MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 5018

February 13, 2009

Debra Shriver, Administrator
Central Minnesota Senior Care
328 5th Street Southwest
Willmar, MN 56201

Re: Results of State Licensing Survey

Dear Ms. Shriver:

The above agency was surveyed on December 16, 17, 18, 22, and 23, 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: Kandiyohi County Social Services
Ron Drude, Minnesota Department of Human Services
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: CENTRAL MN SENIOR CARE INC

HFID #: 20855

Date(s) of Survey: December 16, 17, 18, 22 and 23, 2008

Project #: QL20855006

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 ____ 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 _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
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 _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
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 **Fllow-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

<u>INDICATOR OF COMPLIANCE</u>: # 5

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

Employee BB began employment for the licensee June of 2007. Employee BB's record indicated she had a Mantoux test July 3, 2007, which was read by a licensed practical nurse (LPN)on July 5, 2007. The result was not indicated and could not be verified. There was no chest x–ray report in the record.

When interviewed December 18, 2008, employee BB stated that the LPN did looked at her Mantoux test on July 5, 2007, when it was due.

2. MN Rule 4668.0810 Subp. 6

<u>INDICATOR OF COMPLIANCE</u>: # 4

Based on record review and interview, the licensee failed to maintain a complete record for three of three clients' (# A1, #B1, and #C1) records reviewed. The findings include:

Client #A1's service plan, dated October of 2006, indicated the client received medication set up by the registered nurse (RN) or licensed practical nurse (LPN) weekly. The medication administration record for December, 2008 did not indicate what medications were set up by the licensed practical nurse for the client.

When interviewed, December 16, 2008, the registered nurse stated that the licensed practical nurse did the medication set up and would initial the bottom of the medication administration record but did not indicate what medications were set up.

Client #B1's service plan dated February of 2008, indicated the client received medication set up by the RN or LPN. The medication administration record for October and December, 2008 did not indicate what medications were set up. It only indicated the LPN was to set up medications every seven to fourteen days.

When interviewed, December 18, 2008, the site B LPN stated that she set up the client's medications weekly and initialed the medication administration record as setting it up but not what medications were set up.

Client # C1's service plan dated December of 2006 indicated the client received medication set up by the RN or LPN every seven to fourteen days. The medication administration record for November, and December, 2008 did not indicate what medications were set up.

When interviewed, December 22, 2008, the site C LPN stated that she had set up the medication one time this month and had initialed the line that said RN/ Delegate to set up medications and review compliance but did not indicate what medications were set up.

3. MN Rule 4668.0815 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and/or revised the client's service plan at least annually for two of three clients' (# A1 and # C1) records reviewed. The findings include:

Client #A1's service plan was dated October of 2006. The plan of care which was a part of the service plan was revised by the registered nurse December 12, 2007, fourteen months later.

Client #C1's plan of care which was part of the service plan was reviewed by the registered nurse May 20, 2007 and December 1, 2008, nineteen months later.

When interviewed December 18 and December 22, 2008, the registered nurse stated that she was not aware that it was reviewed late.

4. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed by three of three unlicensed employees' (AB, BB, and CB) records reviewed. The findings include:

Client #A1's Home Health Aide/PCA Plan of Care dated December of 2008, indicated the client was assisted with a Hoyer lift for transfer daily and his client care checklist from December 1 through 17th, 2008, indicated that he was laid down in the morning and after lunch for 2 hours.

When interviewed, December 17th, 2008, employee AB, an unlicensed direct care staff, stated she used the Hoyer lift to lay the client down. She stated that she was trained by the registered nurse (RN) and was observed to perform the task. There was no documentation of demonstrated competency for employee AB for the delegated task of Hoyer lift.

When interviewed, December 17th, 2008, the registered nurse stated that she only signed her name on the instruction sheet after she had observed the staff perform the delegated tasks and did not note competency was observed.

