MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 2810 0001 2558 0804

November 18, 2009

Marion Lyles-Lewis, Administrator
Crest View Home Care
444 Reservoir Boulevard NE
Columbia Heights, MN 55421

Re: Results of State Licensing Survey

Dear Ms. Lyes-Lewis:

The above agency was surveyed on November 3, 4, 5, 6, and 9, 2009, 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: Anoka County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

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: CREST VIEW HOME CARE

HFID #: 20750

Date(s) of Survey: November 3, 4, 5, 6 and 9, 2009

Project #: QL20750007

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
2. 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 _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
3. 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** _X_ Met ____ 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** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ 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** _X_ Met ____ 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
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** _X_ Met ____ 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
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

***Please note*: 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.**

SURVEY RESULTS: ___ 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 4668.0825 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) conducted a nursing assessment of the client's functional status and need for nursing services before delegating nursing services for two of two client's (A1 and B1) records reviewed. The findings include:

Client A1 began receiving delegated nursing services, including medication administration June 30, 2009. A Licensed Practical Nurse (LPN) signed and dated the "RN EVALUATION/BASELINE ASSESSMENT" on June 30, 2009.

When interviewed November 5, 2009, the interim Director of Home Care/RN stated the previous Director of Home Care/RN directed the LPN to perform client A1's evaluation. (An evaluation/baseline assessment was completed by the RN on November 5, 2009.)

Client B1 began receiving delegated nursing services, including medication administration May 5, 2009. The "RN EVALUATION/BASELINE ASSESSMENT' was not signed or dated.

When interviewed November 4, 2009, the interim Director of Home Care/RN stated LPN BA completed the "RN EVALUATION/BASELINE ASSESSMENT" May 5, 2009, because she, the RN, was working in another building/area. The interim Director of Home Care stated she reviewed client B1's evaluation, but did not co-sign or date the evaluation.

A draft copy of this completed form was left with Sarah Erickson, Interim Dir. Of Home Care, and Karen Fantle, Asst. Living Manager, at an exit conference on November 9, 2009. 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).

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 2654

July 14, 2005

Tammy Eidem, Administrator
Crest View Home Care
444 Reservoir Boulevard
Columbia Heights, MNH 55421

Re: Licensing Follow Up Revisit

Dear Ms. Eidem:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Licensing and Certification Program, on June 6, 2005.

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 Assisted Living 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: Shirley Barnes, President Governing Board
Case Mix Review File

10/04 FPC1000CMR

CMR 3199 6/04

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

INFORMATIONAL MEMORANDUM

PROVIDER: Crest View Home Care

DATE OF SURVEY: June 6, 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:
Tammy Eidem RN Director of Home Care
Gigi Chollett Housing Administrator
Debbie Meile HHA
Anita Kottsick Housing Administrator Crest View on 42nd
Sarah Eckman RN

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 November 9, 10, 12, 15, 16, 18, and 24. 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:

MN Rule 4668.0815 Subp. 1 Corrected
MN Rule 4668.0815 Subp. 2 Corrected
MN Rule 4668.0815 Subp. 3 Corrected
MN Rule 4668.0855 Subp. 2 Corrected
MN Rule 4668.0860 Subp. 4 Corrected
MN Statute § 144A.44 Subd. 1 (2) Corrected
MN Statute § 144A.44 Subd. 1 (13) Corrected
MN Statute § 626.557 Subd. 14 (b) Corrected

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9988 0965

January 6, 2005

Tammy Eidem, Administrator
Crest View Home Care
4444 Reservoir Boulevard NE
Columbia Heights, MN 55421

Re: Results of State Licensing Survey

Ms. Eidem,

The above agency was surveyed on November 9, 10, 12, 16, 18, and 24, 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: Shirley Barnes, President Governing Board
Case Mix Review File

CMR 3199 6/04

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: CREST VIEW HOME CARE

HFID # (MDH internal use): 20750

Date(s) of Survey: November 9, 10, 12, 15, 16, 18, and 24, 2004

Project # (MDH internal use): QL20750001

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

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promotes 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 observes 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 X Correction Order(s) issued X 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 X 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 has 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 _X_ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff is 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 follows any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ____ Correction Order(s) issued ____ Education provided ____ N/A
10. The agency has a current license. (MN Statutes 144D.02, 144D.04, 144D.05, 144A.46; MN Rule 4668.0012 Subp.17) Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	The ALHCP license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. The agency operates within its license(s).	_X_ Met ____ Correction Order(s) issued ____ Education provided

