting any h it, including the Bill of  at 12:30 p.m., O-A stated Home Care Bill of Rights upon thought all the clients had | 0 825                                    |  |                               |                          |
| 0 860<br>SS=D   | -  | 3 Comprehensive Assessment   | 0 860                                    |  |                               |                          |

Minnesota Department of Health

|                          | OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | 1 ` '               |  | ` ′   | (3) DATE SURVEY<br>COMPLETED |  |
|--------------------------|---|--|---------------------|--|-------|------------------------------|--|
|                          |   | H35833   | B. WING             |  | 04/1  | ;<br>2/2023                  |  |
|                          | PROVIDER OR SUPPLIER  | 202 HIGH\  | WAY 10              | STATE, ZIP CODE  |       |                              |  |
| OOMI OI                  | THIOANOLLO  | HAWLEY,  | MN 56549            |  |       |                              |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE     |  |
| 0 860                    | Continued From pa   | ge 89  | 0 860               |  |       |                              |  |
|                          | comprehensive hor individualized initial conducted in person the services are proprofessionals, the aconducted by the approfessionals, the aconducted by the approfessionals, the aconducted by the approfessionals, the aconducted by the approvided.  (b) Client monitoring conducted in the client first provided.  (c) Ongoing client number of client aconducted in the needs of the days from the last of monitoring and reast at the client's reside of telecommunications at the client's reside of telecommunications at the client's reside of telecommunications that meeds that | des being provided are ne care services, an assessment must be no by a registered nurse. When ovided by other licensed health ssessment must be opropriate health professional, ent must be completed within ate that home care services of and reassessment must be ent's home no more than 14 that home care services are nonitoring and reassessment as needed based on changes client and cannot exceed 90 ate of the assessment. The essessment may be conducted ence or through the utilization on methods based on practice to the individual client's needs. The individual client's needs and record review, the ensure the registered nurse comprehensive reassessment and ition for one of one clients eviewed.  The defendance of the individual client's needs and record review, the ensure the registered nurse comprehensive reassessment and ition for one of one clients eviewed.  The defendance of the individual client's needs are affected or one or a dients are affected or one or a dients are affected or one or a dients are involved or the |                     |  |       |                              |  |

Minnesota Department of Health

|                          | OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ` ′               | E CONSTRUCTION   | COMPI | LETED                    |
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|                          |  |   |                     |  | С     | ;                        |
|                          |  | H35833  | B. WING             |  | 04/1  | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |       |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH  | WAY 10<br>MN 56549  |  |       |                          |
| 240.15                   | CLINANA DV CTA   | <u> </u>  |                     |  | ON    | ()(5)                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE |
| 0 860                    | Continued From pa  | ge 90   | 0 860               |  |       |                          |
|                          | situation has occurr   | red only occasionally).   |                     |  |       |                          |
|                          | The findings include   | e:  |                     |  |       |                          |
|                          | 2, 2022, and discha  | ne care services on September<br>orged on February 19, 2023.<br>It have any documentation of<br>es.   |                     |  |       |                          |
|                          | hours of services per exercise, basic and plan did not identify who would provide the services. The services are client's wife on February client's wife on February contracts and the services of September client's wife on February contracts.  | dicated the client received 4.5 er week to include "home skilled services." The service what services were provided, the services, or the rate for ervice plan listed an effective 2, 2022, but was signed by the ruary 12, 2023. The service ture from a home care agency  |                     |  |       |                          |
|                          | personnel (ULP) ind<br>C4's wife reported has having pain. Since<br>his right arm and the<br>weight on his left lead<br>the ULP contacted the recommendation<br>non-emergency line<br>assess his pain." The<br>medical transport and<br>the hospital. The properties of the RN was notified<br>the RN was entered next progress note<br>2023, where a ULP<br>bedridden and need<br>hoursclient does in | dicated on January 6, 2023, he fell a few days earlier and gnificant bruising was noted to e client was not able to bear g. The progress note indicated the office and staff were given in "to contact the e for medical transport to he client's wife called for and the client was admitted to ogress note did not indicate if and no documentation from d in the client's record. The entered was on February 14, documented, "client is dis brief changed every two not have appetite for food, he in of applesauce." C4's record any RN visits, assessments. |                     |  |       |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 |                               | COMPLETED   |        |
|--------------------------|---|--|---------------------|-------------------------------|---|--------|
|                          |   | 110 = 000  | R WING              |                               | C   |        |
|                          |   | H35833   | B. WING             |                               | 04/1  | 2/2023 |
| NAME OF I                | PROVIDER OR SUPPLIER  |  | , ,                 | STATE, ZIP CODE               |   |        |
| COMFOR                   | RTING ANGELS  | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |                               |   |        |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |  | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOUL | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |        |
| 0 860                    | Continued From pa   | ge 91  | 0 860               |                               |   |        |
|                          | or other documentation from the RN after he returned home. The client passed away at home on February 18, 2023.   |  |                     |                               |   |        |
|                          | On April 14, 2023 at 1:10 p.m. family member (FM)-X stated the client had been hospitalized and did a short stay at a long term care facility before transferring back home. FM-X did not recall a nurse coming out to do a reassessment after he returned.                   |  |                     |                               |   |        |
|                          | On April 17, 2023, at 12:45 p.m., owner (O)-A stated she would have to go back and look at the client's record to see if an assessment was done and that it would be the RN's responsibility to get assessments completed.  |  |                     |                               |   |        |
|                          | The licensee's Assessment-Comprehensive Services policy, last updated April 5, 2023, indicated ongoing client monitoring and reassessment must be conducted as needed based on changes in the needs of the client but cannot exceed 90 days from the last date of assessment. |  |                     |                               |   |        |
|                          | No further informati  | on was provided.   |                     |                               |   |        |
|                          | TIME PERIOD FOR<br>Twenty-One (21) da   |  |                     |                               |   |        |
|                          | 144A.4791, Subd. 9<br>Implementation & R  |  | 0 865               |                               |   |        |
|                          | care services are finding provider shall finalized plan.  (b) The service plan  | days after the date that home st provided, a home care e a current written service and any revisions must or other authentication by the |                     |                               |   |        |

