MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7274

June 23, 2010

Mariann Snyder, Administrator
The Lutheran Home Cedar Haven
630 Reed Street
Mankato, MN 56001

Re: Results of State Licensing Survey

Dear Ms. Snyder:

The above agency was surveyed on May 3, 4, 6, and 7, 2010, for the purpose of assessing compliance with state licensing regulations. State licensing orders are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me. If further clarification is necessary, an informal conference can be arranged.

A final version of the correction order form is enclosed. This document will be posted on the MDH website.

Also attached is an optional Provider questionnaire, which is a self-mailer, which affords the provider with an opportunity to give feedback on the survey experience.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call our office with any questions at (651) 201-4309.

Sincerely,

Patricia Nelson

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

cc: Blue Earth County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

01/07 CMR3199

CERTIFIED MAIL #: 7009 1410 0000 2303 7274

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900
Home Care and Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	MARIANN L SNYDER	DATE: June 23, 2010
PROVIDER:	THE LUTHERAN HOME CEDAR HAVEN	COUNTY: BLUE EARTH
ADDRESS:	630 REED STREET MANKATO, MN 56001	HFID: 20185

On May 3, 4, 6, and 7, 2010, a surveyor of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed:_____ Date: _____

In accordance with Minnesota Statute §144A.45, this correction order has been issued pursuant to a survey. If, upon re-survey, it is found that the violation or violations cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items may be considered lack of compliance and subject to a fine.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

1. MN Rule 4668.0810 Subp. 6

Based on record review and interview, the licensee failed to maintain a complete record for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted and began receiving home care services October 5, 2000. When the administrator was queried about incident and accident reports related to falls on May 3, 2010, the administrator indicated incident reports related to falls are only kept for one month.

When interviewed May 6, 2010, the administrator recalled that client #1 fell out of her chair the week before Christmas 2009 and it should have been documented in the resident assistant notes. There was no documentation of a fall in the client's record during December 2009.

TO COMPLY: The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services;

(6) names, addresses, and telephone numbers of any responsible persons;

(7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

(9) the client's advance directive, if any;

B. an evaluation and service plan as required under part 4668.0815;

C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;

D. medication and treatment orders, if any;

E. the client's current tuberculosis infection status, if known;

F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;

G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;

I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0815 Subp. 2

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and revised each client's service plan at least annually or more frequently when there was change in the client's condition that required a change in service for two of two clients' (#1 and #2) records reviewed. The findings include:

Client #1 was admitted and began receiving central storage of medication and medication administration October 1, 2007. The service plan, dated October 1, 2007, was not re-evaluated by the RN after October 1, 2007.

Client #2 was admitted and began receiving central storage of medication and medication administration October 5, 2000. The service plan, dated May 17, 2006, was not re-evaluated by the RN after May 17, 2006.

When interviewed May 4, 2010, employee A (RN) did not know the service plans had to be reviewed and revised every year or more frequently when there was a change in the client's condition.

TO COMPLY: A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0855 Subp. 4

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) trained unlicensed personnel in medication administration for one of two unlicensed personnel records (C) reviewed. The findings include:

Employee C was hired February 29, 2008, and began providing direct care, including medication administration. Employee C's unlicensed personnel competency form, dated March 4, 2008, included an area called "Delegated nursing/medical procedures which must be tested by a RN with demo: Packet #10: Med. Administration (MN State EDU.Tool)." The area was blank where documentation of training should have been noted. A note at the bottom of the form indicated a previous RN had observed medication administration on March 7, 2008. There was no evidence of employee C being trained or competency tested by a RN prior to administering medication.

When interviewed May 7, 2010, at 9:15 a.m. employee C stated she was trained at another home care agency to administer medications, but had not been trained to administer medication at this facility, and does administer medications. When interviewed May 7, 2010, the administrator confirmed the area on the unlicensed personnel competency form which indicated training for medication administration was blank, but knew that the training had been done, just probably not documented. No further documentation of training was provided during the survey.

TO COMPLY: Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

(1) the complete procedure for checking a client's medication record;

(2) preparation of the medication for administration;

(3) administration of the medication to the client;

(4) assistance with self-administration of medication;

(5) documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

(6) the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

4. MN Rule 4668.0860 Subp. 2

Based on record review and interview, the licensee failed to obtain a written prescriber's order for each medication administered for two of two clients' (#1 and #2) records reviewed. The findings include:

Client #1's record contained a clinic referral, dated December 17, 2009, which noted a physician's order for acetaminophen (Tylenol) 650 milligrams (mg.) as needed for pain. The April 2010 medication administration record (MAR) indicated Ibuprofen 600 mg. was administered three times for hip pain. There was no prescriber's order for the Ibuprofen.

