MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9971 7759

January 27, 2009

Lucinda Gardner, Adnministrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55442

Re: Results of State Licensing Survey

Dear Ms. Gardner:

The above agency was surveyed on November 3, 4, and 5, 2008, 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 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) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Service
Sherilyn Moe, Office of the Ombudsman
Deb Peterson, Office of the Attorney General

01/07 CMR3199

Class F Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class F home care providers (Class F). Class F licensees may also use this 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 staff, talk with clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class F Home Care services. Completing this Licensing Survey Form in advance may facilitate 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 Class F home care regulations. Any violations of Class F Home Care Provider licensing requirements are noted at the end of the survey form.

Name of CLASS F: COPPERFIELD HILL PHASE II

HFID #: 20297

Date(s) of Survey: November 3, 4 and 5, 2008

Project #: QL20297005

Indicators of Compliance	Outcomes Observed	Comments
1. The provider only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. **Focus Survey** • MN Rule 4668.0815 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0825 Subp. 2 • MN Rule 4668.0845	• 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 understand what care will be provided and what it costs.	**Focus Survey** ____Met _X_Correction Order(s) issued X___Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4200 The provider promotes the clients' rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170 • MN Statute §144D.04 • MN Rule 4668.0870	• Clients are aware of and have their rights honored. • Clients are informed of and afforded the right to file a complaint. • Continuity of Care is promoted for clients who are discharged from the agency.	**Focus Survey** _X_ Met ____ Correction Order(s) issued ____ Education Provided **Expanded Survey** ____ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided
4201 The health, safety, and well being of clients are protected and promoted. **Focus Survey** • MN Statute §144A.46 • MN Statute §626.557 **Expanded Survey** • MN Rule 4668.0035 • MN Rule 4668.0805	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Agency personnel 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.	**Focus Survey** ____ Met _X_ Correction Order(s) issued X Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• 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 that 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. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 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 CLASS F 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) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** _X_Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
8. The provider is in compliance with MDH waivers and variances **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** _#_ ____ New Correction Order issued ____ Education Provided

<u>Please note</u>: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings of the focused licensing survey may result in an expanded survey.

<u>SURVEY RESULTS:</u> ___ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE # 5

Based on record review and interview, the licensee failed to ensure that tuberculosis screening was completed for one of one employee's (# 2) records reviewed. The findings include:

Employee B began employment, and direct client care July of 2008. Employee B's record lacked documentation of having received tuberculosis screening. When interviewed, November 4, 2008, employee B stated she had a positive Mantoux in 1997 and had subsequent negative chest x-rays in 1997, 2005 and 2007.

When interviewed, November 5, 2008, the director stated she was unable to locate any documentation of employee B's Mantoux or chest x-rays.

2. MN Rule 4668.0810 Subp. 6

INDICATOR OF COMPLIANCE # 4

Based on record review and interview the licensee failed to maintain an accurate, up to date record for one of one client (#1) records reviewed. The findings include:

Client #1 was readmitted to the facility October of 2008, from the hospital. Physician's orders dated October of 2008 included several orders for medication administration. Client #1's "Resident Profile" dated, October of 2008, indicated the client received medication administration from unlicensed staff. Client #1's record lacked documentation of medication administration from October 12, 2008 to October 26, 2008, when the client was readmitted to the hospital as some of the client's medication administration records were unavailable. Client #1's "resident profile," dated October 9, 2008, indicated the client was to have laundry done weekly on Thursdays; housekeeping weekly on Wednesdays; bed made, daily; shower assistance every Monday, Wednesday, and Fridays and daily assist with AM cares. The "monthly service chart" for October for client #1 lacked documentation of laundry; AM cares and bed making were documented as being done daily the entire month of October, even though the client was hospitalized from October 1, 2008 to October 2, 2008; October 10, 2008 to October 12, 2008; October 26, 2008 to October 28, 2008; and shower assistance was documented as being provided on October 11, 18 and 22, 2008 only.

When interviewed, November 4, 2008, the licensed practical nurse stated she was unable to find the medication administration records (MAR) for client #1 for this period of time.

When interviewed November 4, 2008, employee D, an unlicensed caregiver who worked with client #1, stated the monthly service charts were to be documented on daily after completing the cares. She did not know why the October service chart did not have documentation of client #1's laundry or why AM cares and bed making were documented as being done daily even while the client was in the hospital. When interviewed, November 4, 2008, client #1 stated the staff did assist with housekeeping and laundry weekly and with showers every other day.

3. MN Rule 4668.0815 Subp. 4

INDICATOR OF COMPLIANCE # 1

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

Client #1 was admitted to the care of the licensee June of 2008. The service plan for client #1, dated June of 2008, indicated the client was to receive "medication management" by the registered nurse and licensed practical nurse. Medication Management was not defined. According to the "Assessment for need for medication reminders, assistance, administration or central storage," dated June of 2008, the client was to receive administration of medications and central storage of medications. This was not on the service plan. On November 4, 2008, it was observed that the client had his medications stored in central storage. The service plan also lacked this service.

When interviewed, November 4, 2008, the licensed practical nurse confirmed that unlicensed personnel administered the medications to client #1. The service plan lacked identification of the unlicensed

personnel as the providers of mediation administration and the schedule or frequency of sessions of supervision. When interviewed, November 5, 2008, the director confirmed the service plans were incomplete.

4. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE # 5

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for two of two clients' (#1 and #2) records reviewed. The findings include:

Client #1's record indicated that November 1, 2008, a blood glucose test had been performed by employee B, an unlicensed staff person. Client #2's Medication Administration Record indicated that on October 22, 2008, employee B recorded a blood pressure (BP) for client #2.

Employee B's record lacked evidence of RN instruction, training and competency for the delegated task of blood glucose testing and checking a client's blood pressure.

When interviewed November 5, 2008, employee B stated she had performed the blood glucose test for client #1 and the BP for client #2. Employee B confirmed the licensee's RN had not instructed her on the performance of blood glucose testing or blood pressure checks, nor had she demonstrated to the RN her ability to competently perform the procedures. The RN who was employed at the time of employee B's employment, was no longer employed by the licensee.