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| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549  202 HIGHWAY 10 HAWLEY, MN 56549  CAMPLET NO FREFIX FROM PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  0 865 Continued From page 92 home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide dinformation to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.  (c) The home care provider must implement and provide all services required by the current service plan.  (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.  (e) Staff providing home care services must be informed of the current written service plan.  This MN Requirement is not met as evidenced by; Based on interview and record review, the licensee failed to ensure the service plan included a signature or other authentication by the provider | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION (X A. BUILDING:   |                |   | (X3) DATE SURVEY<br>COMPLETED |          |
|---|---|--|--|----------------|---|-------------------------------|----------|
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 865  Continued From page 92 home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care. (c) The home care provide must implement and provide all services required by the current service plan. (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable. (e) Staff providing home care services must be informed of the current written service plan.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included  |   |  | H35833   | B. WING        |   |                               |          |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 865  Continued From page 92  home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.  (c) The home care provider must implement and provide all services required by the current service plan.  (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.  (e) Staff providing home care services must be informed of the current written service plan.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure the service plan included  | NAME OF   | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S | STATE, ZIP CODE   |                               |          |
| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  0 865  Continued From page 92  home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.  (c) The home care provider must implement and provide all services required by the current service plan.  (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.  (e) Staff providing home care services must be informed of the current written service plan.  This MN Requirement is not met as evidenced by:  Based on interview and record review, the licensee failed to ensure the service plan included  | COMFO   | COMFORTING ANGELS  |  |                |   |                               |          |
| home care provider and by the client or the client's representative documenting agreement on the services to be provided. The service plan must be revised, if needed, based on client review or reassessment under subdivisions 7 and 8. The provider must provide information to the client about changes to the provider's fee for services and how to contact the Office of the Ombudsman for Long-Term Care.  (c) The home care provider must implement and provide all services required by the current service plan.  (d) The service plan and revised service plan must be entered into the client's record, including notice of a change in a client's fees when applicable.  (e) Staff providing home care services must be informed of the current written service plan.  This MN Requirement is not met as evidenced by:  Based on interview and record review, the licensee failed to ensure the service plan included   | PRÉFIX  | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | PREFIX         | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE                          | COMPLETE |
| to document agreement on the services to be provided for four clients (C1, C2, C3, C4) with records reviewed.  This practice resulted in a level two violation (a violation that did not harm a client's health or safety but had the potential to have harmed 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 large portion or all of the clients).  The findings include:  | 0 865   | home care provider client's representation the services to be must be revised, if review or reassessing. The provider must client about change services and how to Ombudsman for Lo (c) The home care provide all services service plan.  (d) The service plan must be entered into notice of a change applicable.  (e) Staff providing hinformed of the current by:  Based on interview licensee failed to enasted a signature or other to document agreed provided for four of with records review.  This practice results violation that did not safety but had the provided for saccause serious injury was issued at a wide problems are pervasallure that has affer a large portion or all all the provided for or all large portion or all l | r and by the client or the ve documenting agreement be provided. The service plan needed, based on client ment under subdivisions 7 and st provide information to the est to the provider's fee for contact the Office of the ing-Term Care. provider must implement and required by the current and required by the current and revised service plan to the client's record, including in a client's fees when some care services must be rent written service plan. The service plan included and record review, the insure the service plan included authentication by the provider ment on the services to be four clients (C1, C2, C3, C4) ed.  The service of the service plan included authentication by the provider ment on the services to be four clients (C1, C2, C3, C4) ed.  The service of the services to be four clients (C1, C2, C3, C4) ed. |                |   |                               |          |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED  |       |                          |
|--|---|---|---------------------|--|-------|--------------------------|
|  |   | H35833  | B. WING             |  | 04/1  | )<br>2/2023              |
|  | PROVIDER OR SUPPLIER  | 202 HIGH\   |                     | STATE, ZIP CODE  |       |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| 0 865  | C1's service plan we power of attorney a signed by owner (O handwritten date of signature. The service received 4.5 hours medication reminded the basic services plan indicated the conservices was \$32.5 and \$34.50 per hour On April 12, 2023 a requested copies of show the client agreed to a cost of 2023, at 4:51 p.m., additional service perfective date of chaindicated the client for "a couple of wear The service plan lactional service plan laction or his legal resignature from the laction of the service for 24 hour care. The signature from the complex of the service for 24 hour care. The signature from the complex of the signature from the complex of the signature. On March 24, 2023 | ne care services on May 19, and on March 28, 2023.  as not signed by the client's and was not electronically )-A. The service plan had a May 20, 2022 under O-A's ice plan indicated the client of care per day for "basic & ers," but did not specify what provided were. The service ost for unlicensed personnel of per hour during the week of the converse plans that would even the converse plans that would even to 24 hour care and \$730 per day. On April 16, O-A emailed the investigator lans. A service plan with an enge of June 4, 2022, would be getting 24 hour care exist at a rate of \$700 per day. Exist at a rate of \$700 per | 0 865               |  |       |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |  | A. BUILDING:   |                     | COMPLETED  |                        |                          |
|--|--|--|---------------------|--|------------------------|--------------------------|
|  |  | H35833   | B. WING             |  | C<br><b>04/12/2023</b> |                          |
| NAME OF I  | PROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                        |                          |
| COMFOR   | RTING ANGELS   | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |                        |                          |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                  | (X5)<br>COMPLETE<br>DATE |
| 0 865  | Continued From pa  | ge 94  | 0 865               |  |                        |                          |
|  | of care would be an month to \$700 per o   | d been told verbally the cost<br>ywhere from \$25,000 per<br>day and was not sure what<br>be getting charged for   |                     |  |                        |                          |
|  | C2<br>C2 admitted to home care services on November<br>12, 2020, and discharged on March 3, 2023.  |  |                     |  |                        |                          |
|  | C2's record did not contain a service plan.  |  |                     |  |                        |                          |
|  | On March 28, 2023, FM-H stated she did not recall seeing a service plan.   |  |                     |  |                        |                          |
|  | C3 C3 admitted to home care services on August 23, 2022.   |  |                     |  |                        |                          |
|  | C3's undated service plan indicated the client had twice daily "basic and skilled nursing" services for three hours per day, seven days per week. The service plan did not identify what services were provided, who would provide the services, or the rate for the services. The service plan was signed by C3 but did not have a date listed. The service plan lacked a signature from the home care agency representative. |  |                     |  |                        |                          |
|  | didn't remember ev<br>getting any paperwo<br>she was not sure w  | at 12:15 p.m., C3 stated she<br>er seeing a service plan or<br>ork upon admission. C3 stated<br>hat the cost of care was and<br>nce was covering everything. |                     |  |                        |                          |
|  | 2, 2022, and discha  | ne care services on September or services on February 19, 2023.  |                     |  |                        |                          |
|  | C4's service plan in   | dicated the client received 2.5  |                     |  |                        |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                | E CONSTRUCTION  | COMPLETED |                          |
|--------------------------|---|--|--------------------|---|-----------|--------------------------|
|                          |   | H35833   | B. WING            |   | 04/1      | )<br>2/2023              |
| NAME OF P                | ROVIDER OR SUPPLIER   | STREET AD  | DRESS, CITY, S     | STATE, ZIP CODE   |           |                          |
| COMFOR                   | TING ANGELS   | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549 |   |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  |                    | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE      | (X5)<br>COMPLETE<br>DATE |
|                          | basic and skilled se hours of "home exe services" on Fridays care per week. The what services were the service plan listed a 2, 2022, but was signature from a horepresentative.  On April 14, 2023 and did not get any paper services. FM-X statemultiple times to ge paperwork in Septe from her until Januar some paperwork, in 2023, service plan, anything in writing a increasing the number of the cost for services. The licensee's Service plan, anything in writing a increasing the number of the cost for services. The licensee's Service plan, anything in writing a increasing the number of the cost for services. The licensee's Service plan, anything in writing a increasing the number of the cost for services. | rinclude "home exercise, rivices" on Mondays and 2 rcise, basic and skilled s, for a total of 4.5 hours of service plan did not identify provided, who would provide rate for the services. The in effective date of September and by the client's wife on The service plan lacked a me care agency  1:10 p.m. FM-X stated they erwork when C4 admitted for ed they had asked O-A t copies of admission mber but didn't get anything ary. FM-X stated they signed acluding the February 12, but did not recall seeing about the cost of care or ber of hours of care received.  1:130 p.m., O-A stated all a service plan and that it was here were changes to services ces.  1:12:130 p.m., O-A stated all a service plan and that it was here were changes to services ces.  1:12:131 policy, last revised dicated clients would be n about changes to the ervices and all revisions would ient's clinical record. | 0 865              | DEFICIENCY)   |           |                          |
|                          | TIME PERIOD FOR (21) days   | R CORRECTION: Twenty-one   |                    |   |           |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |   | (X3) DATE SURVEY<br>COMPLETED |                          |
|--|---|--|---|-------------------------------|--------------------------|
|  |   |  |   |                               | <b>;</b>                 |
|  | H35833  | B. WING                                  |   | 04/1                          | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S                           | STATE, ZIP CODE   |                               |                          |
| COMFORTING ANGELS  | 202 HIGH'<br>HAWLEY,  | WAY 10<br>MN 56549                       |   |                               |                          |
| PREFIX (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) | _D BE                         | (X5)<br>COMPLETE<br>DATE |
| 0 870 Continued From pa  | ge 96   | 0 870                                    |   |                               |                          |
| 0 870<br>SS=F 144A.4791, Subd. 9   | (f) Content of Service Plan   | 0 870                                    |   |                               |                          |
| (f) The service plan (1) a description of provided, the fees f of each service, acc review or assessme (2) the identification staff who will provid (3) the schedule an reviews or assessm (4) the schedule an providing home car (5) a contingency p (i) the action to be t provider and by the representative if the provided; (ii) information and client's representati provider; (iii) names and con client wishes to hav if there is a significa client's condition; an (iv) the circumstanc medical services ar consistent with cha declarations made chapters.  This MN Requirement by: Based on interview licensee failed to en the required conten C2, C3, C4) with re | the home care services to be or services, and the frequency cording to the client's current ent and client preferences; of the staff or categories of e the services; d methods of monitoring nents of the client; d methods of monitoring staff e services; and lan that includes: aken by the home care client or client's e scheduled service cannot be a method for a client or ve to contact the home care tact information of persons the re notified in an emergency or ant adverse change in the nod ses in which emergency e not to be summoned peters 145B and 145C, and by the client under those ent is not met as evidenced and record review, the nsure service plans included to for four of four clients (C1, |  |   |                               |                          |

Minnesota Department of Health

STATE FORM JRM011 If continuation sheet 97 of 131

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | COMPLETED |                          |
|--------------------------|--|---|---------------------|--|-----------|--------------------------|
|                          |  | 1125022   | B WING              |  | 04/4      |                          |
|                          |  | H35833  | D. WIIVO            |  | 04/1      | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH  |                     |  |           |                          |
|                          |  |   | MN 56549            |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE     | (X5)<br>COMPLETE<br>DATE |
| 0 870                    | Continued From pa  | ge 97   | 0 870               |  |           |                          |
|                          | safety but had the posterior client's health or satisfication cause serious injury is issued at a wides are pervasive or reposterior.  | t harm a client's health or otential to have harmed a fety, but was not likely to y, impairment, or death), and pread scope (when problems present a systemic failure that the potential to affect a large clients).  |                     |  |           |                          |
|                          | The findings include   | <del>2</del> :  |                     |  |           |                          |
|                          | C1 C1 admitted to home care services on May 19, 2022, and discharged on March 28, 2023.  |   |                     |  |           |                          |
|                          | power of attorney a signed by owner (O handwritten date of signature. The serv received 4.5 hours medication reminde the basic services plan indicated the c   | as not signed by the client's nd was not electronically )-A. The service plan had a May 20, 2022, under O-A's ice plan indicated the client of care per day for "basic & ers," but did not specify what provided were. The service ost for unlicensed personnel 0 per hour during the week r on weekends. |                     |  |           |                          |
|                          | content:  -a description of the provided, the fees for each service, according to the each service of each service of each service, according to the each service of the each service of the each each each each each each each ea | nethods of monitoring reviews<br>the client;<br>nethods of monitoring staff<br>e services; and  |                     |  |           |                          |

Minnesota Department of Health

| AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER: |   | A. BUILDING:   |                     | COMPLETED   |      |                          |
|---|---|--|---------------------|---|------|--------------------------|
|   |   | H35833   | B. WING             |   | 04/1 | )<br>2/2023              |
| NAME OF I   | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE   |      |                          |
| COMEO   | RTING ANGELS  | 202 HIGH\  | WAY 10              |   |      |                          |
| COMPOR  | TING ANGELS   | HAWLEY,  | MN 56549            |   |      |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |      | (X5)<br>COMPLETE<br>DATE |
| 0 870   | Continued From pa   | ge 98  | 0 870               |   |      |                          |
|   | -the action to be tak   | client's representative if the   |                     |   |      |                          |
|   | (FM)-D stated she of service plan and had of care would be an month to \$700 per of                         | , at 2:15 p.m., family member did not recall receiving any ad been told verbally the cost sywhere from \$25,000 per day and was not sure what be getting charged for   |                     |   |      |                          |
|   | C2 C2 admitted to home care services on November 12, 2020, and discharged on March 3, 2023.                 |  |                     |   |      |                          |
|   | included the following a description of the provided, the fees for each service, accordingly assessments.   | contain a service plan that ng required content: home care services to be or services, and the frequency cording to the client's current ent and client preferences; the staff or categories of staff is services;   |                     |   |      |                          |
|   | or assessments of the schedule and reproviding home carea contingency plan                                  | nethods of monitoring staff<br>e services; and<br>that includes:   |                     |   |      |                          |
|   | and by the client or scheduled service of information and a representative to contact client wishes to have | cen by the home care provider client's representative if the cannot be provided; method for a client or client's intact the home care provider; t information of persons the representation of persons the representation of persons the representation of persons in th |                     |   |      |                          |
|   | client's condition; au -the circumstances   | ant adverse change in the nd in which emergency medical be summoned consistent with  |                     |   |      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                |   | (X3) DATE SURVEY<br>COMPLETED |                  |
|---|--|---|----------------|---|-------------------------------|------------------|
|   |  |   | 7 50125        |   |                               | •                |
|   |  | H35833  | B. WING        |   |                               | 2/2023           |
| NAME OF   | PROVIDER OR SUPPLIER   | STREET AD   | DRESS, CITY, S | TATE, ZIP CODE  |                               |                  |
|   |  | 202 HIGH  |                | <b>,</b>  |                               |                  |
| COMFO   | RTING ANGELS   |   | MN 56549       |   |                               |                  |
| (X4) ID   |  | TEMENT OF DEFICIENCIES  | ID             | PROVIDER'S PLAN OF CORRECTI   |                               | (X5)             |
| PREFIX<br>TAG   | ,  | MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY) |                               | COMPLETE<br>DATE |
| 0 870   | Continued From pa  | ge 99   | 0 870          |   |                               |                  |
|   | chapters 145B and<br>by the client under t   | 145C, and declarations made those chapters.   |                |   |                               |                  |
|   | On March 28, 2023 recall seeing a serv   | , FM-H stated she did not<br>rice plan.   |                |   |                               |                  |
|   | C3<br>C3 admitted to hom<br>2022.  | ne care services on August 23,  |                |   |                               |                  |
|   | twice daily "basic are three hours per day service plan did not provided, who would rate for the services by C3 but did not had plan lacked a signal agency representate the following required a description of the provided, the fees for each service, acception of the provided, the fees for each service, acception of who will provide the ethe action of the schedule and reproviding home care a contingency pland the action to be taken and by the client or scheduled service of the scheduled servi | chome care services to be or services, and the frequency cording to the client's current ent and client preferences; the staff or categories of staff services; methods of monitoring reviews the client; methods of monitoring staff e services; and that includes: cen by the home care provider client's representative if the |                |   |                               |                  |
|   | didn't remember ev<br>getting any paperwo<br>she was not sure w  | er seeing a service plan or or ork upon admission. C3 stated hat the cost of care was and not was covering everything.  |                |   |                               |                  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING:  |                     | (X3) DATE SURVEY<br>COMPLETED   |                 |                          |
|---|--|---|---------------------|---|-----------------|--------------------------|
|   |  | H35833  | B. WING             |   | C<br>04/12/2023 |                          |
| NAME OF I   | PROVIDER OR SUPPLIER   | STREET ADD  | DRESS, CITY, S      | STATE, ZIP CODE   |                 |                          |
| COMFOR  | RTING ANGELS   | 202 HIGHV<br>HAWLEY,  | NAY 10<br>MN 56549  |   |                 |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE           | (X5)<br>COMPLETE<br>DATE |
| 0 870   | Continued From page 100  |   | 0 870               |   |                 |                          |
|   | C4's service plan in hours of services to basic and skilled se hours of "home exe services" on Fridays care per week. The what services were the services, or the service plan listed a 2, 2022, but was significant to 2, 2022, but was significant to 2, 2022, but was significant to 2, 2022, but was significa | dicated the client received 2.5 include "home exercise, rvices" on Mondays and 2 rcise, basic and skilled s, for a total of 4.5 hours of service plan did not identify provided, who would provide rate for the services. The an effective date of September and by the client's wife on The service plan lacked a me care agency |                     |   |                 |                          |
|   | did not get any paper services. FM-X statemultiple times to get paperwork in Septer from her until Januar some paperwork, in 2023, service plan, anything in writing a increasing the number of the service plan late content:  -a description of the provided, the fees for service, according to the identification of who will provide the the schedule and red or assessments of the service and red assessments of the service and red assessments of the service.  | nethods of monitoring reviews   |                     |   |                 |                          |