Client #2's record contained a progress note which noted physician's orders, dated February 17, 2010. The orders stated that Milk of Magnesia Suspension (for bowel) was to be used as directed, Mirtazapine (antidepressant) 30 mg oral tablet, take 1 tablet daily at bedtime, was discontinued and Namenda (for memory) 10 mg oral tablet, take 1 tablet twice daily, was discontinued. The 2010 medication administration records (MAR) from February 17 to May 6, 2010, indicated Namenda and Mirtazapine were administered every day. The February through May 2010 MAR's indicated the Milk of Magnesia was not administered.

When interviewed March 6, 2010, employee A (registered nurse) indicated the Ibuprofen order for client #1 was from the admission standing orders of 2007 which were not renewed every year. She said a clarification of the discontinued orders for client #2 should have been obtained when the progress note was received by the facility, however the date of receipt of the orders was not known**.**

TO COMPLY: There must be a written prescriber's order for a drug for which an class F home care provider licensee provides assistance with self-administration of medication or medication administration, including an over-the-counter drug.

TIME PERIOD FOR CORRECTION: Seven (7) days

5. MN Rule 4668.0860 Subp. 8

Based on record review and interview, the facility failed to implement an order for one of one client's (#1) record reviewed. The findings include:

Client #1 had a prescriber's order, dated April 21, 2010, for Lamisil (antifungal) to the sole of foot/nails 2-3 times per day. The April and May 2010 medication administration records did not indicate the Lamisil had been applied to the sole of the client's foot.

When interviewed May 6, 2010, employee A (registered nurse/RN) indicated they had not been administering the Lamisil to the sole of the client's foot, and she would check with the prescriber to see what he wanted for sure. On May 7, 2010, employee A indicated the doctor did want the Lamisil applied to the sole of the client's foot.

TO COMPLY: When an order is received, the class F home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

TIME PERIOD FOR CORRECTION: Seven (7) days

6. MN Rule 4668.0865 Subp. 2

Based on observation, record review and interview, the licensee failed to develop a service plan which included central storage of medications for two of two clients' (#1 and #2) records reviewed. The findings include:

Observation of the medication storage cupboards on May 4, 2010, in housing with services sites A and B and documentation in client #1's and #2's records indicated the clients received central storage of medications. The service plans for clients #1 and #2, dated October 1, 2007, and May 17, 2006, respectively did not include central storage of medications.

When interviewed May 4, 2010, employee A (registered nurse) did not know that central storage had to be included on the service plan.

TO COMPLY: For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

TIME PERIOD FOR CORRECTION: Thirty (30) days

7. MN Statute §144A.44 Subd. 1(2)

Based on observation, record review and interview, the facility failed to provide home care services according to acceptable medical and nursing standards related to lack of monitoring of medications. The findings include:

Client #1 was admitted and began receiving medication administration October 1, 2007. The client's record contained physician orders, dated December 17, 2009, for Seroquel (antipsychotic) 200 milligrams (mg.) twice a day, Geodon (antipsychotic) 160 mg. once a day, Invega (antipsychotic) 9 mg. once a day, Effexor XR (antidepressant) 150 mg. every day, Amantadine (antiparkinson) 200 mg. daily at bedtime and Ambien (sedative) 10 mg. every day.

A psychiatric nurse practitioner (SNP) visit, dated January 14, 2010, noted an order to increase the Seroquel from 400 mg. to 600 mg. every day and added Trazadone (antidepressant) 100 mg. every day at bedtime, which could be repeated one time. On April 8, 2010, physician's orders indicated the Seroquel could be repeated one time until 4:00 a.m. and the Trazadone was increased to 2-3 tablets as needed for sleep. The client's record did not contain any evidence of monitoring of the medications for potential side effects nor did the record include a diagnosis for the use of Geodon or Invega.

Client #1 was observed on May 4, 6 and 7, 2010, to have exaggerated mouth/lip movements, rock back and forth, and had frequent movements of legs and arms. The client was observed to exhibit the symptoms the entire time during an approximate 20 minute interview on May 7, 2010. When interviewed May 7, 2010, client #1 stated she does take a lot of pills, but doesn't know why. When interviewed May 7, 2010, at 2:30 p.m. employee A (registered nurse/RN) confirmed that no monitoring of the client's medications had been done.