5. MN Rule 4668.0845 Subp. 2

INDICATOR OF COMPLIANCE # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for one of one client's (#1) records reviewed. The findings include:

Client #1 began receiving services June of 2008. The "Resident Profile," dated October of 2008, indicated the client received assistance with medication administration and bathing by unlicensed personnel. The last supervisory visit documented in the client's record was dated June 24, 2008.

When interviewed, November 4, 2008, the licensed practical nurse (LPN) stated the RN had delegated supervisory visits to other LPNs to perform, although she was unsure if the visits had been completed. The LPN stated the supervisory visit forms should be filed in the client's record if they had been done. When interviewed, November 3, 2008, the director stated she did not know why the supervisory visits had not been done, and stated the RN had terminated her employment on October 31, 2008.

6. MN Rule 4668.0855 Subp. 3

INDICATOR OF COMPLIANCE # 6

Based on observations and interview the licensee failed to ensure that unlicensed staff administered medications that were set up by a nurse, physician or pharmacist for one of one client's (#1) records reviewed. The findings include:

During observation of client #1's central storage of medications, November 4, 2008, it was noted that the bubble pack for the medication omeprazole had directions to "take 2 capsules orally every day." "Bubble" number twenty-four on the bubble pack contained one capsule of omeprazole which had been taped back into the bubble, and should have been administered on November 2, 2008. When interviewed, November 4, 2008, employee C, an unlicensed staff person who had administered morning medications to client #1 November 2, 2008, stated he had no idea why one pill remained in the "bubble." He stated that he had not removed any of client #1's medications from the "bubble pack," for the 7:30 AM administration, as the client's medications had already been set up in a single dose box by another unlicensed staff person. Employee C stated that the unlicensed staff person had set up the medications for six other clients, and that he had administered these medications as well.

When interviewed, November 4, 2008, the licensed practical nurse stated she was unaware that this practice had occurred and that disciplinary action of the employee's involved had been taken.

7. MN Rule 4668.0855 Subp. 4

INDICATOR OF COMPLIANCE # 6

Based on record review and interview, the licensee failed to have a registered nurse (RN) instruct unlicensed personnel on the procedures to follow when assisting a client with self-administration of medications prior to delegating this task, for one of one client's (#1) records reviewed: The findings include:

Client #1 began receiving services June of 2008, which included assistance with self-administration of medications by employee B. There was no evidence that employee B had been trained on the procedures to follow when assisting a client with self-administration of medications.

When interviewed November 4, 2008, employee B stated she provided assistance with medication administration for client #1 by setting up the medications and bringing them to the client. Employee B confirmed she had not been trained by the licensee's registered nurse (RN) in the medication administration procedures. Employee B stated she had been trained as a trained medication assistant (TMA) at a vocational school and when she started working for the licensee, she was trained by another TMA.

8. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE # 6

Based on record review and interview the licensee failed to ensure that medications were administered as prescribed for one of one client's (#1) records reviewed. The findings include:

Client #1's medical record indicated he returned from a hospitalization on October of 2008, and received assistance with medication administration. The hospital order sheet from his return from the hospital indicated the client was to receive Lantus insulin twenty-one units subcutaneously at bedtime and metoprolol tartrate twenty-five milligrams twice a day. The client's October and November 2008 medication administration record (MAR) indicated the client received Lantus insulin thirty units subcutaneously from October 28, 2008, through November 2, 2008, and metoprolol tartrate twenty-five milligrams one time per day from October 29, 2008 through November 4, 2008.

When interviewed November 4, 2008, the licensed practical nurse (LPN) stated the registered nurse (RN), who was no longer employed by the licensee, had implemented the return from hospitalization orders on October of 2008. The LPN stated that upon the client's return from the hospital, the RN questioned the accuracy of the Lantus insulin order with the prescriber. The LPN stated the RN questioned the prescriber by fax and the prescriber returned a faxed order October of 2008, indicating the client was to receive Lantus thirty units every day at bedtime. The LPN stated she was unaware the client's metoprolol tartrate order had been changed October of 2008 and did not know why the RN had not changed the MAR to reflect the current order. The record lacked evidence as to why the medications were not administered as prescribed.

Client #1's return from hospitalization orders included that the client was to receive Plavix 75 milligrams every day, Prilosec 40 milligrams daily, Spiriva one capsule daily, Advair Discus one puff by inhalation twice a day, Metamucil one tablet twice a day, and Zocor 40 milligrams at bedtime. The client's MAR's for October and November 2008, lacked documentation of the administration of Plavix, Prilosec, Spiriva, Advair Discus, and Metamucil on October 30 and 31, 2008, and Zocor on November 1, 2008. When interviewed on November 4, 2008, the LPN stated she did not know if the medications were administered or not. She stated the protocol for the unlicensed staff to follow if they did not administer a medication, was to circle their initials on the day the medication was to be administered and document on the back of the MAR the reason the medication was not administered as prescribed. The record lacked evidence as to why these medications were not administered as prescribed.

During observations of client #1's central storage of medications on November 4, 2008, it was noted that the bubble pack for the omeprazole had directions to "take 2 capsules orally every day." The bubble pack contained two capsules of omeprazole 20 milligrams each in each bubble. The" bubble" for number 24, which should have been administered November 2, 2008, contained one capsule of omeprazole 20 milligrams, which had been taped back into the bubble.

On interview, November 4, 2008, employee C, unlicensed personnel who had administered morning medications to client #1 on November 2, 2008, stated he had no idea why one pill remained in the "bubble." He stated that he had not removed any of client #1's medications from the "bubble pack" for the 7:30 AM administration, as the medications had already been set up in a single dose box by other unlicensed personnel. When interviewed, November 5, 2008, the LPN stated she was unable to determine from staff why one capsule of the omeprazole was taped back into the bubble pack and not administered.

9. MN Rule 4668.0860 Subp. 7

INDICATOR OF COMPLIANCE # 6

Based on record review and interview the licensee failed to obtain a prescriber's signature on an order received by facsimile for one of one client's (#1) records reviewed. The findings include:

Client #1's medical record indicated he returned from the hospital October of 2008, and received assistance with medication administration. Client #1's faxed medication orders from the hospital, were not signed by the prescriber.