Client #B1's Home Health Aide/PCA Plan of care dated February of 2008, indicated that client was assisted with suprapubic catheter care in the morning and evening. Client #B1's client care checklist dated December 1 through 22nd, 2008, indicated that morning and evening cares were provided.

When interviewed November 18, 2008, employee BB, an unlicensed direct care staff, stated she did catheter care with client's B1 morning cares. She stated that the RN had trained her before she started doing any delegated tasks. There was no documentation of demonstrated competency for employee BB for the delegated task of catheter care.

Client #C1 had a physician's order dated December of 2008, for application of triple antibiotic ointment to the left hip and cover with a foam dressing once daily. Client #C1's December 2008, medication administration record indicated that employee CB, an unlicensed direct care staff, did the delegated task of applying triple antibiotic to left hip in the morning.

When interviewed, December 22, 2008, employee CB stated that she was trained by the RN and was observed doing the procedure on client #C1. There was no documentation of demonstrated competency for employee CB for the procedure.

5. MN Rule 4668.0860 Subp. 8

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the facility failed to implement an order for one of three client (#B1) records reviewed. The findings include:

Client #B1 had a physician's order, dated April of 2008, for twice weekly catheter irrigation. The medication records for September, October, November and December, 2008, indicated the procedure had been done once in September and not since then.

When interviewed via phone, December 24, 2008, the licensed practical nurse stated the client had refused to have it done but she had not document it.

A draft copy of this completed form was left with Dawn Frericks, Director and Deb Oleson, Director at an exit conference on December 23, 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 1222 2160

September 22, 2006

Debra Shriver, Administrator
Central MN Senior Care Inc
328 5th Street Southwest
Willmar, MN 56201

Re: Licensing Follow Up visit

Dear Ms. Shriver:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on August 14, 15, 16, and 17, 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.

__X__ 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: Kandiyohi 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

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 2160

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

September 25, 2006

Debra Shriver, Administrator
Central MN Senior Care Inc
328 5th Street Southwest
Willmar, MN 56201

RE: QL20855002

Dear Ms. Shriver:

On August 14, 15, 16, and 17, 2006, 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 an survey completed on December 5, 6, 7, 8, 9, and 14, 2005, with correction orders received by you on March 31, 2006.

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

5. MN Rule 4668.0815 Subp. 2 **$250.00**

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and/or revised the client's service plan at least annually for one of two current clients (# D5) records reviewed at site D, and one of one current clients (#E1) records reviewed at site E. The findings include:

Client #D5's service plan was last updated January 17, 2004. There was no indication that the RN had reviewed or revised client #D5's service plan after January 2004. When interviewed, December 6, 2005, the RN indicated that she was not aware that the service plan had to be reviewed annually.

Client E1's service plan was last reviewed July 1, 2004. When interviewed December 8, 2005, the RN confirmed that the client's service plan had not been reviewed since July 1, 2004 and then reviewed the service plan.

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

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

6. MN Rule 4668.0815 Subp. 4 **$50.00**

Based on record review and interview, the licensee failed to provide complete service plans for three of three clients (#A1, #A2, # A3,) at site A, three of three clients (#B1, #B2, #B3) at site B, and one of two current clients (#D5) at site D. The findings include:

Client #A1's service plan dated, November 5, 2004, indicated the client was to receive "HHA" (home health aide) services. Under "frequency" it stated "24/7." Client #A1's record indicated the client received services which included medication administration, blood sugar monitoring and central storage of medications. Client #A2's service plan dated, November 22, 2004, indicated the client was to receive "HHA" services "QD" (daily) and under frequency of supervision it stated, "q 2 weeks" (every two weeks). Client #A1 and #A2's service plans lacked a description of the specific services that the home health aides were to provide, the frequency of each service, and the fees for the services. On December 6, 2005, client #A1 stated she had received billing related letters from the county, on occasion, but she was unsure of the fees paid for services. When interviewed, December 7, 2005, the registered nurse, stated that the county notified clients' A1 and A2 regarding the fees that the county would pay for the services. She verified that the service plans did not indicate the fees for services or the description of services. On December 8, 2005, client #A2 stated she received a statement from the county monthly on the fees paid to the agency. The service plan for client #A3, dated November 22, 2004, lacked the fees for services.