Client #2 was admitted and began receiving medication administration on October 5, 2000. The client's diagnoses include Alzheimer's dementia, major depression, recurrent, partial remission, and delusional disorder. The client's record contained physician's orders, dated February 17, 2010, which included Abilify (antipsychotic) 10 mg. every day, Lexapro (antidepressant) 10 mg. every day, Mirtazapine (antidepressant) 30 mg. every day and Seroquel (antipsychotic) 25 mg. three times a day as needed (PRN). A prescriber's order, dated April 8, 2010, noted to increase the Abilify to 15 mg. daily. The client's 2010 medication administration records revealed that she received the Seroquel forty six times in February and March, eighty three times in April and thus far sixteen times in May.

Client #2's record did not contain any evidence of monitoring of the medications for potential side effects or provide direction when the Seroquel was to be given as needed.

When interviewed May 7, 2010, at 9:15 a.m. employee C indicated that since the Seroquel had been increased client #2 didn't really want to do much anymore. She won't go outside or color and staff have to wake her up for most everything including meals and toileting.

Client #2 was observed quietly attending church service on May 7, 2010, from approximately 1:00 p.m. to 2:00 p.m. During observation of medication administration at 2:00 p.m. on May 7, 2010, employee C (an unlicensed staff who had not yet been trained in medication administration) set up the 2:00 p.m. Seroquel and indicated she was going to give the Seroquel to client #2. The surveyor intervened and asked why she was giving the PRN Seroquel to the client. Employee C stated that other staff had told her it was supposed to be given three times a day. Employee A (registered nurse/RN) then later explained to employee C that the medication was only to be given PRN.

When interviewed May 7, 2010, at 2:30 p.m. employee A explained that the three times a day PRN meant if needed three times a day it could be given, but it should not be given three times a day routinely. Employee A also confirmed that no monitoring of the client's medications had been done and staff had been administering the Seroquel routinely instead of as needed.

TO COMPLY: A person who receives home care services has these rights:
(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

TIME PERIOD FOR CORRECTION: Fourteen (14) days

cc: Blue Earth County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 0661

September 11, 2006

Mariann Snyder, Administrator
The Lutheran Home Cedar Haven
630 Reed Street
Mankato, MN 56001

Re: Licensing Follow Up visit

Dear Ms. Snyder:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on August 16, 2006.

The documents checked below are enclosed.

__X__ Informational Memorandum
Items noted and discussed at the facility visit including status of outstanding licensing correction orders.

_____ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

_____ Notices Of Assessment For Noncompliance With Correction Orders For Home Care Providers

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to call our office if you have any questions at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Blue Earth County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

Minnesota Department Of Health
Division Of Compliance Monitoring
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: THE LUTHERAN HOME CEDAR HAVEN

DATE OF SURVEY: August 16, 2006

BEDS LICENSED:
HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

CENSUS:
HOSP: _____ NH: _____ BCH: _____ SLF: _____

BEDS CERTIFIED:
SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: ALHCP _____

NAMES AND TITLES OF PERSONS INTERVIEWED:
Marian Snyder, Administrator
Pam Hoffman, Resident Assistant

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: # 1

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to followup on the status of state licensing orders issued as a result of a visit made on April 12, 13, and 15, 2005. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the correction orders issued as a result of a visit made on April 12, 13, and 15, 2005, is as follows:

1. MN. Rule 4668.0030 Subp. 2	**Corrected**
2. MN. Rule 4668.0030 Subp. 3	**Corrected**
3. MN. Rule 4668.0810 Subp. 5	**Corrected**
4. MN. Rule 4668.0825 Subp. 4	**Corrected**
5. MN. Rule 4668.0845 Subp. 2	**Corrected**
6. MN. Rule 4668.0865 Subp. 3	**Corrected**
7. MN. Rule 4668.0865 Subp. 9	**Corrected**

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8715 0529

March 15, 2006

Mariann Snyder, Administrator
The Lutheran Home Cedar Haven
630 Reed Street
Mankato, MN 56001

Re: Results of State Licensing Survey

Dear Ms. Snyder:

The above agency was surveyed on April 12, 13, and 15, 2005, for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if found, are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me, or the RN Program Coordinator. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

A final version of the Licensing Survey Form is enclosed. This document will be posted on the MDH website.

Also attached is an optional Provider questionnaire, which is a self-mailer, which affords the provider with an opportunity to give feedback on the survey experience.