When interviewed, November 4, 2008, the licensed practical nurse (LPN) stated the registered nurse (RN) who no longer was employed by the licensee, had implemented these orders. The LPN stated that when she (the LPN) received orders from the hospital that were not signed she would fax them to the prescriber for signature or write a telephone order for the orders. She did not know why the RN had not faxed the orders for a prescriber's signature; however, the RN had faxed the physician for clarification of some of the medication orders.

10. MN Rule 4668.0865 Subp. 2

INDICATOR OF COMPLIANCE # 6

Based on record review and interview the licensee failed to develop a service plan for the provision of central storage of medications for one of one client's (#1) records reviewed. The findings include:

Client #1 began receiving services from the licensee June of 2008. An assessment dated June of 2008, indicated the client was to receive administration of medications and central storage of medications. The client's service plan did not include central storage of medications.

When interviewed November 4, 2008, the director stated she did not know why the registered nurse (RN), who was no longer employed by the licensee, had not included central storage of medications on the client's service plan.

11. MN Rule 4668.0865 Subp. 3

INDICATOR OF COMPLIANCE # 6

Based on observation, record review, interview the licensee failed to establish and maintain a system that addresses the control of medications for one of one client's (#1) records reviewed. The findings include:

During observation of client #1's central storage of medications, on November 4, 2008, it was noted that the bubble pack for the omeprazole had directions to "take 2 capsules orally every day". The" bubble" for number 24, which should have been administered November 2, 2008, contained one capsule of omeprazole, which had been opened and taped back into the bubble. When interviewed, November 4, 2008, employee C, an unlicensed personnel, who had administered morning medications to client #1 on November 2, 2008, stated he had no idea why one pill remained in the "bubble." He stated that he had not punched any of client #1's medications from the "bubble pack" for the 7:30 AM administration, as

the medications had already been set up in a single dose box by another unlicensed personnel. He also stated that the other unlicensed personnel had set up the medications for six other clients, and that he administered these medications as well. On interview, November 4, 2008, the licensed practical nurse (LPN) stated she was unaware that this had occurred and disciplinary action had been taken regarding this practice.

Client #1's medical record indicated client #1 returned from the hospital October of 2008. The LPN stated client #1 received central storage of medications and assistance with medication administration from unlicensed personnel. Physician orders for October of 2008, indicated the client was to receive metoprolol tartrate 25 milligrams twice a day. The medication administration record (MAR) for client #1 indicated the client received metoprolol tartrate 25 miligrams only once per day from October 29, 2008, through the November 4, 2008. On interview, November 4, 2008, the LPN stated she was unaware the client's metoprolol tartrate order had been changed on October of 2008, and did not know why the RN had not changed the MAR to reflect the current order. The record lacked documentation as to why the medications were not administered as ordered.

Physician orders dated October of 2008, for client #1 also indicated the client was to receive: Plavix 75 milligrams every day; Prilosec 40 milligrams daily; Spiriva, one capsule daily; Advair discus, one puff by inhalation twice a day; Metamucil, one tablet twice a day; and Zocor 40 milligrams at bedtime. The medication administration record for October, 2008 lacked documentation of the administration of Plavix, Prilosec, Spiriva, Advair discus, and Metamucil on October 30 and 31, 2008; and Zocor on November 1, 2008. On interview November 4, 2008, the LPN stated she did not know if the medications were administered and not documented or not administered and not documented. She stated the protocol for the unlicensed staff, if they did not administer a medication, was to circle their initials on the day the medication was to be administered and document on the back of the MAR the reason the medication was not administered as ordered. The MAR lacked documentation as to why these medications were not administered as ordered.

During observation of client #1's central storage of medications, on November 4, 2008, it was noted that the bubble pack for the omeprazole had directions to "take 2 capsules orally every day". The bubble pack contained 2 capsules of omeprazole 20 milligrams each in each bubble. The" bubble" for number 24, which should have been administered November 2, 2008, contained one capsule of omeprazole, 20 milligrams, which had been taped back into the bubble. On interview, November 4, 2008, employee C, an unlicensed personnel, who had administered morning medications to client #1 on November 2, 2008, stated he had no idea why one pill remained in the "bubble". He stated that he had not punched any of client #1's medications from the "bubble pack", for the 7:30 AM administration, as the medications had already been set up in a single dose box by other unlicensed personnel. When interviewed, November 5,

2008, the LPN stated she was unable to determine from staff why one capsule of the omeprazole was taped back into the bubble pack and not administered.

Client #3's record, November 4, 2008, indicated the client received assistance with administration of medications.

On November 4, 2008, the LPN stated the licensee had recently switched the set up of medications for client #3 to a pharmacy that packaged all of the medications given at a specific time in a sealed package. The unlicensed staff could then open, and give the medications to the client at the specific time the medications were ordered to be given. The outside of the package listed the name, dosage, and color of

each medication that was sealed in that package and the time the medications were to be given. At the time the pharmacy delivered the medications to the licensee, the pharmacist and the LPN checked each medication that was ordered to be given at each specific time to make certain the package contained the right medications for the right time of administration. It was during this check that it was noted the pharmacy had missed packaging one of the medications that was to be given at 8 PM to client #3. The LPN called the pharmacy to inform them of the missing medication; the pharmacy sent over the missing medication which the LPN then added to the sealed package by making a small slit into the package, inserting the missing medication and taping the slit with scotch tape. A few days after the LPN had added the missed medication to the package, the physician discontinued the medication and the LPN removed the medication from the packages. The LPN stated that if several days of the sealed packages were left, when the order was changed, the pharmacy would take the set up packages back to the pharmacy and refill them with the proper medications; however, if it was just for a few days, the LPN would make changes by the above method. There was no change on the descriptive listing on the packet when the packets were opened in the facility and medications were added or removed. The LPN stated she had also used this method if a medication change involved discontinuing a medication or changing the dosage etc.

12. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE # 3

Based on record review and interview the licensee failed to establish a written abuse prevention plan for one of one client's (#1) records reviewed. The findings include:

Client #1 began receiving services from the licensee June of 2008. Client #1's record lacked an abuse prevention plan. The Resident Care Plan, dated June of 2008, had a "vulnerability status" assessment area, which was blank.