| Minnesota Department of Health |  |  |                     |  |                  |                          |  |
|--------------------------------|--|--|---------------------|--|------------------|--------------------------|--|
|                                | T OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA  | (X2) MULTIPL        | E CONSTRUCTION   | (X3) DATE SURVEY |                          |  |
| AND PLAN                       | OF CORRECTION  | IDENTIFICATION NUMBER:   | A. BUILDING:        |  | COMP             | LETED                    |  |
|                                |  |  |                     |  | l c              | ;                        |  |
|                                |  | H35833   | B. WING             |  | 04/1             | 2/2023                   |  |
| NAME OF F                      | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |                  |                          |  |
| COMFOR                         | TINIO ANOFI O  | 202 HIGH\  | WAY 10              |  |                  |                          |  |
| COMFORTING ANGELS HAWLEY       |  |  | MN 56549            |  |                  |                          |  |
| (X4) ID<br>PREFIX<br>TAG       | RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL  |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE             | (X5)<br>COMPLETE<br>DATE |  |
| 0 870                          | Continued From pa  | ge 101   | 0 870               |  |                  |                          |  |
| 0 880<br>SS=F                  | providing home carrance a contingency plantate action to be taken and by the client or scheduled service of the clients should have they included all the they included all they included all they included all the they included all they inclu | e services; and that includes: sen by the home care provider client's representative if the cannot be provided at 12:30 p.m., O-A stated all a service plan and thought e required content.  CORRECTION: ays | 0 880               |  |                  |                          |  |
|                                | or complaints. A ho  | me care provider must have a conduct investigations of   |                     |  |                  |                          |  |

Minnesota Department of Health

requested.

complaints made by the client or the client's

representative about the services in the client's

plan that are or are not being provided or other

items covered in the client's home care bill of

rights. This complaint system must provide

reasonable accommodations for any special

needs of the client or client's representative if

(b) The home care provider must document the

complaint, name of the client, investigation, and

STATE FORM 6899 If continuation sheet 102 of 131 JRM011

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ,                 | E CONSTRUCTION   | COMPLETED |                          |
|--------------------------|--|--|---------------------|--|-----------|--------------------------|
|                          |  |  |                     |  | С         |                          |
|                          |  | H35833   | B. WING             |  | 04/1      | 2/2023                   |
| NAME OF P                | ROVIDER OR SUPPLIER  | STREET ADI   | ORESS, CITY, S      | STATE, ZIP CODE  |           |                          |
| COMFOR                   | TING ANGELS  | 202 HIGH\<br>HAWLEY,   | WAY 10<br>MN 56549  |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   |  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |           | (X5)<br>COMPLETE<br>DATE |
| 0 880                    | Continued From page  | ge 102   | 0 880               |  |           |                          |
|                          | resolution of each of provider must main regarding complaint the complaint was reprovider's investigated complaint. This comeach event for at lease the entry and must be a for review.  (c) The required confor written notice to representative that it (1) the client's right provider about the second the home care provider about the second that negative for a cation that negative for a complaint made the client or the client that against retaliation and the client or the clien | complaint filed. The home care tain a record of all activities its received, including the date eceived, and the home care tion and resolution of the inplaint record must be kept for ast two years after the date of available to the commissioner includes: to complain to the home care services received; of the person or persons with ider to contact with ider to contact with ider to contact with ider to contact with its prohibited coording to paragraph (d). Evider must not take any ly affects a client in retaliation de or a concern expressed by int's representative.  The provider is prohibited cording to paragraph (d). Evider must not take any ly affects a client in retaliation de or a concern expressed by int's representative.  The provider is prohibited cording to paragraph (d). Evider must not take any ly affects a client in retaliation de or a concern expressed by int's representative.  The provider is prohibited cording to paragraph (d). Evider must not take any ly affects a client in retaliation de or a concern expressed by int's representative.  The provider is prohibited cording to paragraph (d). Evider must not take any ly affects a client in retaliation de or a concern expressed by int's representative.  The provider is prohibited cording to paragraph (d). Evider must not take any ly affects a client in retaliation de or a concern expressed by int's representative. |                     |  |           |                          |
|                          | violation that did not safety but had the p  | •  |                     |  |           |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | COMP | PLETED                   |
|--------------------------|--|---|---------------------|--|------|--------------------------|
|                          |  | H35833  | B. WING             |  | 04/1 | 2/ <b>2023</b>           |
|                          | PROVIDER OR SUPPLIER   | 202 HIGH  | , ,                 | STATE, ZIP CODE  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| 0 880                    | was issued at a wide problems are pervaluation failure that has affer a large portion or all. The findings include On April 4, 2023, at stated the agency has complaints. O-A state feedback from client or issues and their canything documents. C1  On March 24, 2023 (FM)-D stated she had reported to the bill because she that staff were not personal use.  On March 27, 2023 she had reported to missing two guns at to her that she suspection (ULP)-M might have on the concerns on his bill conduct or misapprowas asked again if the concer | y, impairment, or death), and espread scope (when sive or represent a systemic cted or has potential to affect I of the clients).  12:30 p.m., owner (O)-A ad not had any recent ted she had not heard any its or staff regarding concerns complaint log did not have ed in it.  4 at 2:15 p.m., family member had asked O-A questions on e was being billed for hours bresent in the home. FM-D eed concerns to O-A that staff using C1's credit card for  5 at 9:15 a.m., FM-D stated O-A that C1 was potentially and that O-A had replied back bected unlicensed personnel | 0 880               |  |      |                          |
|                          | month's charges to right so it was credi   | ad brought concerns over one her attention and "she was ted back." O-A stated she did ncerns involving staff using  |                     |  |      |                          |