Please feel free to call our office with any questions at (651) 215-8703.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Michael Klatt, President Governing Body
Blue Earth County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
CMR File

Assisted Living Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use the Licensing Survey Form during an on-site visit to evaluate the care provided by Assisted Living home care providers (ALHCP). The ALHCP licensee may also use the form to monitor the quality of services provided to clients at any time. Licensees may use their completed Licensing Survey Form to help communicate to MDH nurses during an on-site regulatory visit.

During an on-site visit, MDH nurses will interview ALHCP staff, make observations, and review some of the agency's documentation. The nurses may also talk to clients and/or their representatives. This is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Assisted Living services. Completing the Licensing Survey Form in advance may expedite the survey process.

Licensing requirements listed below are reviewed during a survey. A determination is made whether the requirements are met or not met for each Indicator of Compliance box. This form must be used in conjunction with a copy of the ALHCP home care regulations. Any violations of ALHCP licensing requirements are noted at the end of the survey form.

Name of ALHCP: THE LUTHERAN HOME CEDAR HAVEN

HFID # (MDH internal use): 20185

Dates of Survey: April 12, 13, and 15, 2005

Project # (MDH internal use): QL20185001

Indicators of Compliance	Outcomes Observed	Comments
1. The agency only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. (MN Rules 4668.0050, 4668.0800 Subpart 3, 4668.0815, 4668.0825, 4668.0845, 4668.0865)	Each client has an assessment and service plan developed by a registered nurse within 2 weeks and prior to initiation of delegated nursing services, reviewed at least annually, and as needed. The service plan accurately describes the client's needs. Care is provided as stated in the service plan. The client and/or representative understands what care will be provided and what it costs.	___ Met X Correction Order(s) issued X Education provided

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promote the clients' rights as stated in the Minnesota Home Care Bill of Rights. (MN Statute 144A.44; MN Rule 4668.0030)	No violations of the MN Home Care Bill of Rights (BOR) are noted during observations, interviews, or review of the agency's documentation. Clients and/or their representatives receive a copy of the BOR when (or before) services are initiated. There is written acknowledgement in the client's clinical record to show that the BOR was received (or why acknowledgement could not be obtained).	___ Met _X_ Correction Order(s) issued _X_ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff observe infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	_X_ Met ___ Correction Order(s) issued ___ Education provided
4. The agency has a system to receive, investigate, and resolve complaints from its clients and/or their representatives. (MN Rule 4668.0040)	There is a formal system for complaints. Clients and/or their representatives are aware of the complaint system. Complaints are investigated and resolved by agency staff.	_X_ Met ___ Correction Order(s) issued ___ Education provided
5. The clients' confidentiality is maintained. (MN Statute 144A.44; MN Rule 4668.0810)	**Client personal information and records are secure.** **Any information about clients is released only to appropriate parties.** Permission to release information is obtained, as required, from clients and/or their representatives.	___ Met _X_ Correction Order(s) issued _X_ Education provided
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	_X_ Met ___ Correction Order(s) issued ___ Education provided

Indicators of Compliance	Outcomes Observed	Comments
7. The agency employs (or contracts with) qualified staff. (MN Statutes 144D.065; 144A.45, Subd. 5; MN Rules 4668.0070, 4668.0820, 4668.0825, 4668.0030, 4668.0835, 4668.0840)	Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff who are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	___ Met _X_ Correction Order(s) issued _X_ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	___ Met _X_ Correction Order(s) issued _X_ Education provided ___ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ___ Correction Order(s) issued ___ Education provided ___ N/A
10. The agency has a current license. (MN Statutes 144D.02, 144D.04, 144D.05, 144A.46; MN Rule 4668.0012 Subp.17) Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	The ALHCP license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. The agency operates within its license(s).	_X_ Met ___ Correction Order(s) issued ___ Education provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other violations may be cited depending on what systems a provider has or fails to have in place and/or the severity of a violation. Also, the results of the focused licensing survey may result in an expanded survey where additional interviews, observations, and documentation reviews are conducted.