When interviewed, November 4, 2008, the licensed practical nurse stated the registered nurse had terminated employment October 31, 2008, and she was unaware of the assessments that were done on the clients.

A draft copy of this completed form was faxed to Lucinda Gardner at an exit telephone conference on November 18, 2008. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. Class F Home Care Provider general information is available by going to the following web address and clicking on the Class F Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

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).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1220 4692

January 24, 2007

Lucinda Gartner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422

Re: Licensing Follow Up visit

Dear Ms Gartner:

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 December 19, 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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: COPPERFIELD HILL PHASE II

DATE OF SURVEY: December 19, 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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Roslyn Walker RN, Nurse Administrator

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: # 4

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on June 22, 23, and 25, 2004 and subsequent follow up visits made on February 10 and 14, 2005, October 31, 2005 and July 19, 2006. 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 February 10 and 14, 2005 and October 31, 2005 and July 19, 2006 is as follows:

1. MN Statute §144A.44 Subd. 1 (2) Corrected.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 1743

August 15, 2006

Lucinda Gartner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55442

Re: Licensing Follow Up visit

Dear Ms. Gartner:

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 July 19, 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.

__X__ 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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

06/06 FPC1000CMR

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 1743

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOLLOWING A SUBSEQUENT REINSPECTION FOR ASSISTED LIVING HOME CARE PROVIDERS

August 15, 2006

Lucinda Garner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55442

RE: QL20297006

Dear Ms. Gartner:

1. On July 19, 2006, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of follow up visits to an original survey completed on June 22, 23, and 25, 2004, and subsequent follow up visits made on February 10 and 14, 2005, with correction orders received by you on September 9, 2004, July 18, 2005, and December 22, 2005, and found to be uncorrected during an inspection completed on October 31, 2005.

As a result of correction orders remaining uncorrected on the October 31, 2005 re-inspection, a penalty assessment in the amount of $250.00 was imposed on December 20, 2005.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on July 19, 2006.

1. MN Statute §144A.44 Subd. 1(2) $500.00

Based on observation, record review, and interview the licensee failed to provide services subject to acceptable nursing standards for three of three clients (#1, #2 and #3). The findings include:

Client #1 had a current service plan dated June 2, 2004. The service plan indicated that the agency would provide "medication management." During a home visit, February 10, 2005, client#1 stated that facility staff did not clean her nebulizer equipment and that it was dirty. The nebulizer equipment was observed to be dirty and had left over medication in it. Client #1 received assistance with administration of Duoneb 2.5 –0.5mg/ 3 ml solution 1 vial per nebulizer four times daily. A licensed practical nurse (LPN) was present during the interview and

confirmed the nebulizer set up was dirty. She stated staff "are supposed to clean it but they don't." During the visit the LPN cleaned the nebulizer equipment and then laid it on a wooden ledge to dry.

Client #3 had a current service plan dated June 2, 2004. The service plan indicated that the agency would provide "medication management." During a home visit, February 10, 2005, client #3's nebulizer mask was observed to be dirty. Client #3 received Albuterol and Atrovent nebulizers four times daily. Client #3 stated "I clean it sometimes but don't know to clean this part (points to mask)." He added that he cleaned the nebulizer equipment himself because "I don't think they know how." When interviewed February 10, 2005, the agency LPN stated that "medication management" meant ordering medications from the pharmacy, updating orders and medication sheets with changes, medication set up and giving it to the clients. When interviewed February 10, 2005, the Vice President of Clinical Services verified medication management included medication administration.

TO COMPLY: 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;

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $500.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **$500.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Division of Compliance Monitoring, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the correction orders have not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine.

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 will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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.

August 15, 2006

If you have any questions, please feel free to give me a call at 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

Minnesota Department Of Health
Health Policy, Information and Compliance Monitoring Division
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: COPPERFIELD HILL PHASE II

DATE OF SURVEY: July 19, 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 _____

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Jennifer Anderson, Manager/Chief Operating Officer
Quenna Sloane, LPN Manager, Becky Anderson LPN, Eliza Wilson TMA

SUBJECT: Licensing Survey _____ Licensing Order Follow Up #3

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to followup on the status of state licensing orders issued as a result of follow up visits to an original visit made on June 22, 23, and 25, 2004 and subsequent follow up visits made on February 10 and 14, 2005 and October 31, 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 order issued from the survey on February 10 and 14, 2005 is as follows:

1. MN Statute §144A.44 Subd. 1(2) Not Corrected $500.00

Based on observation, record review and interview the licensee failed to provide services subject to acceptable nursing standards for one of two clients (#3) records reviewed. The findings include:

Client #3's service plan dated December 23, 2005 indicated the assisted living agency provided medication management, medication administration, and central storage of medications. During a home visit, July 19, 2006 at 2pm, client #3's nebulizer (breathing treatment) mask had dried white crusty debris observed on it. It remained attached to the tubing. There were 2 unopened dosage vials of medication were in the nebulizer machine

holding are awaiting administration for that day at 4pm and 8pm.

When interviewed during this home visit client #3 stated staff never wash his nebulizer equipment "I do." Client #3 indicated he "sometimes" got supplies and changed the tubing and stated he cleaned the medication chamber one to two times per week with soap but not the mask.
Client #3's undated Medication Assessment, signed by a registered nurse no longer at the agency, identified that client #3 needed assistance to administer inhaled medications. The physician's orders dated November 11, 2005 indicated Albuterol and Atrovent nebulizers four times daily per self.
When interviewed, July 19, 2006, employees A, B, and C, licensed practical nurses and a trained medication aide, stated client #3 self administered nebulizers. They stated that was why the cleaning wasn't getting done since they do it when the client requires medication assistance and then they sign off the cleaning on the Medication Administration Record. They confirmed client#3's nebulizer equipment had not been cleaned or had the tubing or mask replaced by staff. This reviewer showed employees A, B, and C the June and July 2006 medication sheets on which approximately half of the nebulizer doses were signed by staff as administered by staff and approximately half were marked as "self." Employees A, B, and C confirmed that all nebulizer doses should have been signed as "self" since client #3 did it independently.
When interviewed, July 19, 2006, the Chief Operating Officer confirmed there was a "Nebulizer Treatment Cleaning Procedure" and indicated she was not aware client #3's nebulizer equipment had not been cleaned or of the discrepancies related to nebulizer administration.