Clients B1, B2 and B3 had service plans dated July 6, 2004. The service plans for client #B1, B2, and B3 dated July 6, 2004, October 22, 2005, and June 6, 2004 respectively, lacked the actions to be taken if scheduled services could not be provided. The service plan for client #B3 lacked the fees for services.

When interviewed, December 7, 2005, the licensed practical nurse verified this information was not indicated on any of the clients' service plans and was unable to locate any information related to the cost of the services noted on the client's service plan.

Client #D5's service plan dated January 17, 2004 indicated registered nurse (RN) supervision every 62 days and RN medication set up weekly. The fees for these services were not indicated on the service plan. When interviewed, December 7, 2005, the registered nurse confirmed the fees for these services had not been listed.

TO COMPLY: The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the assisted living home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the assisted living home care provider licensee whenever staff are providing services; (3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the assisted living home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $50.00.

11. MN Rule 4668.0855 Subp. 9 **$300.00**

Based on record review and interview, the licensee failed to ensure medication administration records were complete for one of two current clients (#A1) records reviewed at site A. The findings include:

Client #A1 had physician orders, November 28, 2005, which indicated the client was to receive Lovenox 60 milligrams (mg) subcutaneously (SQ) every day and one Nephrocap at bedtime. Client #A1 had weekly medication set-up by licensed staff and daily medication administration by unlicensed staff.

The Medication Administration Record for December 2005 lacked documentation of both of these medications being administered. The record also lacked documentation as to why the medication administration was not completed as prescribed. The licensed staff that performed the weekly set-up of medications did not document each medication set-up. Client A1's medication administration record had several medications for December 3, and 4, 2005 that were not documented as given and the record lacked evidence of any documentation as to why the medication administration was not completed as prescribed nor any follow up procedures that were provided. On December 3 and 4, 2005 the Medication Administration Record (MAR) was

documented as "R." The record lacked any documentation why the medication was "refused" and lacked the initials of the staff that provided assistance with medication administration for the refused medication. There was a notation in the unlicensed staff notes for client #A1, dated December 4, 2005, that indicated the client was given an "Imodium AD." There was no documentation as to the time of administration of the Imodium or the signature and title of the person who provided assistance with administration of the medication. The Imodium was not listed on the MAR for December 2005 for client #A1.

On interview, December 7, 2005, the licensed practical nurse (LPN) stated that unlicensed personnel could provide assist with "PRN"(as needed) medications if they were documented on the backside of the MAR, which listed the "PRN" medication, dosage, route of administration, and orders for use. The LPN also stated she did not know why the unlicensed staff had not documented the administration of all the medications administered. She indicated she thought the staff probably forgot to document on the MAR after giving the medications.

TO COMPLY: The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $300.00.

12. MN Rule 4668.0865 Subp. 2 **$350.00**

Based on record review and interview, the licensee failed to conduct an assessment of the client's functional status and need for central medication storage and develop a service plan for the provision of central storage of medications for one of two current clients (#A1) at site A and one of one current clients' at site E (#E1) who received central storage of medications. The findings include:

Client #A1 and client #E1 began receiving central storage of medications November 5, 2004, and January 27, 2004, respectively.

Client #A1 and # E1's records did not include an assessment for central storage of medications nor was the provision of that service indicated on the Service Plan. When interviewed, December 7, 2005, the registered nurse confirmed that the licensee provided central storage of medications to these clients. She indicated that she was unaware of the need for the assessment and service plan.