Survey Results:

_____ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met and/or education provided, list the number, regulation number, and example(s) of deficient practice noted:

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
#1	MN Rule 4668.0845 Subp. 2 Services the require supervision by a registered nurse	X	X	Based on record review and interview, the agency failed to have a registered nurse (RN) supervise unlicensed personnel who perform services that require supervision for two of four clients' (A2 and B2) records reviewed. The findings include: Client A2 received delegated nursing services, including assistance with medication administration. The client's record contained an RN supervisory visit dated May 11, 2004. The administrator verified this was the last recorded supervisory visit for the client. Client B2 received delegated nursing services, including assistance with delegated nursing procedures. The client's record contained an RN supervisory visit dated May 12, 2004. The administrator verified this was the last recorded supervisory visit for the client. When interviewed, April 13, 2005, the administrator stated the agency had recently hired a new RN and following her hire it became evident that 62 day supervisory visits had not been consistently conducted. **Education:** Provided
#2	MN Rule 4668.0030 Subp. 2 Notification of client	X	X	Based on record review and interview, the agency failed to provide an up to date copy of the Minnesota Home Care Bill of Rights to one of four clients' (A1) records reviewed. The findings include:

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				Client A1 began receiving services July 2004 and received a copy of the bill of rights dated July 1999. When interviewed, April 13, 2005, the administrator verified the client did not have a copy of the current bill of rights. **Education:** Provided
#2	MN Rule 4668.0030 Subp. 3 Time of notice	X	X	Based on record review and interview, the agency failed to provide a written copy of the Minnesota Home Care Bill of Rights to one of four clients' (B2) records reviewed. The findings include: Client B2 began receiving services March 1997. There was no evidence that client B2 had been provided a copy of the home care bill of rights. When interviewed, April 13, 2005, the administrator verified the client did not have a copy of the bill of rights. **Education:** Provided
#5	MN Rule 4668.0810 Subp. 5 Form of entries	X	X	Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name of the person making the entry for four of four clients' (A1, B1, A2, and B2) records reviewed. The findings include: Clients A1, B1, A2 and B2's records contained narrative notes by resident assistants, which were authenticated with only their initials and title. When interviewed, April 13, 2005, the administrator verified the resident assistants used only their initials when making entries in the client record. **Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
#7	MN Rule 4668.0825 Subp. 4 Performance of routine procedures	X	X	Based on record review and interview, the agency failed to retain documentation of demonstration of competencies for staff performing delegated nursing procedures for two of four clients' (A1 and B2) records reviewed. The findings include: Client A1 had a physician's order for a treatment procedure. When interviewed, April 13, 2005, employee C, a resident assistant, stated the registered nurse (RN) had instructed her on the treatment procedure and indicated there were instructions in the resident's medication book on the procedure. When interviewed, April 13, 2005, the RN stated she had provided the training on the treatment procedure, but had not completed or retained any documentation related to employee C's training and competency on the procedure. Client B2's record contained documentation that employee E provided a delegated nursing procedure for her/him. When interviewed, April 13, 2005, the RN indicated the procedure for the delegated nursing procedure was in the medication book and available for all staff to review. The RN verified there was no documentation of employee E's demonstrated competency for this delegated nursing procedure. **Education:** Provided
#8	MN Rule 4668.0865 Subp. 3 Control of Medications	X	X	Based on observation and interview, the agency failed to maintain a system for the control of medications. The findings include: The medication storage area for building A was observed on April 12, 2005 with the registered nurse (RN) in attendance. The following expired

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				items were noted; client A3 had medications that expired June 6, 2004 and January 2005; client A4 had a bottle of lotion that expired November 13, 2003; client A2 had a container of Accu-Chek comfort curve lancets with an expiration date on the box for October 29, 2004; and a stock supply bottle of Rulox suspension had an expiration date of March 2005. The RN removed the outdated items from the medication storage area. The RN stated she began her employment with the agency about three weeks ago and was unaware that the medication storage area contained outdated items. **Education:** Provided
#8	MN Rule 4668.0865 Subp. 9 Storage of Schedule II drugs	X	X	Based on observation and interview, the agency failed to assure that schedule II drugs were properly stored. The findings include: The medication storage area for building A was reviewed April 12, 2005 with the registered nurse (RN) in attendance. A bubble pack of a controlled medication for client A5 was observed in a metal box, in a drawer. The metal box was not permanently affixed to the drawer and/or physical plant. The RN stated there was no current system in use to store controlled drugs, which attached the metal box to the physical plant. **Education:** Provided

A draft copy of this completed form was left with Marianne Snyder, Administrator at an exit conference on date April 15, 2005. Any correction orders issued as a result of the on-site visit and the final Licensing Survey Form will arrive by certified mail to the licensee within 3 weeks of this exit conference (see Correction Order form HE-01239-03). If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 215-8703. After supervisory review, this form will be posted on the MDH website. General information about ALHCP is also available on the website:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurvey.htm

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

(Form Revision 7/04)