2) MN Rule 4668.0855 Subp. 2 **Corrected**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 004 8711 9625

Lucinda Gartner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422

RE: QL20297006

Dear Ms. Gartner:

On November 18, 2005 you were sent a Notice Of Assessment For Noncompliance With Correction Orders as the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. **Please disregard the information that was mailed to you.** Subsequent to that mailing, an error was noted in the information that was mailed to you.

Attached is the corrected Notice Of Assessment For Noncompliance With Correction Orders. The amended information that has been corrected is underscored and the stricken [~~stricken~~] information has been removed.

The documents checked below are enclosed.

_____ 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.

__X__ Notice Of Assessment For Noncompliance With Correction Orders Home Care Providers

Feel free to call our office if you have any questions at (651) 215-8703.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Darrel Farr, President Governing Board
Gloria Lehnertz, Minnesota Department of Human Services
Hennepin County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 9625

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR ASSISTED LIVING HOME CARE PROVIDERS
AMMENDED

December 20, 2005

Lucinda Gartner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422

RE: QL20297006

Dear Ms. Gartner:

On October 31, 2005 a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during a survey completed on June 22, 23, and 25, 2004, with correction orders received by you on September 9, 2004, and a follow-up survey completed on February 10 and 14, 2005, with correction orders received by you on July 18, 2005.

The following correction orders from the February 10 and 14, 2005 follow-up survey were not corrected in the time period allowed for correction:

1. MN Statute §144A.44 Subd. ~~2~~ 1(2) **$250.00**

Based on observation, record review, and interview the licensee failed to provide services subject to acceptable nursing standards for three of three clients (#1, #2 and #3). The findings include:

Client #1 had a current service plan dated June 2, 2004. The service plan indicated that the agency would provide "medication management." During a home visit, February 10, 2005, client#1 stated that facility staff did not clean her nebulizer equipment and that it was dirty. The nebulizer equipment was observed to be dirty and had left over medication in it. Client #1 received assistance with administration of Duoneb 2.5 –0.5mg/ 3 ml solution 1 vial per nebulizer four times daily. A licensed practical nurse (LPN) was present during the interview and confirmed the nebulizer set up was dirty. She stated staff "are supposed to clean it but they don't." During the visit the LPN cleaned the nebulizer equipment and then laid it on a wooden ledge to dry.

Client #3 had a current service plan dated June 2, 2004. The service plan indicated that the agency would provide "medication management." During a home visit, February 10, 2005, client

#3's nebulizer mask was observed to be dirty. Client #3 received Albuterol and Atrovent nebulizers four times daily. Client #3 stated "I clean it sometimes but don't know to clean this part (points to mask)." He added that he cleaned the nebulizer equipment himself because "I don't think they know how." When interviewed February 10, 2005, the agency LPN stated that "medication management" meant ordering medications from the pharmacy, updating orders and medication sheets with changes, medication set up and giving it to the clients. When interviewed February 10, 2005, the Vice President of Clinical Services verified medication management included medication administration.

TO COMPLY: 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;

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 250.00.

2. MN Rule 4668.0855 Subp. 2 **$350.00**

Based on observation, interview, record review, the licensee failed to have a registered nurse assess the functional status and need for assistance with medication administration for two of three clients (#1 and #3) reviewed who receive assistance with medication administration. The findings include:

Client # 1's service plan dated June 2, 2004 indicated "medication management" services. Client #1 received multiple oral and inhaled medications. The ordered medications included a physician's order dated June 7, 2004, for "Duoneb 2.5 –0.5mg/ 3 ml solution 1 vial per neb. 4 times daily at 8am, noon, 4 pm, and 8pm." The February medication administration record (MAR) stated "self" for administration of the four daily doses of inhaled medication. All other medications were signed as administered by staff.
When interviewed, February 10, 2005, client #1 stated staff assisted her with all medications except she took her inhaled medication by her self. Client #1 also stated that she took her Duonebs "every 4 hours: 8 am, 11 am, 3pm, 6pm and 8 pm" thus indicating she took her nebulizer treatments five times a day rather than four times a day as ordered. When interviewed, February 10, 2005, the licensed practical nurse (LPN) stated that client #1 was assessed as being independent with her nebulizer treatments. There was no documentation in client #1's medical record to reflect that she had been assessed for the nebulizer treatments or assistance with medications.
Client # 3's service plan dated June 21, 2004 indicated "medication management" services. Client #3 received oral and inhaled medications. The ordered medications included a physician's orders for Albuterol + Atrovent Nebs QID (four times daily) and Advair Disc 500/50 1 puff 2 times daily. The February 2005 medication administration record indicated "Advair Disc 500/50 1 puff 2 times daily; SELF." When interviewed, February 10, 2005, client #3 stated that he administered the Advair, Albuterol and Atrovent by himself. When interviewed February 10, 2005 the agency LPN stated that "medication management" meant ordering medications from the pharmacy, updating orders and medication sheets with changes, medication set up and giving it to the clients. She stated client #3 was assessed as able to give his own nebulizer and inhalers since he could demonstrate how. She added that staff gave his oral medication twice daily because he couldn't read information about the pills. Client #3's record did not contain any

assessments of his functional status or need for assistance with medication administration. During an interview February 10, 2005, the Vice President of Clinical Services verified medication management included medication administration.

TO COMPLY: For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services 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, and must be maintained as part of the service plan required under part 4668.0815.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 350.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: $ 600.00. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to this Department within 15 days of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/the correction orders have) not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine.