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

and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

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

14. Rule 4668.0865 Subp. 9 **$300.00**

Based on observation and interview, the agency failed to provide locked affixed storage for schedule II drugs in one of five storage areas observed. The findings include:

On December 6, 2005, the storage area for schedule II drugs at Southview Manor was observed with the registered nurse. The registered nurse removed a locked black metal box from a locked kitchen cabinet. She placed the narcotic box on the counter in the kitchen area. The box contained Tylenol # 3 pills.

TO COMPLY: An assisted living home care provider licensee providing central storage of medications must provide separately locked compartments, permanently affixed to the physical plant or medication cart, for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $300.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), **the total amount you are assessed is: $1250.00.** 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 Licensing and Certification Section of 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, Compliance and Monitoring 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 4668.0800Subp. 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.

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.

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: Kandiyohi 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
Division Of Compliance Monitoring
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: CENTRAL MN SENIOR CARE INC

DATE OF SURVEY: August 14, 15, 16, and 17, 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:
Deb Oleson, Director of Central MN Senior Care, Inc.
Andrea Krusemark, RN
Heidi Lundgren, RN
Pam Brede, Director of Nursing
Cori Thompson, LPN
Deb Friedrichs, Director
Erica Naig, LPN
Lorraine Schwartz, HHA
Jacequeline, Johnson, HHA
Tammy Miller, HHA
Sherri Watkins, HHA

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

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 December 5, 6, 7, 8, 9, and 14, 2005. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the correction orders issued as a result of a visit made on December 5, 6, 7, 8, 9, and 14, 2005 is as follows:

1. **MN Rule 4668.0030 Subp. 2** **Corrected**

2. **MN Rule 4668.0065 Subp. 3** **Corrected**

3. MN Rule 4668.0810 Subp. 5 **Corrected**

4. MN Rule 4668.0810 Subp. 6 **Corrected**

5. MN Rule 4668.0815 Subp. 2 **Not corrected** **$250.00**

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and/or revised the client's service plan at least annually for two of five clients' (A1 and A2) records reviewed who have received care for more than 12 months. The findings include:

Client A1's service plan, dated April 14, 2006, was established by the program director, who was not a registered nurse (RN). The previous service plan was dated November 5, 2004. There was no indication that the RN had reviewed and/or revised client A1's service plan after November 2004. Client A2's service plan, signed April 12, 2006, was established by the program director, not an RN. The previous service plan was dated November 22, 2004. There was no indication that the RN had reviewed and/or revised client A2's service plan after November 2004. When interviewed August 15, 2006, the RN stated she did not review the service plans and that the program director did them.

6. MN Rule 4668.0815 Subp. 4 **Not Corrected** **$50.00**

Based on record review and interview, the licensee failed to provide complete service plans for eight of eight clients (A1, A2, A4, C2, C6, C7, and L1) records reviewed. The findings include:

Client A1's Service Plan, signed April 14, 2006, indicated the client was to have "personal cares, homemaking, laundry, cook, and clean, administer meds, and community outs." The service plan did not indicate the frequency of these services. Client A1 also received central storage of medications. The service plan, dated April 14, 2006, did not include central storage of medications. When interviewed, August 17, 2006, the registered nurse (RN), confirmed the service plan did not contain central storage of medication, or the frequency of services.

Client A2's service plan, dated April 12, 2006, indicated the client was to have "aid with med. reminders, arrange transportation, personal cares, homemaking, laundry, transfers," the frequency for these services was listed as "24 hours." When interviewed, August 17, 2006, the RN stated they provided these services whenever the client requested them and was unaware they needed the frequency to be more specific. The Medical Emergency Plan on client A2's service plan, dated April 12, 2006 was blank. When interviewed, August 15, 2006, the licensed practical nurse (LPN), confirmed the current service plan lacked the medical emergency plan. She indicated the previous service plan, for client A2, dated November 22, 2004, contained a medical emergency plan.