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
	MN Rule 4668.0815, Subp.1 Evaluation and service plan	X	X	Based on record review and staff interviews, the licensee failed to have a registered nurse completed an individualized evaluation within two weeks after initiation of assisted living home care services for two of twelve clients (B5 and C3) reviewed. The findings include: Client B5 was admitted May 29, 2003. When reviewed November 18, 2004, client B5's individualized nursing evaluation, which was to be completed within two weeks of admission, was not completed, signed, or dated. Client C3 was admitted January 3, 2003. When reviewed November 18, 2004, client C3's individualized nursing evaluation that was to be completed within two weeks of admission was observed in the record and was noted to be unsigned and undated. When interviewed November 18, 2004 the site C registered nurse verified the individual nursing assessment for client C3 had not been signed and dated. When interviewed November 18, 2004 the site A registered nurse verified the individual nursing assessment for client B5 had not been completed, signed, and dated. **Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
1	MN Rule 4668.0815,Subp. 2 Service plan reevaluation	X	X	Based on record review and staff interview, the licensee failed have a registered nurse review and revise a clients' evaluation and service plan when there was a change in condition that required a change in service for one of one clients (B3) reviewed. The findings include: Client B3's current service agreement dated September 26, 2004, indicated that nursing staff were to set up oral medications weekly. Client B3's oral medications included: Lisinopril 40 mg and Atenolol 50 mg daily for hypertension, Detrol XL 4 mg daily for bladder spasms, Isosorbide 2.5 mg four times a day for angina, and Asacol 800mg three times a day for bowel needs. She also had an order to self administer one tablet of either Darvocet N-100 every six hours as needed (PRN) Aleve 250 mg every six hours PRN or Vicodin one tablet every 4-6 hours PRN. Documentation June 23, 2004 in the Nursing Visit Record indicated that client B3 missed taking set-up medications on five of seven days. The weekly Nursing Visit Records July 14, 2004 through November 3, 2004 stated client B3,"continues to forget numerous pills," and "client continues to miss majority of meds." A nurse's note November 3, 2004 stated "family and doctor aware." This was the only notation that indicated the medication issue was communicated. Client B3's record did not contain any re-evaluation to determine why she was not taking the medication as prescribed. During a survey home visit November 16, 2004, client B3 showed this reviewer that her medications were stored in her room. She stated that she took Tylenol and at times Aleve for pain. She was not aware that she had

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
				Darvocet and Vicodin available to use for pain or where the medications were located. Client B3's pill box for the week of November 14, 2004 to November 20, 2004 was observed to be full of medications for the dates of November 14, 2004 to November 18, 2004. There was one tablet left for November 19, 2004 and two tablets left for November 20, 2004. Client B3 looked at the pillbox sections for November 19, 2004 and November 20, 2004 and stated that "there is nothing here" indicating that she could not see the tablets that were remaining in the pillbox. When interviewed November 16, 2004 the registered nurse (RN) home care director stated staff placed one dose of the Darvocet and Aleve daily in the medication container for client B3 to self-administer. November 16, 2004 this reviewer revisited client B3 at home with the RN home care director. With the clients permission the RN found the container of Darvocet locked in client B3's medication box and stated that she was not aware as to why it was locked up. She could not locate the Vicodin. The RN confirmed that only staff had the key to client B3's medication box. During the home visit client B3 was observed to have a basket with multiple medication bottles that included over-the-counter vitamins. One of the bottles was labeled Darvocet N. The RN opened the bottle labeled Darvocet N. It contained a mixture of various tablets, which staff could not identify. **Education:** Provided
1	MN Rule 4668.0815,Subp. 3 Service plan modifications	X	X	Based on record review and interview the licensee failed to modify service plans when there were changes in the services provided for three of twelve