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 will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Darrel Farr, President Governing Board
Gloria Lehnertz, Minnesota Department of Human Services
Hennepin County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Minnesota Department Of Health
Health Policy, Information and Compliance Monitoring Division
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: COPPERFIELD HILL PHASE II

DATE OF SURVEY: October 31, 2005

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Mike Stenke Director of Housing
Julie Lensegrav Corporate Director of Nursing
Olivia Morris TMA
Linda Briercliffe LPN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up # 2 X

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow up on the status of state licensing orders issued as a result of a visit made on June 22, 23, and 25, 2004 and a follow-up visit on February 10 and 14, 2005. The results of the surveys were delineated during the exit conferences. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

   The status of the Correction orders issued on June 22, 23, and 25, 2004 is as follows:

   1. MN Rule 4668.0800 Subp. 3 **Corrected**

   The status of the correction orders issued on February 10 and 14, 2005, is as follows:

   1. MN Statute § 144A.44 Subd. 1 (2) **Not Corrected** **$250.00**

   Based on observation, record review and interview, the licensee failed to provide services subject to acceptable nursing standards for two of two clients' (#3 and #6) records reviewed. The findings include:

   Client #3's August 18, 2005, service plan indicated the agency provided medication management and medication administration. During a home visit on October 31, 2005, client #3's nebulizer

mask was observed to be dirty, attached to the tubing and filled with medication. When asked if staff cleaned the nebulizer equipment, client #3 stated, "No - I clean it (points to medication chamber) two times per week with dish soap; but not that (points to mask)." Client #3 takes Albuterol and Atrovent nebulizers four times per day.

Client #6's August 31, 2005, service plan indicated the agency provided medication management and medication administration. Client #6 received assistance with administration of DuoNeb per nebulizer four times daily. During a home visit with client #6 October 31, 2005, the mouthpiece and the T-piece were observed to be dirty and were in a bowl on the table with four inhaler bottles. When interviewed, October 31, 2005, regarding who cleans the nebulizer equipment, client #6 stated, "I do it myself- I use hot water and rubber gloves to clean it (points to mouthpiece) once a week, sometimes more." When asked if staff cleaned it, client #6 replied, "they've never cleaned it."

When interviewed, October 31, 2005, employee #7, a licensed practical nurse, stated that all clients are independent in nebulizer, inhaler and equipment use. When interviewed October 31, 2005, employee F, a trained medication aide (TMA), was asked if nebulizer equipment was cleaned by staff and she replied, "No, it's not on the med sheet; as a TMA, I do everything on the med sheet." When interviewed, October 31, 2005, the corporate director of nursing stated that staff were trained regarding the "Nebulizer Treatment Cleaning Procedure" and she was not aware this procedure had not been implemented and indicated there had been recent staffing changes.

2. MN Rule 4668.0855 Subp. **Not Corrected** **$350.00**

Based on observation, record review, and interview, the licensee failed to have a registered nurse assess the functional status and need for assistance with medication administration for two of two clients' (#3 and #6) records reviewed who received assistance with medication administration. The findings include:

Client #3's August 18, 2005, service plan included medication management and medication administration. Client #3 had an undated assessment by an RN stating he "needs assistance with oral and inhaled medications; administration of medications." When interviewed, October 31, 2005, the trained medication aide stated client #3 did not receive help with inhalers or nebulizers. The September and October 2005 medication administration records indicated that inhalers and nebulizer treatments were self-administered. No nursing assessment could be found to indicate client's independence with inhaler and nebulizer medication administration. When interviewed, October 31, 2005, the corporate director of nursing verified the preceding findings.

Client #6's August 31, 2005, service plan indicated the agency provided medication management and medication administration. There was no evidence in client #6's record to indicate the RN had assessed her for the nebulizer treatments or assistance with medications.

When interviewed, October 31, 2005, the corporate director of nursing stated the RN on-site had terminated employment the week before and she was going through charts in alphabetical order to see what was needed and had not reviewed client #3 or #6's records.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 3507

July 22, 2005

Lucinda Gartner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422

Re: Amended Licensing Follow Up Revisit

Dear Ms. Gartner:

On July 14, 2005 you were sent a Notice Of Assessment For Noncompliance With Correction Orders, the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. **Please disregard the information that was mailed to you.** Subsequent to that mailing, an error was noted in the information that was mailed to you.

Attached is the corrected Notice Of Assessment For Noncompliance With Correction Orders. The amended information that has been corrected is underscored and the stricken [~~stricken~~] information has been removed.

The documents checked below are enclosed.

_____ 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.

__X__ Notice Of Assessment For Noncompliance With Correction Orders Home Care Providers

Feel free to call our office if you have any questions at (651) 215-8703.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure (s)

Cc: Daniel Farr, President Governing Board
Case Mix Review File

10/04 FPC1000CMR AMMENDED

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 3507

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR ASSISTED LIVING HOME CARE PROVIDERS

July 22, 2005

Lucinda Gartner, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422

RE: QL20297006

Dear Ms. Gartner:

On February 10 and 14, 2005, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders found during an inspection completed on June 22, 23, and 25, 2004, with correction orders received by you on September 9, 2004.

The following correction orders were not corrected in the time period allowed for correction:

1. MN Rule 4668.0800, Subp. 3 **Fine $350.00**

Based on observation, record review, and interview the licensee failed to provide central storage of medication as required by a client's service plan for one of four active client (#1) reviewed.

Client #1 had a registered nurse (RN) assessment May 28, 2004 that indicated she needed "total assist with medication". The service agreement for client #1 indicated central storage of medication was to be provided. On June 23, 2004 this reviewer conducted a home visit interview with client #1. Four boxes of Duonebs (breathing medication) were noted on floor in the client's home and two doses were in the nebulizer apparatus.

The RN and licensed practical nurse (LPN) were interviewed June 23, 2004. They stated the nebulizer medication was bulky so it was not stored on a medication cart, that it "should be" and they would make that change. The RN also stated that client #1 needs "total assist with medication". On June 25, 2004 client #1 was interviewed again and stated her nebulizer boxes had been removed. This reviewer noted two doses of Duonebs in the nebulizer apparatus and asked client #1 if there were any more nebulizer medications in her home. Client #1 indicated yes and showed this reviewer two boxes in her dining room cabinet containing ten-day supply (forty doses) of Duonebs. This reviewer returned at 2:30 pm on June 25, 2004 and noted both vials that had been in the apparatus were no longer there. Client #1 said she had one at noon and

the next one was in the nebulizer for her 4:00 p.m.dose so that she would not forget to take it.

TO COMPLY: An assisted living home care provider licensee must provide all services required by a client's service plan under part 4668.0815.