Client A4's service plan, dated May 1, 2006, indicated the client was to have "set-up med; every 14 days: medication administration; prepare meal/snack; assist in transportation; homemaking/laundry; personal care" and the frequency for these services was listed as "24 hr." The Medication Assessment/Delegation Form, dated May 1, 2006, indicated the client required weekly set up of medications by the nurse. The area of the assessment form that assessed assist with medication administration was blank. When interviewed, August 15, 2006, the LPN indicated client A4 was independent in medication administration after medications were setup for the client, which the LPN did weekly.

Client L1's service plan, signed June 14, 2006, indicated the client was to have "personal cares; prepare food; transportation; and all homemaking." The frequency of services was listed as "24 hrs." When interviewed, August 17, 2006, the RN stated she was unaware the frequency of services needed to be more specific for clients A4 and L1.

Clients C2 and C7's service agreements dated January 9, 2006 and client C6's service agreement signed June 16, 2006 all indicated that they received home health aide (HHA) supervision 24 hr., HHA - medication administration, meal/snack preparation, assistance with transportation, homemaking/laundry, personal care, and socialization. The frequency for HHA services were not specific, they were all 24 hours per day. When interviewed, August 14, 2006, the RN, indicated that the service agreement was not specific enough.

7. MN Rule 4668.0845 Subp. 2	**Corrected**	
8. MN Rule 4668.0855 Subp. 5	**Corrected**	
9. MN Rule 4668.0855 Subp. 6	**Corrected**	
10. MN Rule 4668.0855 Subp. 7	**Corrected**	
11. MN Rule 4668.0855 Subp. 9	**Not corrected**	**$300.00**

Based on record review and interview, the licensee failed to ensure medication administration records were complete for four of five (A1, A4, C1 and C6) client's records reviewed, which received assistance with medication administration. The findings include:

On August 13, 2006, an unlicensed personnel documented in the unlicensed staff notes, that client A1 had received "4 Tylenol". However, the MAR for August, 2006 did not indicate the client had received Tylenol on August 13, 2006. On August 6, 2006 the initials by the Miralax, which is to be administered daily, were scratched out with no documentation as to why the medication was not administered as ordered. On August 7 and 11, 2006, the initials for Miralax were circled as not given, however, there was no documentation as to why the medication was not administered as ordered. On August 14, 2006, the hydrocortisone, which is to be administered every morning, was circled as not given with no explanation as to why it was not administered as ordered. The July MAR lacked any initials for the Levemir insulin, which was to be administered every day at bedtime, on July 21, 22 and 26, 2006, and there was no documentation why the medication was not administered as ordered. On interview, August 15, 2006, the licensed practical nurse stated that she had made medication error reports for these medications that were not documented as given. On interview, August 17, 2006, the registered nurse, employee AB, confirmed she was aware that the LPN had written medication error reports for these medications.

Client A4's Service Plan, dated May 1, 2006 indicated that client A4 had medication set-up every fourteen days. Client A4 lacked medication administration records. On interview, August 15, 2006, the licensed practical nurse stated she set-up the medications per the "medication chart", which lists the name of medication, strength, dose, route, frequency and description, and she documented in the progress notes that she had, "set-up the medications x 1 wk.", however, the LPN did not document each medication that was set-up. On interview, August 17, 2006, the registered nurse, employee

AB, stated that when licensed staff set-up medications, they were instructed to indicate on the MAR, by their initials, the days that they had set-up.

Client # C1 had a physician's order for Ensure liquid twice daily on April 19, 2006. The medication administration record for May, 2006 indicated that Ensure was not given on May 07, 09, 10 and 18, 2006. It was not signed off on those days. It was refused on May 03, and 17, 2006. There was no documentation in the client's record why it was not given.

Upon interview of employee #CA, RN, she did not know why it was not given.

Client #C6 medication administration record for May, 2006 indicated that the 2p.m. and 8 p.m. medications were all circled. No documentation was noted in the communication book nor the health care progress notes. The nurse's notes on May 21, 2006 indicated that the client was admitted to the hospital that morning.