Minnesota Department of Health

|                          |   |  | (X3) DATE<br>COMP   | SURVEY   |        |                          |
|--------------------------|---|--|---------------------|--|--------|--------------------------|
|                          |   | H35833   | B. WING             |  | 04/1   | 2/ <b>2023</b>           |
|                          | PROVIDER OR SUPPLIER  | 202 HIGH   | , ,                 | STATE, ZIP CODE  |        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE | (X5)<br>COMPLETE<br>DATE |
| 0 880                    | assistant (AA)-I star have 24 hour care it or they would be sle stated "she'll bill like time but in all reality isn't someone there was "well aware of been notified by her personal items bein staff using his credit themselves. AA-I stallegations the clier did not know any of allowed to do billing.  O-A failed to document the inverse complaint.  C2  On March 28, 2023 asked O-A question showed \$341,288.1 raised concerns regulated to document the inverse complaint.  C3  O-A failed to document the inverse complaint.  C3  On April 4, 2023, at was not aware of an involving C2's service.  C3  On April 4, 2023, at was not aware of an involving C2's service. | ersonal use.  at 8:20 a.m., administrative ted O-A had pushed C1 to out staff weren't always there eeping while on the clock. AA-I e someone is there the whole y, the majority of the time there e all the time." AA-I stated O-A what was going on" and had reself and other staff about his ig taken by caregivers and t card for things for tated she was aware of at was being charged a lot but her details as the only person was O-A.  Then the complaint and failed vestigation and resolution of the due. In addition, FM-H garding C2's care.  1:20 p.m., O-A stated she my concerns or complaints ces or billing.  Then the complaint and failed vestigation and resolution of the complaint services or the co | 0 880               |  |        |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE | SURVEY<br>PLETED         |
|--------------------------|---|--|---------------------|--|-----------|--------------------------|
|                          |   | H35833   | B. WING             |  |           | C<br><b>12/2023</b>      |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE   |           |                          |
| COMFOR                   | RTING ANGELS  | 202 HIGH   |                     |  |           |                          |
|                          |   |  | , MN 56549          |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPIDE DEFICIENCY) | OULD BE   | (X5)<br>COMPLETE<br>DATE |
| 0 880                    | Continued From pa   | ge 105   | 0 880               |  |           |                          |
|                          | voiced concerns to  | at 12:20 p.m., C3 stated she O-A regarding possible theft ications from her home.  |                     |  |           |                          |
|                          |   | nent the complaint and failed restigation and resolution of  |                     |  |           |                          |
|                          | _   | 1:35 p.m., O-A stated she ny concerns with services or services or billing.  |                     |  |           |                          |
|                          | _   | t 1:15 p.m. FM-X stated she is to O-A regarding the client's insurance claims.   |                     |  |           |                          |
|                          |   | nent the complaint and failed restigation and resolution of  |                     |  |           |                          |
|                          | would frequently getheir family members saying they had been why something was son called wanting four visits when standifferent client's fand charged for visits when stated she was directly to O-A and she was | at 8:20 a.m., AA-I stated she at calls from many clients or as with concerns on billing an double billed or didn't know billed. AA-I stated one client's to know why he was billed for an only came twice and a anily called after they were and there staff didn't show up. AA-I acted to report those concerns a not allowed to discuss billing to clients as only O-A client billing. |                     |  |           |                          |
|                          | had received many   | at 9:45 a.m., AA-O stated she phone calls from various as of being double billed or  |                     |  |           |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ´                 | E CONSTRUCTION   | COMPI    |                          |
|--------------------------|---|---|---------------------|--|----------|--------------------------|
|                          |   | H35833  | B. WING             |  | 04/1     | ;<br>2/2023              |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     |  | <u> </u> | 2/2020                   |
| NAIVIE OF I              | PROVIDER OR SUPPLIER  | 202 HIGH  | , ,                 | STATE, ZIP CODE  |          |                          |
| COMFOR                   | RTING ANGELS  |   | MN 56549            |  |          |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE    | (X5)<br>COMPLETE<br>DATE |
| 0 880                    | Continued From pa   | ge 106  | 0 880               |  |          |                          |
|                          | asking why an hour more than that. AAsometimes the care the client would still only O-A did the client assist with answering stated O-A would saget it sorted out but complain they can't doesn't answer. AAsometimes that they can't doesn't answer.   | long visit was charged for O stated she thought givers wouldn't show up but get billed. AA-O stated since ent billing, she was not able to get their questions. AA-O ay she'll talk to the client and then clients will call and get ahold of O-A or she O stated O-A was aware to get ahold of her to voice on was provided.   |                     |  |          |                          |
| 02015<br>SS=F            | 626.557, Subd. 3 Ti   | ming of Report  | 02015               |  |          |                          |
|                          | believe that a vulne been maltreated, or vulnerable adult has which is not reason immediately report common entry point vulnerable adult sol admitted to a facility required to report stindividual that occur unless:  (1) the individual was another facility and believe the vulnerable previous facility; or (2) the reporter know that the individual is | orter who has reason to rable adult is being or has who has knowledge that a sustained a physical injury ably explained shall the information to the t. If an individual is a ely because the individual is a, a mandated reporter is not uspected maltreatment of the red prior to admission, as admitted to the facility from the reporter has reason to ble adult was maltreated in the ws or has reason to believe a vulnerable adult as defined, subdivision 21, paragraph |                     |  |          |                          |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549   (X4) ID PREFIX TAG  COMFORTING ANGELS  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)  O2015  Continued From page 107  (a), clause (4), (b) A person not required to report under the provisions of this section may voluntarily report as described above, (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.  (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.  (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reported error was not neglect according to the criteria under section 826.5572, subdivision 17, paragraph (c), clause (5), the   |          | NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ,            | E CONSTRUCTION  | (X3) DATE<br>COMPI | SURVEY<br>LETED |
|--|----------|--|--|----------------|---|--------------------|-----------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549  [X4] ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  D2015  Continued From page 107  (a), clause (4), (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, |          |  |  |                |   | C                  | <b>;</b>        |
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGK  REGULATORY OR LSC IDENTIFYING INFORMATION)  02015  Continued From page 107  (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,   |          |  | H35833   | B. WING        |   | 04/1               | 2/2023          |
| COMPORTING ANGELS   HAWLEY, MN 56549   | NAME OF  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S | STATE, ZIP CODE   |                    |                 |
| (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  02015  Continued From page 107  (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report deror was not neglect according to the criteria under section 626.5572,  | COMFO    | RTING ANGELS   |  |                |   |                    |                 |
| PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (a), clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,  | (V 4) ID | SLIMMARY STA   | ,  |                | PROVIDER'S PLAN OF CORRECTI                                 | ON                 | (X5)            |
| (a), clause (4).  (b) A person not required to report under the provisions of this section may voluntarily report as described above.  (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.  (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.  (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,   | PRÉFIX   | (EACH DEFICIENCY   | MUST BE PRECEDED BY FULL   | PREFIX         | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE               | COMPLETE        |
| (b) A person not required to report under the provisions of this section may voluntarily report as described above.  (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.  (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.  (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead investigative agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572,   | 02015    | Continued From pa  | ge 107   | 02015          |   |                    |                 |
| reporter or facility may provide to the common entry point or directly to the lead investigative agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead investigative agency shall consider this information when making an initial disposition of the report under subdivision 9c.  This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to immediately report to the Minnesota Adult Abuse Reporting Center (MAARC) suspected maltreatment of financial exploitation for four of four clients (C1, C2, C3,  |          | (a), clause (4). (b) A person not reconstructions of this set described above. (c) Nothing in this set known or suspected knows or has reason been made to the construction (d) Nothing in this set reporter from also reason to believe the 626.5572, subdivisity (5), occurred must resubdivision. If the resubdivision is the critical subdivision is the critical subdivision in the critical subdivision is the critical subdivision in the critical subdivis | quired to report under the ection may voluntarily report as ection requires a report of a maltreatment, if the reporter in to know that a report has sommon entry point. ection shall preclude a eporting to a law enforcement orter who knows or has eat an error under section on 17, paragraph (c), clause make a report under this eporter or a facility, at any time estigation by a lead y will determine or should reported error was not neglect teria under section 626.5572, agraph (c), clause (5), the may provide to the common by to the lead investigative explaining how the event explaining how the event explaining how the ex |                |   |                    |                 |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |   | <b>  `</b> ´  | E CONSTRUCTION      | (X3) DATE<br>COMP  | SURVEY |                          |
|---|---|---|---------------------|--|--------|--------------------------|
|   |   | H35833  | B. WING             |  | 04/1   | 2/2023                   |
| NAME OF   | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | TATE, ZIP CODE   |        |                          |
| COMFO   | RTING ANGELS  | 202 HIGH<br>HAWLEY,   | WAY 10<br>MN 56549  |  |        |                          |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE  | (X5)<br>COMPLETE<br>DATE |
| 02015   | violation that did no safety but had the policent's health or sacause serious injury was issued at a wide problems are pervafailure that has affer a large portion or all the findings included the licensee failed investigate allegation after unlicensed perconcerns with ULP items for their own personal use, and offer services.  C1 admitted to home 2022 and discharged to the license plan where the power of attorney a signed by owner (Ohandwritten date of signature. The service plan where the basic services processed to the large that the basic services plan which (FM)-D on August 5 August 7, 2022. The Angels LLC, d/b/a [Angels Home Care | ed in a level two violation (a t harm a client's health or potential to have harmed a fety, but was not likely to y, impairment, or death), and lespread scope (when sive or represent a systemic cted or has potential to affect I of the clients).  e:  to immediately report and ons of financial exploitation resonnel (ULP) reported taking the client's personal use, using his debit card for concerns of being overcharged are care services on May 19, and on March 28, 2023.  as not signed by the client's nd was not electronically 19-A. The service plan had a May 20, 2022 under O-A's ice plan indicated the client of care per day for "basic & ers," but did not specify what |                     |  |        |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>NOF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|---|--|---------------------|--|-------------------|--------------------------|
|                          |   |  | 71. BOILDING.       |  |                   | •                        |
|                          |   | H35833   | B. WING             |  | 04/1              | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| 001450                   |   | 202 HIGH   | WAY 10              |  |                   |                          |
| COMFO                    | RTING ANGELS  | HAWLEY,  | MN 56549            |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE            | (X5)<br>COMPLETE<br>DATE |
| 02015                    | Continued From pa   | ge 109   | 02015               |  |                   |                          |
|                          | services provided to<br>Clients will have 48<br>disputes, no action<br>disputes for ach wil   | would "email invoice for its the undersigned client. hours to address any needed when there is no I be processed after 48 hours invoiced amount, which may   |                     |  |                   |                          |
|                          | withdrew \$246,726.   | ndicated D&G Angels LLC<br>70 from the client's account<br>actions from June 2022<br>023.  |                     |  |                   |                          |
|                          | unauthorized charg  | nk records indicated 13 es in December 2022 and e client's debit card adding up  |                     |  |                   |                          |
|                          | she had not received the client's care but \$25,000 per month withdrawals but did account for several it, she noticed a lot and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and so she asked C statements from Jumonth which were endeaded and statements from Jumonth | ed any billing statements for a was told it would cost and she agreed to ACH n't check the client's bank months. When she checked of money had been taken out D-A for billing statements and ne 2022 through the current emailed to her from O-A on e email was sent from the nent of the home care agency A's first name and first letter M-D stated the statements of worked and it didn't add up they were being charged for ad asked O-A questions on the last being billed for hours that ent in the home and the eup to what was taken from count but did not get any real ted she had provided O-A with |                     |  |                   |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--|---|---------------------|--|-------------------|--------------------------|
|  |   |                     |  |                   |                          |
|  | H35833  | B. WING             |  | 04/1              | 2/2023                   |
| NAME OF PROVIDER OR SUPPLI   | R STREET AD   | DDRESS, CITY, S     | TATE, ZIP CODE   |                   |                          |
| COMFORTING ANGELS  | 202 HIGH  |                     |  |                   |                          |
| OVAND SLIMMADV   | STATEMENT OF DEFICIENCIES   | , MN 56549          | PROVIDER'S PLAN OF CORRECT   |                   | (VE)                     |
| PREFIX (EACH DEFICIE   | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 02015 Continued From   | page 110  | 02015               |  |                   |                          |
| anywhere so the snacks, or other suspicious charge reported those of deactivated the dapparent not all FM-D stated after O-A would put at on invoices but the sometimes receivabout some of the On March 27, 20, she had reported potentially missing the state of the control of the other control of the control | 23, at 9:15 a.m., FM-D stated to O-A that the client was guns and that O-A had er that she suspected ULP-M  |                     |  |                   |                          |
| assistant (AA)-I have 24 hour can or they would be stated "she'll bill time but in all resisn't someone the was "well aware been notified by personal items be staff using his cruthemselves. AA-allegations the could not know any allowed to do bill.  On April 12, 202 was aware other personal credit of at places like resident.  | B, at 8:20 a.m., administrative stated O-A had pushed C1 to be but staff weren't always there sleeping while on the clock. AA-I like someone is there the whole ality, the majority of the time there are all the time." AA-I stated O-A of what was going on" and had herself and other staff about his eing taken by caregivers and edit card for things for stated she was aware of ient was being charged a lot but other details as the only personing was O-A.  B, at 9:05 a.m., ULP-B stated she ULP had been using the client's ard for purchases for themselves taurants, gas stations, fast food e. ULP-B stated there were times |                     |  |                   |                          |