~~**1. MN Rule 4668.0800 Subp .3 Fine $350.00**~~

~~Based on observation, record review, and interview, the licensee failed to provide central storage of medication as required by a client's service plan for three of three clients (#1, #2 and #3) reviewed. The findings include:~~

~~Clients #1, #2, and #3 had current service plans dated June 2, 2004, June 9, 2003, and June 2, 2004 respectively. The service plans indicated that the agency would provide "medication management."~~
~~During a home visit, February 10, 2005 client #1 showed this reviewer two boxes of silver foil wrapped packages containing Duoneb 2.5 –0.5mg/ 3 ml solution vials that were stored in her dining room cabinet. There were five vials in each box. Client #1 stated that when her supply of medication vials gets down to two boxes "I tell the nurse so I don't run out."~~

~~Client #2's June 11, 2003, Assessment for Need for Medication Reminders, Assistance, Administration or Central Storage indicated "Needs assistance" with oral and inhaled medications. Services needed were identified as "Medication set-ups and administration of medication." During a home visit February 10, 2005 with client #2 this reviewer observed nebulizer equipment with five doses of Duonebs sitting on the equipment, and six packages (30 doses) of Duonebs in a baggie behind the equipment on kitchen table. Nasonex nasal spray, as well as Advair, and Combivent inhalers were also on the kitchen table. When interviewed February 10, 2005 the licensed practical nurse (LPN) #1 stated, that as of February 1, 2005 the medications had been stored in client #2's room, and before February, the medications "were stored in the cart." LPN #2 stated "I leave the meds out in the nebulizer so the TMA" (trained medication aide) "on the next shift sees it. The inhalers and nasal spray have been on the kitchen table all month before they were on the cart."~~

~~During a home visit, February 10, 2005, with client #3 an Advair inhaler, as well as Albuterol and Atrovent nebulizer medications were observed on the coffee table in the living room. During interviews, February 10, 2005, the licensed practical nurses (LPN) on duty both verified that "medication management" included central storage of medication.~~

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $350.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the total amount you are assessed is**: **$350.00.** This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to this Department within 15 days of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/the correction orders have) not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine.

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 will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Jocelyn Olson, Assistant Attorney General
Daniel Farr, President Governing Board
Kelly Crawford, Minnesota Department of Human Services
Hennepin County Social Services
Mary Henderson, Program Assurance Unit
Case Mix Review File

MINNESOTA DEPARTMENT OF HEALTH
DIVISION OF FACILITY & PROVIDER COMPLIANCE
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: COPPERFIELD HILL PHASE II

DATE OF SURVEY: February 10, and 14, 2005
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___

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Gail Sheridan Vice President of Clinical Services Tealwood Care Centers
Nanette Cool LPN, Colleen Kavanagh LPN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up _____X_____

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 June 22, 23, and 25/2004. 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 is as follows:

1. MN Rule 4668.0800 Subp. 3 **Fine $350.00**

Based on observation, record review, and interview, the licensee failed to provide central storage of medication as required by a client's service plan for three of three clients (#1, #2 and #3) reviewed. The findings include:

Clients #1, #2, and #3 had current service plans dated June 2, 2004, June 9, 2003, and June 2, 2004 respectively. The service plans indicated that the agency would provide "medication management."
During a home visit, February 10, 2005 client #1 showed this reviewer two boxes of silver foil wrapped packages containing Duoneb 2.5 –0.5mg/ 3 ml solution vials that were stored in her dining room cabinet. There were five vials in each box. Client #1 stated that when her supply of medication vials gets down to two boxes "I tell the nurse so I don't run out."

Client #2's June 11, 2003, Assessment for Need for Medication Reminders, Assistance, Administration or Central Storage indicated "Needs assistance" with oral and inhaled medications. Services needed were identified as "Medication set-ups and administration of medication." During a home visit February 10, 2005 with client #2 this reviewer observed

nebulizer equipment with five doses of Duonebs sitting on the equipment, and six packages (30 doses) of Duonebs in a baggie behind the equipment on kitchen table. Nasonex nasal spray, as well as Advair, and Combivent inhalers were also on the kitchen table. When interviewed February 10, 2005 the licensed practical nurse (LPN) #1 stated, that as of February 1, 2005 the medications had been stored in client #2's room, and before February, the medications "were stored in the cart." LPN #2 stated "I leave the meds out in the nebulizer so the TMA" (trained medication aide) "on the next shift sees it. The inhalers and nasal spray have been on the kitchen table all month before they were on the cart."

During a home visit, February 10, 2005, with client #3 an Advair inhaler, as well as Albuterol and Atrovent nebulizer medications were observed on the coffee table in the living room. During interviews, February 10, 2005, the licensed practical nurses (LPN) on duty both verified that "medication management" included central storage of medication.

2. MN Rule 4668.0865 Subp. 3 **Corrected**

2.) The exit conference was not tape- recorded.

3.) Although a State licensing survey was not due at this time, correction orders were issued.

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: COPPERFIELD HILL PHASE II

HFID # (MDH internal use): 20297

Date(s) of Survey: February 10, and 14, 2005

Project # (MDH internal use): QL20297006

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- ____ Correction Order issued ____ 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.	___ 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.	___ 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 ___ Correction Order(s) issued ___ 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.	___ 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 ___ Correction Order(s) issued ___ 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.	___ 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).	___ 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:
2	Mn Statute §144A.44 Subd. 2	X	X	Based on observation, record review, and interview the licensee failed to provide services subject to acceptable nursing standards for three of three clients (#1, #2 and #3). The findings include: Client #1 had a current service plan dated June 2, 2004. The service plan indicated that the agency would provide "medication management." During a home visit, February 10, 2005, client#1 stated that facility staff did not clean her medication administration device and that it was dirty. The medication administration device was observed to be dirty and had left over medication in it. Client #1 received assistance with administration of a medication to be administered per a medical device four times daily. A licensed practical nurse (LPN) was present during the interview and confirmed the medical device set up was dirty. She stated staff "are supposed to clean it but they don't." During the visit the LPN cleaned the medical device and then laid it on a wooden ledge to dry. Client #3 had a current service plan dated June 2, 2004. The service plan indicated that the agency would provide "medication management." During a home visit, February 10, 2005, client #3's medication administration device was observed to be dirty. Client #3 received administration of a medication per a medical device four times daily. Client #3 stated "I clean it sometimes