Upon interview on August 15, 2006, the LPN indicated that the client was admitted to the hospital the morning of May 21, 2006 and so the medications were not given that afternoon and evening, that's why it was initialed and circled by the HHA.

12. MN Rule 4668.0865 Subp. 2 Not corrected $350.00

Based on record review and interview, the licensee failed to have the registered nurse conduct an assessment of the client's functional status and need for central medication storage and develop a service plan for the provision of central storage of medications for five of five clients (A1, C1, C2, C7 and L1) who received central storage of medications. The findings include:

Client A1's "Medication Assessment/Delegation Form", dated April 21, 2006, indicated that client A1 was required to have "medications set-up by the nurse weekly; assist with medications four times daily which consisted of medication administration; administration of insulin daily; and medications were to be kept in individual containers in locked assisted living office." Client A1's record lacked a functional assessment and need for central medication storage and the Service Plan for Client A1 lacked a provision of central storage of medications and the frequency of supervision of the person providing the task.

Client L1's "Medication Assessment/Delegation Form" indicated that client L1 was to have the nurse set up the medications weekly; to have medications administered four times daily; and medications were to be locked up. Client L1's record lacked a functional assessment and need for central medication storage and the Service Plan for Client L1 lacked a provision of central storage of medications and the frequency of supervision of the person providing the task. On interview, August 17, 2006, the registered nurse, employee AB, stated she was unaware that the assessment lacked the functional assessment for the need for assist with administration of medications and central storage of medications.

Client #C1 RN Evaluation / Baseline Assessment dated November 22, 2004 indicated that the client has memory impairments and forgetfulness and received administration of medication but not central storage of medication. It was not address in the service plan.

Upon interview of employee #CA, RN on August 14, 2006, she indicated that all the clients have

central storage of medication. It was not addressed in the service plan.

Client #C2 Assessment for Need for Medication Reminders, Assistance, Administration or Central Storage dated July 30, 2004 indicated that the client had swallowing problem and needed central storage of medication. It was not addressed in the service plan.

Client #C7 Assessment for Need for Medication Reminders, Assistance, Administration or Central Storage dated November 15, 2004 indicated that the client had memory impairment and forgetfulness and needed central storage of medication. It was not addressed in the service plan.

13. MN Rule 4668.0865 Subp. 8 **Corrected**

14. MN Rule 4668.0865 Subp. 9 **Not corrected** **$300.00**

Based on observation and interview, the agency failed to provide locked permanently affixed storage for schedule II drugs in one of two storage areas observed. The findings include:

On August 15, 2006, the storage area of schedule II drugs at the Becker Apartments was observed with the licensed practical nurse and the registered nurse. The permanently affixed box was unlocked and it contained Dilaudid pills. On interview, August 15, 2006, the LPN stated that the box should have been locked, and it generally was, however, she stated that they sometimes have difficulty unlocking and locking the box. On interview, August 15, 2006, the registered nurse, employee AD, stated that the schedule II box was not currently locked but that it should be and verified that it contained Dilaudid for client A1.

15. MN Rule 4668.0870 Subp. 2 **Corrected**

16. MN Statute § 626.557 Subd. 14 (b) **Corrected**

2) 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 this Licensing Survey Form during on-site visits to evaluate the care provided by Assisted Living home care providers (ALHCP). ALHCP 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 Assisted Living 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 ALHCP home care regulations. Any violations of ALHCP licensing requirements are noted at the end of the survey form.