Minnesota Department of Health

| H35833 B. WING 04/12/20   |                          |
|---|--------------------------|
| Порозо  | C<br>04/12/2023          |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE  |                          |
| 202 HIGHWAY 10  |                          |
| COMFORTING ANGELS HAWLEY, MN 56549  |                          |
|   | (X5)<br>COMPLETE<br>DATE |
| she bought groceries for the client herself since he was out of certain things and the next time she worked, the items would be missing. ULP-B stated there was one time staff said they bought things for the client at Sam's Club, but she didn't see evidence of anything in the client's home. ULP-B stated there were many times where ULP came in to the client's home, clocked in and left, then came back at the end of their shift to clock out and the client would be billed for the full visit time. ULP-B confirmed she was aware C1 was missing guns and knew that O-A had been updated. ULP-B stated O-A was also made aware of the potentially fraudulent charges on the client's credit card and the missing personal items and she had assumed O-A was taking care of it since "we're mandated reporters."  On April 4, 2023, at 1:15 p.m. O-A stated C1 "was an easy client" and she had assumed O-A was taking care of it since "we're mandated reporters."  On April 4, 2023, at 3:15 p.m. O-A stated C1 "was an easy client" and she had not received any concerns on his bills or concerns with staff conduct or misappropriation of his funds. O-A stated there were no gaps in C1's care and a caregiver was always present 24/7, except for when FM-D came to visit and sent some caregivers home. O-A confirmed staff will sleep on the overnight shifts but she directed them to set an alarm for every hour so they can get up and check on the client. O-A was asked again if she had been updated of any concerns with C1. O-A stated FM-D had brought concerns over one month's charges to her attention and "she was right so it was credited back." O-A stated she did now know of any concerns involving staff using his credit card for personal use. |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | (X3) DATE SUR COMPLETE |                          |
|--------------------------|--|--|---------------------|--|------------------------|--------------------------|
|                          |  | H35833   | B. WING             | _  | 04/1                   | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S      | STATE, ZIP CODE  |                        |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH   | WAY 10<br>MN 56549  |  |                        |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE                  | (X5)<br>COMPLETE<br>DATE |
| 02015                    | immediately report and having food and by the licensee and 24 hour care.  C2 admitted to hom 12, 2020, and discheduled payment automatic withdraw by C2 on Novembe authorized D&G And where such withdraw scheduled payment applicable taxes or at the time of such authorization signed 2021, and O-A on FD&G Angels to "chacard on the date Cocreates its invoice fundersigned client." by C2 and O-A on CD&G Angels "to chacard. Comforting An invoice for its service undersigned client." address any dispute there is no dispute 48 hours of email, f which may vary invoiced to the part of the card. Can be card. The card is no dispute the card and the card comforting and client. The card is no dispute the card is no dispute the card and card invoice for its service a | ion, the licensee failed to and investigate allegations of a supplies that were provided gaps in the client's scheduled are care services on November larged on March 3, 2023.  contain a service plan.  ed three authorizations for als. One authorization signed at 14, 2020, indicated the client gels to initiate "withdrawals wals shall be equal to each periodically due plus any other amounts due and owing withdrawal." Another drope my bank account or credit arge my |                     |  |                        |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′            | ECONSTRUCTION  | (X3) DATE<br>COMP | SURVEY<br>PLETED |
|---|--|----------------|--|-------------------|------------------|
|   |  | , a Boilbinto. |  |                   |                  |
|   | H35833   | B. WING        |  |                   | 2/2023           |
| NAME OF PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S | TATE, ZIP CODE   |                   |                  |
|   | 202 HIGH   | , ,            | <b>,</b>   |                   |                  |
| COMFORTING ANGELS   |  | , MN 56549     |  |                   |                  |
| (7(1)12   | TEMENT OF DEFICIENCIES   | ID             | PROVIDER'S PLAN OF CORRECT   |                   | (X5)             |
|   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) |                   | COMPLETE<br>DATE |
| 02015 Continued From pa   | ige 113  | 02015          |  |                   |                  |
| D&G Angles LLC of   | 6 was withdrawn via ACH by<br>ver a 16 month period from<br>ough February 2023.  |                |  |                   |                  |
| manager (PM)-F st<br>wasn't paying her a<br>November 2022 an<br>her well being since<br>and didn't leave her<br>caregivers. PM-F st<br>when the police are<br>took a man out of h<br>PM-F stated he had<br>isolated, being final<br>struggling to make<br>stated he was able  | ated he became aware C2 association bills around d they were concerned about a she was mostly bedbound rapartment and had 24 hour tated he recalled back in 2021 ived at C2's apartment and her apartment in handcuffs. It concerns C2 may be neally exploited, and may be decisions on her own. PM-F to reach out to a family no was able to step in and take in.   |                |  |                   |                  |
| she lives out of state very involved with Compower of attorney as she was notified by bills had not been plooking at C2's ban came to visit C2 in on. FM-H stated she was difficult to get a obtained bank recompliance should be and almost \$50,000 account. FM-H state about the billing, she \$100,000 so she respectively. | te and had not previously been C2's care until she obtained few months ago. FM-H stated C2's property manager that baid so that's when she started k statements and eventually person to see what was going the tried talking to O-A but she shold of. FM-H stated she and for C2 and noticed about a taken from one bank account D was missing from a savings the ed after she spoke with O-A the was told C2 still owed about she could not locate any bills 2. FM-H stated the bills O-A out \$341,000, or about, which "seemed shocking" |                |  |                   |                  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ` ′               | E CONSTRUCTION   | (X3) DATE | SURVEY<br>LETED          |
|---|---|---------------------|--|-----------|--------------------------|
|   |   | A. BOILDING.        |  |           |                          |
|   | H35833  | B. WING             |  | 04/1      | ;<br>2/2023              |
| NAME OF PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | TATE, ZIP CODE   |           |                          |
|   | 202 HIGH  | , ,                 |  |           |                          |
| COMFORTING ANGELS   |   | , MN 56549          |  |           |                          |
| (VA) ID SLIMMARY STA  | ATEMENT OF DEFICIENCIES   | ,<br>               | PROVIDER'S PLAN OF CORRECT   | TION      | (Y5)                     |
| PREFIX (EACH DEFICIENC)   | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE    | (X5)<br>COMPLETE<br>DATE |
| 02015 Continued From pa   | ige 114   | 02015               |  |           |                          |
| considering the poor stated O-A had three condo if the \$100,00 FM-H stated she first requested there informed her if she which was estimate "cut her a deal" for never came back would work. FM-H cash in C2's CD's (investments) to condominate to open C2 she had served as almost a year. ULF allowed to open C2 check her mailbox the office and let the there and either O- | or care she was getting." FM-Heatened to put a lien on C2's 100 she still owed was not paid. In ally got bills for January 2022 2023 several weeks after she in. FM-H stated O-A had paid the outstanding bill, and to be \$100,000, she would the remained of the year but with a proposal on how that stated O-A had suggested she certificate of deposit wer her bills.  By at 10:15 a.m., ULP-G stated a primary caregiver for C2 for 2-G stated caregivers were not 2's mail but they were to go and daily and would have to call em know if there was any mail A or BM-J would drive to her |                     |  |           |                          |
| not allowed to oper what happened to office staff. ULP-G  | t it up. ULP-G stated they were the mail and she's not sure that after it was taken by the stated she noticed a few   |                     |  |           |                          |
| would often commoney." ULP-G state  | from time to time and that C2 ent to her, "[O-A] is stealing my ted she wasn't sure if that was ut it "seemed pretty shady."  |                     |  |           |                          |
| ran out of groceries<br>even after telling O  | were a few times where C2 or incontinence products, -A she needed to order some. spent about \$300 of her own   |                     |  |           |                          |
| money the last few incontinence produble been reimbursed been secondary.  | months buying groceries and cts for C2 and that she has not y O-A yet. ULP-G stated she   |                     |  |           |                          |
| paychecks were late   | licensee after a few of her<br>e and she is still waiting to get<br>of approximately \$600. ULP-G<br>ed O-A several times when her  |                     |  |           |                          |