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				but don't know to clean this part (points to part of the medication device)." Client stated that he cleaned the medical device himself because "I don't think they know how." When interviewed February 10, 2005, the agency LPN stated that "medication management" meant ordering medications from the pharmacy, updating orders and medication sheets with changes, medication set up and giving it to the clients. When interviewed February 10, 2005, the Vice President of Clinical Services verified medication management included medication administration. **Education:** Provided
8	MN Rule 4668.0855 Subp. 2	X	X	Based on observation, interview, record review, the licensee failed to have a registered nurse assess the functional status and need for assistance with administration medication per a medical device for two of three clients (#1 and #3) reviewed who receive assistance with medication administration. The findings include: Client # 1's service plan dated June 2, 2004 indicated "medication management" services. Client #1 received multiple medications. The ordered medications included a physician's order dated June 7, 2004, for a medication to be administered per a medical device "4 times daily at 8am, noon, 4 pm, and 8pm." The February medication administration record (MAR) stated "self" for administration of the four daily doses of this medication. All other medications were signed as administered by staff. When interviewed February 10, 2005, staff stated that client #1 was assisted

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				her with all medications except for the medication administered per a medical device (self administered). Client #1 also stated that she took this medication per a medical device "every 4 hours: 8 am, 11 am, 3pm, 6pm and 8 pm" thus indicating she took her treatments administered per medical device five times a day rather than four times a day as ordered. When interviewed, February 10, 2005, the licensed practical nurse (LPN) stated that client #1 was assessed as being independent with her medication treatments administered per the medical device. There was no documentation in client #1's medical record to reflect that she had been assessed for assistance with all medications. Client # 3's service plan dated June 21, 2004 indicated "medication management" services. Client #3 received oral and inhaled medications. The ordered medications included a physician's orders for medication to be administered QID (four times daily) per a medical device and another medication to be administered 1 puff 2 times daily; the February 2005 medication administration record indicated for this medication "SELF." When interviewed, February 10, 2005, client #3 stated that he administered both of these medications by himself. When interviewed February 10, 2005 the agency LPN stated that " medication management" meant ordering medications from the pharmacy, updating orders and medication sheets with changes, medication set up and giving it to the clients. She stated client #3 was assessed as able to give his own medications per a medical device since he could demonstrate how. She added that staff gave his oral medication twice

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				daily because he couldn't read information about the pills. Client #3's record did not contain any assessments of his functional status or need for assistance with medication administration. During an interview February 10, 2005, the Vice President of Clinical Services verified medication management included medication administration. **Education:** Provided

A draft copy of this completed form was left with Deborah Kettler at an exit conference on February 14, 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)

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 0194

September 7, 2004

Kim Fox, Administrator
Copperfield Hill Phase II
4020 Lakeland Avenue North
Robbinsdale, MN 55422

Re: Results of State Licensing Survey

Dear Ms. Fox:

The above agency was surveyed on June 22, 23, and 25, 2004 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: Daniel Farr, President Governing Board
Case Mix Review File

CMR 3199 6/04

Assisted Living Home Care Provider

LICENSING SURVEY FORM

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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: COPPERFIELD HILL PHASE II

HFID # (MDH internal use): 20297

Date(s) of Survey: June 22, 23, and 25, 2004

Project # (MDH internal use): QL20297006

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, Subp. 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).	X Met ___ Correction Order(s) issued ___ 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.	X Met ___ Correction Order(s) issued ___ 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 Statute 144D.065; 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.	_X_ Met ____ Correction Order(s) issued ____ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800, Subp. 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 ____ Correction Order(s) issued ____ 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 4668.001, Subd. 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: # 1	Regulation: MN Rule 4668.0800, Subp. 3 Fulfillment of Services	X Correction Order Issued X Education provided
Statement(s) of Deficient Practice: #1 Education: #1	Based on observation, record review, and interview the licensee failed to provide central storage of medication as required by a client's service plan for one of four active client (#1) reviewed. Client #1 had a registered nurse (RN) assessment May 28, 2004 that indicated she needed "total assist with medication". The service agreement for client #1 indicated central storage of medication was to be provided. On June 23, 2004 this reviewer conducted a home visit interview with client #1. Four boxes of Duonebs (breathing medication) were noted on floor in the client's home and two doses were in the nebulizer apparatus. Education was provided regarding storage of medications as outlined in the rule regarding central storage of medications.	
Indicator of Compliance: # N/A	Regulation: MN Rule 4668.0865, Subp. 3 Control of Medications	X Correction Order Issued X Education provided
Statement(s) of Deficient Practice:	Based on client and staff interview, record review, and observation the licensee failed to assure that a system to control medications administered had been developed for one of four active client (#1) reviewed. When interviewed June 23, 2004, client #1 indicated a nebulizer is used four times per day (QID) to help breathing. Physician orders, May 27, 2004 state, "Duonebs (Ipratropium Bromide 3.0 mg with Albuterol Sulfate 2.5 mg) QID". Client #1's medication administration record (MAR) had Duoneb initialed and circled on the front side and on the back of the MAR, the Nurses Medication Notes stated "all out, not given" for the following doses: 8 a.m., 12noon, 4 p.m. on June 5, 2004; 8 a.m. and 12 noon on June 22, 2004. Three trained medication assistants (TMA) were interviewed on June 23 and 25, 2004. They stated they are to tell either the licensed practical	

Education:	nurse (LPN) or registered nurse (RN) if they are low on medications so they don't run out. On June 23, 2004 the LPN and RN were interviewed. They stated the TMA's are to let them know if medications are getting low. On June 23, 2004 the corporate director of nursing interviewed and provided, "Wildflower Lodge LLC Policies and Procedures for Reordering Medications or Supplies", which states, "Residents will have ample supply of medications." Education provided to corporate director of nursing regarding control of medications as outlined in the rule.	
Education Provided	1) CLIA WAIVER had expired therefore education provided to maintain current waiver and information about CLIA waivers was provided; 2) Corporate director was given a copy of the education module about nursing delegation.	____ Correction Order Issued _X_ Education provided

A draft copy of this completed form was left with Candy Gislason, Corporate Director of Nursing at an exit conference on June 25, 2004. 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).