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
				clients (A2, A5 and B5) reviewed. The findings include: Client A2's current service plan was modified September 23, 2004 and did not include an added service called "escort to meals." Documentation on the home health aide form October 24, 2004 to October 30, 2004 indicated staff was escorting client A2 to meals. When interviewed November 10, 2004 client A2 and the registered nurse (RN) home care director verified that staff was providing the escort services. Client A5's current service plan was modified September 26, 2004 and indicated that nursing staff were to set up medications and home health aides were to provide medication reminders. The medication and side effect sheet dated August 17, 2004 indicated that staff was to apply Desitin powder twice daily to client A5's groin until it was healed. Documentation on the home health aide (HHA) charting form dated October 31, 2004 to November 13, 2004 stated, "Apply Nystatin powder to groin." The medication tracking form through November 13, 2004 indicated Desitin powder twice daily to client A5's groin. When interviewed November 13, 2004 the RN home care director confirmed staff was providing topical medication administration and that topical medication administration was not on the service plan. **Education:** Provided
3	MN Statute 626.557 Subd. 14 (b)	X	X	Based on record review and staff interview the licensee failed to develop an individual abuse prevention plan for one of twelve clients [client C4]. The findings include:

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
				Client C4's Vulnerability Assessment dated 04/26/04 stated that client C4 was not oriented to time, place, and person, did not have the ability to follow directions consistently, was not able to give accurate information consistently, did not have full range of motion, did not have adequate endurance and strength, was unable to report abuse and/or neglect and was unable to manage finances. This assessment form had an area where staff were to document a plan to address the areas of vulnerabilities. This area was observed to be blank. When interviewed on 11/18/04, staff C2 stated that she had not documented a plan to address client C4's areas of vulnerabilities. Staff C2 also stated that she had incorrectly indicated on the form that client C4 was not vulnerable. **Education:** Provided
3	MN Statute §144A.44, Subd. 1 (2) Bill of Rights-Right to receive care and services subject to accepted standards	X	X	Based on record review and staff interview, the licensee failed to assure that staff assessed and documented their actions for two of two clients (C4 and A2) who fell. The findings include: Client C4 began receiving services in the memory care unit April 26, 2004. She was diagnosed with Dementia and had severe cognitive impairment and was unable to communicate basic needs. The July 6, 2004 Nursing Visit Record for client C4 indicated that a home health aide (HHA) found client C4 on the floor next to her bed on her buttocks. On July 6, 2004 the registered nurse (RN) supervisor documented that client C4 had no apparent serious injury, had some facial scrapes and abrasions on her forehead, nose and chin and that she notified client C4's daughter. There was no further evaluation or assessment in relation to

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
				client C4's fall and safety needs in client C4's record. On August 2, 2004 the home health aide (HHA) documented in the staff communication book that when she went into client C4's room to do cares client C4 was observed sitting at the foot of her bed and indicated that she had fallen. The documentation stated that client C4 had blood all over her clothes and the carpet, a cut on her upper lip, a bruise under her right eye and she had broken her denture. On August 3, 2004 a HHA documented on client C4 in the staff communication book. The entry stated "If she's awake please check her BP and go ahead and get her up for the day. If she's still asleep go ahead and let her sleep and get her up at the usual time. This will be on your next schedule An August 12, 2004 Nursing Visit Record note indicated that client C4 had "3 stitches removed from upper lip. Scab came off with removal of stitches. No bleeding. No redness. Denies any pain. No discomfort throughout procedure." The record lacked follow-up assessments and monitoring of client C4's injuries. When interviewed November 18, 2004, the RN supervisor verified that client C4 had been taken to the hospital by her daughter [date unknown] where she received three stitches in her upper lip to close the cut she sustained when she fell August 2, 2004. On September 16, 2004 the RN home care director documented a telephone triage note that indicated that she had received a call notifying her that Client C4 had fallen at 6:20 a.m. and sustained a dime size cut on her right knee. This was client C4's third fall since July 6, 2004. The RN home care director documented that she instructed the