Minnesota Department of Health

| NAME OF PROVIDER OR SUPPLIER  COMFORTING ANGELS  (X4) ID PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D2015  C 04/12/2023  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10  HAWLEY, MN 56549  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE  O2015  Continued From page 115  O2015   | ` '  | VIDER/SUPPLIER/CLIA<br>TIFICATION NUMBER:  | TATEMENT OF<br>ND PLAN OF C  |  | ` ,          | ECONSTRUCTION                 | (X3) DATE<br>COMP | SURVEY<br>LETED |
|---|--|--|--|--|--------------|-------------------------------|-------------------|-----------------|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  02015 Continued From page 115  |  |  |  |  | A. DOILDING. |                               |                   |                 |
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DATE  102015  Continued From page 115  202 HIGHWAY 10 HAWLEY, MN 56549  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O2015   | H;   | 5833   |  |  | B. WING      |                               |                   |                 |
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DATE  102015  Continued From page 115  202 HIGHWAY 10 HAWLEY, MN 56549  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O2015   | NAME OF PROVIDER OR SUPPLIER   | STREET AD  | AME OF PROV  | STREET ADD   | DRESS CITY S | TATE, ZIP CODE                |                   |                 |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  O2015 Continued From page 115  HAWLEY, MN 56549  ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  O2015 Continued From page 115   | TURNIL OF THOUSEN ON OUT LIEN  |  |  |  | , ,          | 7.7.2, 2.11 3322              |                   |                 |
| (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  O2015 Continued From page 115  O2015 PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  O2015 Continued From page 115  | COMFORTING ANGELS  |  | OMFORTIN   |  |              |                               |                   |                 |
| PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  O2015 Continued From page 115  PREFIX TAG REGULATORY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  O2015 Continued From page 115  O2015   | (X4) ID SUMMARY STATEMENT (  | F DEFICIENCIES   | (X4) ID  | NCIES  | ID           | PROVIDER'S PLAN OF CORRECTI   | ON                | (X5)            |
|   | PRÉFIX (EACH DEFICIENCY MUST BE  |  | PRÉFIX   |  | PREFIX       | CROSS-REFERENCED TO THE APPRO |                   | COMPLETE        |
|   | 02015 Continued From page 115  |  | 02015 Co   |  | 02015        |                               |                   |                 |
| final paycheck is coming and has been getting worried since she's heard from other former staff they had not gotten paid or their paychecks bounced. ULP-G stated there were often times where caregivers didn't show up for their scheduled shifts and she'd stay whenever she could but wasn't able to stay more than 16 hours. ULP-G stated O-A was aware of the holes in the schedule but didn't really do anything about it.  On March 30, 2023, at 1:57 p.m., FM-H emailed the investigator a summary of her work figuring out C2's finances. FM-H wrote she contacted O-A in January 2023 and told her she'd be coming up the end of the month and would need access to all of C2's mail. FM-H provided the investigator with text messages between her and O-A, one of which read, "Just to forewarn you, I will be back on January 16 and I'm going to talk to [C2] about her bill and at this point I probably will have no choice but to put her in a nursing home her bill is astronomical with me, it's over \$100,000 which I will also put a lien against her condo any and any (sic) assets that she has" FM-H wrote in her summary that she sent O-A a text asking for C2's bank statements and O-A had told her she had a couple of them and would email them to FM-H, which she never did. FM-H stated "(C2) had a pretty good filing system so it was clear that almost all the statements were missing." FM-H wrote she kept asking for copies of the statements from O-A's services multiple times over January and February 2023, and finally got then towards the end of February. FM-H wrote O-A had been asking around to get C2's social security number but neither she nor C2 would provide it to O-A. FM-H wrote she "became friendly" with one of the unlikensed personnel | final paycheck is coming ar worried since she's heard for they had not gotten paid or bounced. ULP-G stated they where caregivers didn't show scheduled shifts and she'd could but wasn't able to state ULP-G stated O-A was away schedule but didn't really down on March 30, 2023, at 1:57 the investigator a summary out C2's finances. FM-H wrin January 2023 and told he the end of the month and wall of C2's mail. FM-H proving with text messages betwee which read, "Just to forewa on January 16 and I'm goin her bill and at this point I prochoice but to put her in a nuastronomical with me, it's owill also put a lien against he (sic) assets that she has" summary that she sent O-A bank statements and O-A hounded of them and would end which she never did. FM-H pretty good filing system so almost all the statements worde she kept asking for costatements from O-A's servover January and February then towards the end of Felo-A had been asking arour security number but neither provide it to O-A. FM-H wroted it | om other former staff heir paychecks re were often times w up for their stay whenever she more than 16 hours. re of the holes in the anything about it.  p.m., FM-H emailed of her work figuring ote she contacted O-A r she'd be coming up ould need access to led the investigator in her and O-A, one of in you, I will be back of to talk to [C2] about obably will have no rsing home her bill is rer \$100,000 which I ler condo any and any FM-H wrote in her a text asking for C2's ad told her she had a mail them to FM-H, stated "[C2] had a it was clear that ere missing." FM-H opies of the ces multiple times 2023, and finally got oruary. FM-H wrote d to get C2's social she nor C2 would se she "became | fination the bold who school who school who school who school with a with who her chool with the all with who her could who see the O-see pro- | r former staff checks often times their never she nan 16 hours. holes in the g about it.  VI-H emailed ork figuring contacted O-A ne coming up nd access to nvestigator d O-A, one of will be back to [C2] about ill have no me her bill is ,000 which I n any and any rote in her sking for C2's ner she had a m to FM-H, C2] had a near that ing." FM-H the tiple times nd finally got M-H wrote C2's social C2 would necame |              |                               |                   |                 |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′             | CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY           |
|---|--|-----------------|--|-------------------|------------------|
|   |  | /\. DOILDING.   |  |                   | _                |
|   | H35833   | B. WING         |  | 04/1              | 2/2023           |
| NAME OF PROVIDER OR SUPPLIER  | STREET AF  | DDRESS, CITY, S | TATE ZIP CODE  | -                 |                  |
| TV/TVIL OF TITOVIDER OR OUT LIER  | 202 HIGH   | , ,             | TATE, ZII OODE   |                   |                  |
| COMFORTING ANGELS   |  | , MN 56549      |  |                   |                  |
| (X4) ID SUMMARY ST  | ATEMENT OF DEFICIENCIES  | ID              | PROVIDER'S PLAN OF CORRECT   | ION               | (X5)             |
| PREFIX (EACH DEFICIENC  | Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | JLD BE            | COMPLETE<br>DATE |
| 02015 Continued From pa   | age 116  | 02015           |  |                   |                  |
| incontinence product what she needed. Unlicensed person out of her own poor wanted her to contribute if she wanted access C2, she had to go On April 4, 2023, a from the time two latercation at the could be used to the clients have 48 ho to voice concerns gotten any concern they did everything wiped their hands was getting 24 hou there would always stated she has been because she has recently when she and 15th of each in would get money for account of about \$ that is what she'd was counts when C2 full "just so I'd be poor care usually remonth. O-A was shown on C2's bar | icts as O-A was not providing FM-H wrote she sent that nel \$128 via Venmo as the nel was paying for food for C2 ket. FM-H wrote O-A never act the caregivers directly and as to C2 or wanted to contact |                 |  |                   |                  |
|   | been pulled from C2's account 4 to 5 withdrawals were made   |                 |  |                   |                  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | <b>`</b> '          | E CONSTRUCTION  | (X3) DATE<br>COMP | SURVEY                   |
|---|--|---------------------|---|-------------------|--------------------------|
|   | H35833   | B. WING             |   | 04/1              | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | TATE, ZIP CODE  |                   |                          |
| COMFORTING ANGELS   | 202 HIGH   |                     |   |                   |                          |
|   | <u> </u>   | MN 56549            |   | 1011              | 0.15                     |
| PREFIX (EACH DEFICIENC)   | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
| 02015 Continued From pa   | age 117  | 02015               |   |                   |                          |
| in a month. O-A state would only be one billing twice a month ACH withdrawals restatement. O-A state C2's mail because opened anything for seeing her own may of C2's mail in to the C2's mail in to the C2's mail in to the C3's mail in to the C4's mail in to the C4's mail in to the C5's | ated for ACH withdrawals, there done monthly until she began th, then there should be two eflected on the bank ted she would take and open she would "scream if we or her," and had no interest in il. O-A stated the scanned all              |                     |   |                   |                          |
| C3 The licensee failed investigate a client Gabapentin (anti-set treat nerve pain) per employee of the license made to the addition, the license perpetrator, ULP-L client after the alleger  | to immediately report and is report of a bottle of eizure medication and used to otentially being taken by an ensee as well as an attempted e client's credit card. In ee allowed the alleged, to continue working with the gations were made. |                     |   |                   |                          |
| 2022.   | ne care services on August 23,   |                     |   |                   |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ,                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
|                          |   | H35833  | B. WING             |  | 04/1              | )<br>2/2023              |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET ADI  | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| COMFOR                   | RTING ANGELS  | 202 HIGH\<br>HAWLEY.  | NAY 10<br>MN 56549  |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE              | (X5)<br>COMPLETE<br>DATE |
| 02015                    | Continued From pa   | ge 118  | 02015               |  |                   |                          |
|                          | _   | uded quadriplegia (spinal cord aralysis in all or part of the vic organs).  |                     |  |                   |                          |
|                          | client had twice dail services for three had week. The service p  | ned service plan indicated the y "basic and skilled nursing" ours per day, seven days per plan did not identify what ded, who would provide the services.   |                     |  |                   |                          |
|                          | c3 had called to repart after she noticed so taken. The report in through February 12 were taken. A bottle taken on January 12 occasions, four pills 48 pills were taken  | February 15, 2023, indicated port a theft from a caregiver ome medications had been diated from January 12, 2023, 2, 2023, 209 Gabapentin pills of 153 pills was reported 2, 2023, then on two others were taken each time, and on February 12, 2023. The oted missing immediately evided care to C3.   |                     |  |                   |                          |
|                          | nurse (CN)-N stated with C3 around Feb an entire bottle of g refilled was missing attempted to use C3 purchase at Walma with C3 again on Fe informed by C3 that missing. CN-N stated make a police report stated she had contact 2023, and told O-A | at 10:40 a.m., community a health guide had visited ruary 8, 2023, and discovered abapentin that had just been In addition, someone had as credit card for an \$800 rt. The health guide visited about 200 pills were now and C3 was encouraged to rt by the health guide. CN-N facted O-A on February 16, that ULP-L was an alleged and not go anywhere near the care to C3. |                     |  |                   |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ′                 | E CONSTRUCTION   | COMP | LETED                    |
|--------------------------|---|--|---------------------|--|------|--------------------------|
|                          |   | H35833   | B. WING             |  | 04/1 | )<br>2/2023              |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD  202 HIGH  | , ,                 | STATE, ZIP CODE  |      |                          |
| COMFOR                   | RTING ANGELS  |  | MN 56549            |  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (INCOMPAGE OF THE APPROPERT | D BE | (X5)<br>COMPLETE<br>DATE |
| 02015                    | was made aware the missing after C3 called to count her pills be alleged perpetrator, her scheduled shift called her after ULF additional medications she advised C3 to find she did not feel from the home care to file one. O-A state probation so she has officer to see if they weren't able to. O-A MAARC report becauser. O-A confirm documentation of a the theft of medicate do anything." O-A stated, "my definity definition of a dult because she of press charges. O-A vulnerable adult und O-A stated, "my definition guess everyone confirmed she would reporter and did not missing medication investigation was not on April 4, 2023, at (RN)-C stated C3 we because she makes. On April 6, 2023, at investigator a copy report. The partially was electronically s | 12:50 p.m., O-A stated she at narcotic medications were lled and told her a bottle was at that time she advised C3 fore ULP-L, the suspected came to her apartment for later that day. O-A stated C3 P-L's shift ended and reported ons were missing. O-A stated ile a police report at that time I it was necessary for a report agency since C3 was going ed she knew ULP-L was on ad contacted her probation of could test her but they astated they did not submit a cuse the police were already ed there was no may kind of investigation in to it investigation in to it investigation in to it investigation in to it investigation and inition of a vulnerable adult is I ald be vulnerable." O-A did be considered a mandated it make any report on the stated C3 was not a formal of completed.  1:00 p.m., registered nurse was not a vulnerable adult is laid be vulnerable adult is I investigation.  1:33 p.m., O-A emailed the of the requested incident report igned by O-A on April 6, 2023, | 02015               |  |      |                          |
|                          | investigator a copy report. The partially was electronically s  | of the requested incident completed incident report  |                     |  |      |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>I OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ´                 | CONSTRUCTION   | (X3) DATE | SURVEY<br>PLETED         |
|--------------------------|---|---|---------------------|--|-----------|--------------------------|
|                          |   | H35833  | B. WING             | _  |           | C<br>1 <b>2/2023</b>     |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, ST     | TATE, ZIP CODE   |           |                          |
| COMFO                    | RTING ANGELS  | 202 HIGH  |                     |  |           |                          |
|                          |   | HAWLEY,   | MN 56549            |  |           |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH) | ULD BE    | (X5)<br>COMPLETE<br>DATE |
| 02015                    | pills missing (Gabay which are located in not sure what happed one working Friday and Sunday day shounday evening which left there were Tuesday morning a report for we would get a replacement for report, police noti [C3] which I just report by [C3]. I did call [Uabout the incident by wouldn't be able to alcohol."  | in [C3] regarding a Bottle of pentin) she received 3 bottles in her island drawer (kitchen) ened to them, [ULP-L] was the night, both shifts on Saturday ift. [ULP-L] was scheduled for nich we did leave her on after 45 pills missing I spoke to [C3] and told her to make a police need report documentation to for missing pills. She did ed (sic) me after a visit with ported what was given to me LP-L]'s probation ocer (sic) but he felt that he probably do anything for he is just for at 12:20 p.m., C3 stated  | 02015               |  |           |                          |
|                          | and evening to get do a bowel program C3 stated she had oget in and out of be mechanical lift and out of bed. C3 state where staff did not shad six employees night, "the guy who show uptwice last the storm and cared dependent on staff out of bed. I have a and water and if I ke by my bed." C3 state Gabapentin refilled 153 tablets in one be and a smaller bottle 390 tablets. C3 state | licensee come every morning her out of and back in to bed, a, get her dressed and ready. Quadraplegia and is not able to d on her own and needs a staff assistance to get in and ed there have been times show up and one time they quit in a week. C3 stated last was putting me to bed didn't week I stayed in bed due to givers couldn't come outI'm so if no one comes, I can't get neighbor who can bring food now it'll storm, I keep a cooler ed she had just gotten her and the pharmacy usually did ottle, 153 tablets in another, with the rest since they send ed one whole bottle was yed the other ones to her |                     |  |           |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3) DATE S  COMPL |  |       |                          |
|--------------------------|--|--|---|--|-------|--------------------------|
|                          |  | H35833   | B. WING   |  | 04/1  | )<br>2/2023              |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET ADI   | DRESS, CITY, S  | TATE, ZIP CODE   |       |                          |
| COMFO                    | RTING ANGELS   | 202 HIGH<br>HAWLEY,  | WAY 10<br>MN 56549  |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | _D BE | (X5)<br>COMPLETE<br>DATE |
| 02015                    | again after ULP-L fi enough, there were ULP-L was coming about four pills miss and if she worked do be off during the we stated she discover Lexapro and Trama in her drawer one discratched off it. C3 report her concerns probation currently police and file a repontinued to work a police were notified what the licensee dinoted O-A came out ULP-L was schedul after. C3 stated she with her credit card admitted for home of provided it. C3 stated time in February to charges on her credit attempted to charge she noticed she had missing, and was cattempted to be used aware of the attempted to be used aware of the attempted to didn't think anyton on April 11, 2023, and was not aware med C3's apartment and a police officer came asked why he was the was not managing the did not get involved. | ge 121  ed them. C3 counted them nished working and "sure some missing." C3 stated if daily, there would usually be sing each time she worked uring the weekend and would tek, she'd take more. C3 ed she was also missing dol and found some Tramadol ay with the numbers stated she called O-A to and was told ULP-L was on and was directed to call the ort. C3 stated ULP-L sher caregiver after the . C3 stated she has no idea id for an investigation but to her apartment when ed to work and left shortly was asked to provide O-A information when she care services and she ed her bank called her some report potential fraudulent dit card when someone es \$800 at WalMart. C3 stated of towels missing, pills, oncerned after her card was ed. C3 stated O-A was made of to charge \$800 at WalMart hing was done about it.  It 2:10 p.m., RN-C stated she ications were missing from was only made aware when e to O-A's office and she here. RN-C stated since she he client's medications, she and did not know about any at happened to staff as that | 02015   |  |       |                          |