Name of ALHCP: CENTRAL MN SENIOR CARE INC

HFID #: 20855

Date(s) of Survey: August 14, 15, 16, and 17, 2006

Project #: QL20855002

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. • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0815 • 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 understands what care will be provided and what it costs.	Annual Licensing Survey ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 1 _X_ New Correction Order issued _X_ Education Provided
2. The provider promotes the clients' rights. • MN Rule 4668.0030 • MN Rule 4668.0040 • MN Rule 4668.0170 • 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 provider.	Annual Licensing Survey ____Met ____Correction Order(s) issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
• MN Statute §144A.44 • MN Statute §144D.04		Follow-up Survey #____ ____New Correction Order issued ____Education Provided
3. The health, safety, and well being of clients are protected and promoted. • MN Rule 4668.0035 • MN Rule 4668.0805 • MN Statute §144A.46 • MN Statute §144D.07 • MN Statute §626.557	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Provider 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.	Annual Licensing Survey ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #____ ____New Correction Order issued ____Education Provided
4. The clients' confidentiality is maintained. • 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.	Annual Licensing Survey ____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. • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0830 • MN Rule 4668.0835 • MN Rule 4668.0840 • MN Rule 4668.0065 • MN Rule 4668.0070 • MN Statute §144D.065 • MN Statute §144A.45 • MN Statute §144A.461	• 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.	Annual Licensing Survey ____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. • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0855 • MN Rule 4668.0860 • 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 provider 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.	Annual Licensing Survey ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 1 _X_New Correction Order issued _X_Education Provided
7. The provider has a current license. • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0019 • MN Rule 4668.0220 • MN Statute §144A.47 • MN Statute §144D.02 • MN Statute §144D.04 • MN Statute §144D.05 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) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	Annual Licensing Survey ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided
8. The is in compliance with MDH waivers and variances • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	Annual Licensing Survey ____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 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, list the rule or statute number and the findings of deficient practice noted.

1. MN Rule 4668.0815 Subp. 1

AREA OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to have a registered nurse (RN) establish a service plan for one of two client's(A4) admitted after May 2006, records reviewed. The findings include:

The service plan for client A4, dated May 2006 was established by the Program Director, not a RN. When interviewed August 15, 2006, the Program Director stated that she had completed the Service Plan for client A4, but that in the future the registered nurse would be establishing the service plans.

2. MN Rule 4668.0860 Subp. 7

AREA OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that an order received by facsimile was communicated to the supervising registered nurse (RN) within one hour of receipt for one of one clients' (A1) records reviewed, who received physician orders by facsimile. The findings include:

Client #A1's record contained orders by facsimile dated July 13, 2006 and July 19, 2006. The record lacked documentation that the RN was notified of these orders. When interviewed August 15, 2006, the licensed practical nurse stated she did not notify the RN within one hour when receiving orders by facsimile. She indicated that she would inform the Home Care registered nurse, who provides assessment services for client A1, on a weekly basis of any order changes, however, the LPN stated she did not notify the licensee's RN of receiving new orders by facsimile. On August 15, 2006, the Home Care registered nurse stated she provided assessment services and did not provide supervision of medication administration.

3. MN Rule 4668.0865 Subp. 5

AREA OF COMPLIANCE: # 6

Based on record review and interview the licensee failed to have the current directions for use for a legend drug for one of one (A1) client's records reviewed with central storage of medications. The findings include:

Client A1's Medication assessment/Delegation Form indicated that client A1's "medications kept in individual container in locked AL office". On August 14, 2006 the licensed practical nurse stated that client A1 requires central storage of medications. On July 6, 2006 the insulin dosage was increased from 32 units to 36 units at bedtime. On July 13, 2006 the licensee received a faxed prescriber's order to increase the insulin from 36 units to 44 units. During the inspection of central storage of medications on August 15, 2006, it was noted that the label on the insulin indicated the client was to receive 32 units daily. On interview the licensed practical nurse stated that the insulin had not been refilled since the order change and no label change had been done. When questioned if the pharmacy would provide a new label with the correct orders, she stated that they would.