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				HHA to make the facility nurse aware of the fall in case she wanted to assess the knee. When interviewed November 18, 2004, the registered nurse (RN) supervisor stated that she had been informed of client C4's July 6, 2004 fall and that there was no follow up done in relation to this fall. She also verified she had forgotten to document the August 2, 2004 fall in the client's record and stated the communication book was not a part of the client record, nor was it permanently maintained documentation. She stated that after client C4 fell August 2, 2004 she had started a HHA reassurance check on client C4 in August to be done each morning at 5:00 a.m. The RN supervisor indicated that she had forgotten to document client C4's hospital visit, from the August 2, 2004 fall and did not have any orders or documentation from the hospital for follow-up care of client C4 including the removal of the sutures. The RN supervisor stated that she had been informed of client C4's September 16, 2004 fall and that there was no follow up done in relation to client C4's knee or her fall. A September 6, 2004 Nursing Visit Record note indicated that client A2 stated she tripped and fallen onto her room floor. It stated client A2 complained of pain on her left side and back and self-administered Tylenol for the pain. The note indicated that client A2's vital signs were "Temperature "100.2" degrees Fahrenheit, pulse "92," and BP "130/60." The documentation reflected that client A2 notified her daughter of the incident and client A2 was asked to notify staff if her pain persisted. When interviewed November 10, 2004 the RN home care

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				director indicated that there was no follow up charting or assessment of client A2's condition regarding her temperature of 100.2. A September 22, 2004 Nursing Visit Record note indicated that the home health aide (HHA) had paged the nursing supervisor from the adjoining nursing home [who was a pool staff] to come to the assisted living unit to see client A2 because she had been walking in the hallway and had fallen. The Nursing Visit Record reflects that after client A2 fell, an activity person assisted her to her room and subsequently, client A2 called the HHA and stated that she had left sided low back pain. The pool nurse documented that client A2 had "ROM (range of motion) WNL (within normal limits). Neuro's intact. No bruising or skin tears noted. Vital signs 98.5- 76- 20- 130/76. No pain medication in room." Client A2 received medication set up and administration from staff for all meds had orders for Tylenol 325 mg 1-2 Po q 4-6 hr PRN for pain and Vicoden 1-2 po q 4-6 hr pain. There was no follow up documentation regarding the fall or pain assessment in the record for client. When interviewed November 10, 2004 the RN home care director verified that no pain medication was given to client A2. **Education:** Provided
3	MN Statute 144A.44,Subd. 1 (13) Bill of Rights-right to be served by staff who are properly trained and competent to perform their duties	X	X	Based on record review and interview, the licensee failed to assure accurate medication administration and documentation for one of one client (client A5) who had orders for a topical medication administration. The findings include: Client A5 had physician's orders August 17, 2004, for Desitin powder to

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				his groin area twice daily. The October 31, 2004 to November 13, 2004 Home Health Aide (HHA) charting form stated that the HHA's were to apply Nystatin powder to client A5's groin daily at 7:00 a.m. and at 7:00 p.m. There was no physician order for substitution of medication or for the Nystatin. The October 14, 2004 physician medication order sheet did not include an order for Desitin or for Nystatin. An October 30, 2004 HHA communication book note stated that client A5 had a shower and that the Nystatin powder was not available. The HHA also documented that client A5's groin was red and so she borrowed another client's medication and applied it to client A5. A November 1, 2004 HHA communication book note stated that client A5's "left side [groin] looks bad." The HHA's continued to document in the communication book that client A5 was out of Nystatin powder until, during the survey, November 10, 2004 when a HHA documented "Client didn't have any Nystatin powder. Nurse notified." The Nystatin and Desitin powders were not the same medication under a different brand name. The 1999 Physicians' Desk Reference for Nonprescription Drugs and Drug Supplements identified Desitin powder as "combines zinc oxide (10%) with topical starch (cornstarch) for topical application. Also contains: fragrance and calcium phosphate." It indicated use was " to protect from wetness, help prevent and treat diaper rash, and other minor skin irritations." The 2004 Drug Facts and Comparisons identified Nystatin powder as an antifungal agent in talc that is used for local treatment of candidiasis (yeast) infection.