Minnesota Department of Health

|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | ` ′                 | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY                   |
|--------------------------|---|---|---------------------|--|-------------------|--------------------------|
|                          |   |   |                     |  |                   | <b>)</b>                 |
|                          |   | H35833  | B. WING             |  |                   | 2/2023                   |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, S      | STATE, ZIP CODE  |                   |                          |
| COMEO                    | RTING ANGELS  | 202 HIGH  | WAY 10              |  |                   |                          |
| COMIT OF                 | TINGANGLES  | HAWLEY,   | MN 56549            |  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE             | (X5)<br>COMPLETE<br>DATE |
|                          | MAARC report show would be a vulneral investigator what a then stated that no, because "[the client | O-A. RN-C was asked if a uld have been made since C3 ole adult. RN-C asked the MAARC report was. RN-C C3 was not a vulnerable adult notified the proper people,"                  |                     |  |                   |                          |
|                          | The investigator as did not press charg the licensee's employed bed and if staff didner             | he didn't want to file charges. ked RN-C if it was possible C3 es because she depended on oyees to help her get out of i't show up, she wouldn't be C stated, "no because she has |                     |  |                   |                          |
|                          | her only resource." be considered a vul Minnesota statute o own personal defini                     | vate caregivers so we're not RN-C was asked if C3 could nerable adult under lefinitions as opposed to her tion of a vulnerable adult.   |                     |  |                   |                          |
|                          | vulnerable adult, sh<br>impairment at all lik<br>most of us. Don't pu                               | ught it through and she's not a e's very, she has no cognitive e zero. She's pry smarter than ut that in there. She's very od support system. That's a                            |                     |  |                   |                          |
|                          | now we're all vulner<br>not going to answer<br>to some degree so                                    | n. I am a vulnerable adult right able adults in this era so I'm that. Everyone is vulnerable I'm not going to deny she's [MAARC] report to be placed,                             |                     |  |                   |                          |
|                          | there was no harm, vulnerability issue was no harm, and the focus." RN-C                            | emotional trauma, no vith the incident that happened was asked if they had I exploitation had occurred  |                     |  |                   |                          |
|                          | after C3's medication stolen. RN-C stated [C3] is not cognitive not impaired becau                  | ons were presumed to be I, "why would we do that when ly impaired, financially she's se her insurance paid for the then stated, "You go   |                     |  |                   |                          |
|                          | ask her every quest<br>being a vulnerable   | I hope you do it tomorrow,<br>tion. If I get in trouble for her<br>adult, I will get an attorney<br>ng to insinuate she's a   |                     |  |                   |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   | ` ,                 | E CONSTRUCTION   | COMP  | SURVEY                   |
|--------------------------|---|--|---------------------|--|-------|--------------------------|
|                          |   | H35833   | B. WING             |  | 04/1  | 2/2023                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD  | DRESS, CITY, S      | STATE, ZIP CODE  |       |                          |
| COMFO                    | RTING ANGELS  | 202 HIGHY<br>HAWLEY,   | WAY 10<br>MN 56549  |  |       |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | .D BE | (X5)<br>COMPLETE<br>DATE |
| 02015                    | adult, she would be her"  On April 12, 2023, a they did not manage not a need to report O-A stated when she missing medication police so since the there was no need stated "the bottom I disrupted, it needs advice to call police very self sufficient in at that time, my que her care, would we interrupt her care." to continue working suspected she took that was ok. O-A state inappropriate to decision and didn't compelled to say she depended on the age C4  The licensee failed investigate allegation after staff were made overcharged for serect C4 admitted to hom 2, 2022, and discharced to the services to basic and skilled see hours of "home exercises." | o not put [C3] as a vulnerable very offended, it's not fair to at 12:30 p.m., O-A stated since e C3's medications, there was a potential theft of medications. It was made aware of the so, she directed C3 to call the police were already notified, to make her own report. O-A ine is if there's any care to be reportedI gave her but she's in sound mind and an managing medications and estion is if this did not interrupt report this because it didn't O-A stated she allowed ULP-L with C3 after it was a medications because C3 said ated she didn't think it would have the client make that think she would feel he was ok with it because she gency to provide care. |                     |  |       |                          |

Minnesota Department of Health

|                          | I OF DEFICIENCIES  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | COMP | SURVEY                   |
|--------------------------|--|--|---------------------|--|------|--------------------------|
|                          |  | H35833   | B. WING             |  | 04/1 | 2/ <b>2023</b>           |
|                          | PROVIDER OR SUPPLIER   | 202 HIGH   | , ,                 | STATE, ZIP CODE  |      |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE |
| 02015                    | what services were the service plan indicate billing Humana 80% reassessments at deper visit with schedulists at \$140 and he 80% and client 20% effective date of Sesigned by the client The service plan was staff.  Nursing assessment of provincluded entries for September 2, 2022 December 8, 2022, Progress notes for assessment did not a signature from the there. The visit times 12:00 p.m., three here. The visit times 1:20 p.m., three here. | service plan did not identify provided, who would provide rate for the services. The ed payment would be "split and client 20%" and nurse lays 14, 30, 90 would be \$155 uled and unscheduled nurse ur with split billing Humana at the service plan listed an ptember 2, 2022, but was as wife on February 12, 2023. As not signed by home care at some for C4 were requested, but wided to the investigator RN assessments on September 14, 2022, and December 27, 2022 the September 2, 2022, RN include any documentation or eclient indicating she was a was listed as 9:00 a.m. to be client indicating she was a was listed as 10:20 a.m. to be client indicating she was a was listed as 10:20 a.m. to |                     |  |      |                          |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | , ,                 | E CONSTRUCTION  | (X3) DATE S |                          |
|--|---|---------------------|---|-------------|--------------------------|
|  |   |                     |   | С           | ,                        |
|  | H35833  | B. WING             |   | 04/1        | 2/2023                   |
| NAME OF PROVIDER OR SUPPLIE  | 202 HIGH  | , ,                 | STATE, ZIP CODE   |             |                          |
|  | <u> </u>  |                     |   | 1011        | 0.45                     |
| PREFIX (EACH DEFICIE   | TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | ILD BE      | (X5)<br>COMPLETE<br>DATE |
| 02015 Continued From   | page 125  | 02015               |   |             |                          |
| 9  | was there. The visit time was n. to 4:00 p.m., seven hours.   |                     |   |             |                          |
| assessment did<br>a signature from   | or the December 27, 2022, RN not include any documentation or the client indicating she was ne was listed as 12:00 p.m. to ours.  |                     |   |             |                          |
| responsible party September 2, 20 on February 19, sent prior to this from the account her first name an the email. The st \$3,721.52 was d billed at \$8.90 per reassessments w visit as identified RN rate was billed | statements for services from 22, through the client's discharge 2023. No statements had been ime. O-A identified herself as ng department and used only difirst letter of her last name in atements indicated a total of ie. The hourly ULP rate was r hour, 20% of \$44.50. RN ere billed by the hour, not by the in the service plan. The hourly d at \$31 per hour, 20% of \$155. Sment was billed for seven |                     |   |             |                          |
| responsible party for services from client's discharge identified herself department and letter of her last i statements indica The hourly ULP i 20% of \$30. RN the hour, not by t service plan. The                  | an updated set of statements September 2, 2022, through the on February 19, 2023. O-A as from the accounting used only her first name and first ame in the email. The uted a total of \$2,685.19 due. ate was billed at \$6 per hour, eassessments were billed by ne visit as identified in the hourly RN rate was billed at \$31 \$155. One RN reassessment en hours.  |                     |   |             |                          |

Minnesota Department of Health

|                          | OF DEFICIENCIES OF CORRECTION   |   |                     | SURVEY   |             |                          |
|--------------------------|---|---|---------------------|--|-------------|--------------------------|
|                          |   | H35833  | B. WING             |  |             | C<br><b>12/2023</b>      |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DDRESS, CITY, ST    | TATE, ZIP CODE   |             |                          |
| COMEO                    | RTING ANGELS  | 202 HIGH  | IWAY 10             |  |             |                          |
| COMPOR                   | TING ANGELS   | HAWLEY  | , MN 56549          |  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CO<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (X5)<br>COMPLETE<br>DATE |
| 02015                    | Continued From pa   | ae 126  | 02015               |  |             |                          |
|                          | On April 4, 2023, a was not aware of a client's services or representative was  | t 1:25 p.m. O-A stated she my concerns regarding the care. O-A stated the client's emailed statements each ided to bill the client's  |                     |  |             |                          |
|                          | would frequently ge their family members saying they had been why something was directed to report the was not allowed to   | at 8:20 a.m., AA-I stated she t calls from many clients or rs with concerns on billing en double billed or didn't know billed. AA-I stated she was ose concerns to O-A and she discuss anything regarding only O-A was allowed to do  |                     |  |             |                          |
|                          | she had not billed the yet but had obtained around the time the September. O-A stated told her the client's indefinite period of send any updates, at o qualify for ongoin she did not receive never submitted and company to be paid she missed deadlin would no longer be insurance. O-A combilled at her highest for ULP services. Of the client was billed client's cares were it would cost more that able to describe how | at 12:25 p.m., O-A confirmed the client's insurance company of an authorization number client admitted for services in ated the insurance company care would be covered for an time and she did not need to assessments, or recertification ag coverage. O-A confirmed any of this in writing and y invoices to the insurance of the insurance of the client's firmed the client was initially thourly rate of \$44.50 per hour of the higher amount was based off the fact the more complex and difficult so o provide care. O-A was not we the client's cares were more ard home care services. O-A |                     |  |             |                          |

Minnesota Department of Health

| H35833 B. WING 04/12   | 2/2023                   |  |  |  |  |  |
|--|--------------------------|--|--|--|--|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10  COMFORTING ANGELS   |                          |  |  |  |  |  |
| HAWLEY, MN 56549   |                          |  |  |  |  |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | (X5)<br>COMPLETE<br>DATE |  |  |  |  |  |
| admission and the service plan completed shortly before the client passed away lacked details on cost and services provided. O-A stated she never discusses the cost of care and services with clients until a service plan is completed and initially stated she did not recall discussing a dollar amount with the client's family. O-A confirmed she sent out a second batch of statements after the client's representative asked why the rate was higher than initially discussed and stated she did not recall taking about the cost for services when the client admitted. O-A stated to avoid any difficulties with the client, she agreed to lower her price back down to \$30 per hour and ended up sending out a second set of statements. O-A stated she didn't tell the client that insurance had covered his care and did not remember telling them it was being covered at \$44,50 per hour for services from ULP. O-A stated bills were not sent out on time and there were issues with bills because she had ongoing issues with her billing software and had fired several office staff over issues with billing.  On April 13, 2023, at 12:20 p.m., ULP-Z stated he was one of the primary caregivers for C4. ULP-Z stated the client was preity independent and needed moderate assistance of one for transfers but could still walk with a walker, eat on his own, and go to the bathroom. ULP. Z stated the client did not have any complex cares or care needs and most of the visit he would help with housekeeping, do exercises with the client, and socialize.  On April 14, 2023, at 1:20 p.m., FM-X stated they did not receive any admission paperwork or any bills for the client's care for several months and she requested for the information to be sent several times from O-A, FM-X stated O-A kept |                          |  |  |  |  |  |

Minnesota Department of Health

|  |   | (X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING: |  |      | 3) DATE SURVEY<br>COMPLETED |  |  |
|--|---|---|--|------|-----------------------------|--|--|
|  |   | 71. BOILDING.                                 |  |      |                             |  |  |
| H35  | 833   | B. WING                                       |  | 04/1 | <i>2</i> /2023              |  |  |
| NAME OF PROVIDER OR SUPPLIER   | STDEET AD   | DDESS CITY S                                  | STATE ZID CODE   | •    |                             |  |  |
| NAME OF PROVIDER OR SUPPLIER   |   |   | STATE, ZIP CODE  |      |                             |  |  |
| COMFORTING ANGELS  | 202 HIGH  | MN 56549                                      |  |      |                             |  |  |
|  |   |   |  | ON   | ()/[)                       |  |  |
| (X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PREGULATORY OR LSC IDENTIFY)  | RECEDED BY FULL   | ID<br>PREFIX<br>TAG                           | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE | (X5)<br>COMPLETE<br>DATE    |  |  |
| 02015 Continued From page 128  |   | 02015   |  |      |                             |  |  |
| coming up with new reasons been sent yet and the paper sent to an address she had repart years before she was finally worth of paperwork and bills. had to send back the paperwork because the owner kept saying that an employee didn't file it stated she did not ever get mand was reassured more that insurance was covering the of they'd only be responsible for they were told by O-A the clie covering 80%. FM-X stated they'd only be responsible for they were told by O-A the clie covering 80%. FM-X stated they were that the client's insural paid her company \$44.50 pewas a higher amount than they on amount of \$30 per hour owe their 20% cost of care. Fasked the owner why they were when the insurance company \$15 per hour more than the casked why the amount change hour they were initially told be answer other than the insurance inhoursed above that amount also questioned the hours liss staff were not working or produring some of the times reflecting from they were told upon stated the client's insurance record of the home care age claims or being paid by the informal from the client's be however, they declined each | work was eventually not lived at for a few sent several months FM-X stated they work more than once ing she didn't get it or properly. FM-X nonthly statements in once that cost of care and in a 20% co pay since ent's insurance was hey were told by the ince company had in hour for care, which is originally agreed in hour for care, which is e originally agreed in hour for care, which is e originally agreed in hour for care, which is eventually agreed in hour for care. FM-X ged from the \$30 per cut did not get an ince company int. FM-X stated she ted on the bills as viding services ected on the bills as viding services ected on the bills. It, the owner sent her is ed the 20% of \$30 admission. FM-X company has no incy submitting any insurance company. Incouraged them is make an ACH wank account |   |  |      |                             |  |  |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  |   | (X2) MULTIPLE CONSTRUCTION |   | ` '      | (X3) DATE SURVEY<br>COMPLETED |  |
|--|---|----------------------------|---|----------|-------------------------------|--|
|  |   | A. BUILDING:               |   |          |                               |  |
|  | H35833  | B. WING                    |   |          | C<br><b>12/2023</b>           |  |
| NAME OF PROVIDER OR SUPPLIE  |   | DDESS CITY S               | STATE ZID CODE  |          |                               |  |
| NAME OF PROVIDER OR SUPPLIED   | 202 HIGH  |                            | STATE, ZIP CODE   |          |                               |  |
| COMFORTING ANGELS  |   | , MN 56549                 |   |          |                               |  |
| OVA ID CLIMMADY C  |   | <i>-</i>                   |   | CTION    | ()/5)                         |  |
| PREFIX (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRI<br>(EACH CORRECTIVE ACTION SI<br>CROSS-REFERENCED TO THE AP<br>DEFICIENCY) | HOULD BE | (X5)<br>COMPLETE<br>DATE      |  |
| 02015 Continued From p   | age 129   | 02015                      |   |          |                               |  |
| impression the ov<br>ACH than a check  | ner would rather they pay via   |                            |   |          |                               |  |
| •  | 23, the licensee had not filed<br>ts for C1, C2, C3, and C4.  |                            |   |          |                               |  |
| indicated in compall Comforting Angindividually asses vulnerability to abspecific plan to molent. In addition, care are mandate (including suspect vulnerable adult to services, local polent or appropriate lice through the MAAF Reporting Center) following definition years of age or old the person is living abuse or neglect impairment of me | dated Vulnerable Adult policy liance with Minnesota Statutes, gels employees are required to sclients to determine use or neglect and develop a inimize the risk of abuse to that all employees providing home d to report abuse and/or neglect and abuse or neglect) of the sed abuse or neglect) of the other appropriate county social ice department, county sheriff ensing or certifying organization RC (Minnesota Adult Abuse). The policy included the of the policy directed "the borne of the policy directed "the policy directed "the borne of the policy directed "the borne of the policy directed "the policy |                            |   |          |                               |  |
| care employee ha<br>a. Assessment of<br>client upon admis<br>includes self abus  | The policy directed "the home s responsibility for the following: vulnerability status of each sion. Susceptibility to abuse e and neglect and risk of abuse s, including other vulnerable  |                            |   |          |                               |  |
| adults or minors, Physical 2) Verba Sexual 4) Financi The client's risk o adults within the right The vulnerable ac  | n the following areas: 1) (emotional/psychosocial) 3) al Exploitation 5) Self Abuse b. f abusing other vulnerable esidence shall be assessed. c. fult status assessment shall be e clinical record. d. An individual  |                            |   |          |                               |  |
| abuse prevention   | plan shall be established for dult for whom home care   |                            |   |          |                               |  |

Minnesota Department of Health

| H35833  NAME OF PROVIDER OR SUPPLIER  COMFORTING ANGELS  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES  B. WING  B. WING  COMFORT  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10  HAWLEY, MN 56549  (X5)  | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |         | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |          |  |  |
|--|--|---------|--|-------------------------------|----------|--|--|
| NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  10 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE   |  |         |  | C                             |          |  |  |
| COMFORTING ANGELS  202 HIGHWAY 10 HAWLEY, MN 56549  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  DEFICIENCY)  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLET CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DATE   | H35833   | B. WING |  | 04/1                          | 2/2023   |  |  |
| (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLET TAG  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  | COMFORTING ANGELS  |         |  |                               |          |  |  |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)   |  |         |  | ON                            | 045)     |  |  |
| 02015 Continued From page 130 02015  | PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL   | PREFIX  | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO | LD BE                         | COMPLETE |  |  |
|  | 02015 Continued From page 130  | 02015   |  |                               |          |  |  |
| services are provided. 1) The plan shall contain statements of specific measure to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2) The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary.  3) Documentation will include results of the implementation."  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) days | services are provided. 1) The plan shall contain statements of specific measure to be taken to minimize the risk of abuse to that person and other vulnerable adults. 2) The plan will be implemented immediately and evaluated at each supervisory visit or more frequently, if necessary. 3) Documentation will include results of the implementation."  No further information was provided.  TIME PERIOD FOR CORRECTION: Seven (7) |         |  |                               |          |  |  |