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				The October 31, 2004 to November 13, 2004 HHA charting indicated that staff had twenty-two opportunities to apply the ordered powder for client A5. Of these twenty-two opportunities, Desitin powder as ordered was never documented as being applied. Treatment documentation indicated that Nystatin powder was applied seventeen times even though they had documented in the communication book that client A5 did not have any Nystatin powder available. The documentation indicated no type of powder was administered four times and one area for documenting the powder was blank. When interviewed November 10, 2004 the RN home care director verified the findings. She stated the communication book was not a permanent part of the record. When asked why Nystatin was used instead of Desitin and why the nurse was not informed of medication unavailable for client A5's use until November 10, 2004 she stated, "I don't know why. I don't know how that could happen." **Education:** Provided
8	MN Rule 4668.0855,Subp. 2 Nursing assessment and service plan	X	X	Based on record reviews and staff interviews, the licensee failed to conduct an assessment for twelve of twelve clients (clients A2, A1, A4, A5, B2, B3, B4, B5, C4, C1, C3, and C5) to determine their need for medication administration. The findings include: Client A2's service plan dated September 23, 2004 stated "med administration" up to 3 X's (times) a day." It indicated that staff was to administer her medications. When reviewed, client A2's record did not contain any assessments to determine the need for medication administration.

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				Clients A1, A4, A5, B3, and B5 all had service plans dated September 26, 2004, which identified that staff was to administer the clients' medications. When reviewed, clients A1, A4, A5, B3, and B5's records did not contain any assessments to determine the need for medication administration. Client C4 had a service plan dated October 12, 2004, which identified that staff was to administer her medications. When reviewed, client C4's record did not contain any assessments to determine the need for medication administration. Clients C1 and C3 had service plans dated October 13, 2004, which identified that staff was to administer their medications. When reviewed, client C1 and C3's records did not contain any assessments to determine the need for medication administration. Client C5 had a service plan dated October 20, 2004, which identified that staff was to administer her medications. When reviewed, client C5's record did not contain any assessments to determine the need for medication administration. Client B2 had a service plan dated November 1, 2004, which identified that staff was to administer her medications. When reviewed, client B2's record did not contain any assessments to determine the need for medication administration. Client B4 had a service plan dated November 4, 2004, which identified that staff was to administer her medications. When reviewed, client B4's record did not contain any

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				assessments to determine the need for medication administration. When interviewed on November 9, 2004, the registered nurse home care director stated that nursing assessments to determine the need for medication administration had not been conducted on any of the Licensees ALHCP clients including clients A1, A2, A4, A5, B2, B3, B4, B5, C1, C3, C4 and C5. **Education:** Provided
8	MN Rule 4668.0860, Subp. 4 Medication and treatment orders	X	X	Based on record review and interview, the licensee failed to have medication and treatment orders dated and signed by the physician for three of twelve clients (A2, A5 and B2) reviewed. The findings include: Client A2 received assistance with medication administration and had physician's orders that did not include the date, name or signature of the physician. The orders stated, "1) start Aricept, 2) see Dr. [name] in 3-4 weeks, 3) ↑ Zoloft back to previous dose, 4) Doxycycline for the skin rash, 5) Advise ↑ protein intake (Had test showed low protein)." The medication sheet indicated that on September 15, 2004 indicated Aricept, Zoloft, and Doxycycline were begun. When interviewed November 12, 2004 the registered nurse home care director verified that client A2's orders did not include the date, name or signature of the physician. Client A5 received assistance with medication administration and had an undated telephone order that stated "continue same Coumadin re (check) 2 wks-T.O. Dr. [name]/[nurse's name]." On May 31, 2004 the physician sent the order back to the facility and

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				documented "I didn't give this order. I was in Canada fishing." When interviewed November 10, 2004 the registered nurse (RN) RN home care director stated that staff could not recall which physician gave her the telephone order. Client B2 was admitted October 29, 2004 and received assistance with medication administration. Client B2's record had a Medication and Treatment Orders Form dated October 29, 2004 that was not signed by the prescriber listing the following orders: Lantus Insulin 15u SQ (injected) QD (daily), Norvasc 10 mg PO (orally) QD, Lopressor 50 mg PO BID (twice daily), Metformin 1500 mg PO Q AM (every morning), Metformin 1000 mg PO QPM (every evening), Detrol LA, 2 mg, PO, QHS (every bedtime), Glucotrol XL 10 mg PO QD, Lisinopril 10 mg PO BID, ASA 325 mg PO QD, and accuchecks 2x/day (twice daily). Client B2's Medication Tracking Schedule for November 2004 indicated that client B2 had been receiving these medications within the agency. When interviewed November 15, 2004 the RN home care director verified that staff were administering medications to client B2 without signed physician orders. **Education:** Provided

A draft copy of this completed form was left with Shirley Barnes at an exit conference on November 24, 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).

(Form Revision 7/04)