A draft copy of this completed form was left with Deb Oleson at an exit conference on August 17, 2006. 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. 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 supervisory review, this form will be posted on the MDH website. General information about ALHCP is also available on the MDH 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).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 9465

March 29, 2006

Debra Shriver, Administrator
Central Minnesota Senior Care Inc
328 5th Street Southwest
Willmar, MN 56201

Re: Results of State Licensing Survey

Dear Ms. Shriver:

The above agency was surveyed on December 5, 6, 7, 8, 9, and 14, 2005, for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if found, are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me, or the RN Program Coordinator. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

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

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

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

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Debra Shriver, President Governing Body
Kandiyohi County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
CMR File

Assisted Living Home Care Provider

LICENSING SURVEY FORM

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

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

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

Name of ALHCP: CENTRAL MN SENIOR CARE INC

HFID # (MDH internal use): 20855

Date(s) of Survey: December 5, 6, 7, 8, 9, and 14, 2005

Project # (MDH internal use): QL20855002

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

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promote the clients' rights as stated in the Minnesota Home Care Bill of Rights. (MN Statute 144A.44; MN Rule 4668.0030)	No violations of the MN Home Care Bill of Rights (BOR) are noted during observations, interviews, or review of the agency's documentation. Clients and/or their representatives receive a copy of the BOR when (or before) services are initiated. There is written acknowledgement in the client's clinical record to show that the BOR was received (or why acknowledgement could not be obtained).	____ Met __X__ Correction Order(s) issued __X__ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff observe infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	____ 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.	____ Met __X__ Correction Order(s) issued __X__ Education provided
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	__X__ Met ____ Correction Order(s) issued __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 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 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	___ Met X Correction Order(s) issued X Education provided ___ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	X Met ___ Correction Order(s) issued X 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 X Education provided

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
#1	MN Rule 4668.0815 Subp. 2 Reevaluation	X	X	Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and/or revised the client's service plan at least annually for one of two current clients (# D5) records reviewed at site D, and one of one current clients (#E1) records reviewed at site E. The findings include: Client #D5's service plan was last updated January of 2004. There was no indication that the RN had reviewed or revised client #D5's service plan after January 2004. When interviewed, December 6, 2005, the RN indicated that she was not aware that the service plan had to be reviewed annually. Client E1's service plan was last reviewed July of 2004. When interviewed December 8, 2005, the RN confirmed that the client's service plan had not been reviewed since July of 2004 and then reviewed the service plan. **Education:** Provided
#1	MN Rule 4668.0815 Subp. 4 Contents of service plan	X	X	Based on record review and interview, the licensee failed to provide complete service plans for three of three clients (#A1, #A2, # A3,) at site A, three of three clients (#B1, #B2, #B3) at site B, and one of two current clients (#D5) at site

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				D. The findings include: Client #A1's service plan dated, November of 2004, indicated the client was to receive "HHA" (home health aide) services. Under "frequency" it stated "24/7." Client #A1's record indicated the client received services which included medication administration, blood sugar monitoring and central storage of medications. Client #A2's service plan dated, November of 2004, indicated the client was to receive "HHA" services "QD" (daily) and under frequency of supervision it stated, "q 2 weeks" (every two weeks). Client #A1 and #A2's service plans lacked a description of the specific services that the home health aides were to provide, the frequency of each service, and the fees for the services. On December 6, 2005, client #A1 stated she had received billing related letters from the county, on occasion, but she was unsure of the fees paid for services. When interviewed, December 7, 2005, the registered nurse, stated that the county notified clients' A1 and A2 regarding the fees that the county would pay for the services. She verified that the service plans did not indicate the fees for services or the description of services. On December 8, 2005, client #A2 stated she received a statement from the county monthly on the fees paid to the agency. The service plan for client #A3, dated November of 2004, lacked the fees for services. Clients B1, B2 and B3 had service plans dated July of 2004. The service plans for client #B1, B2, and

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				B3 dated July of 2004, October of 2005, and June of 2004 respectively, lacked the actions to be taken if scheduled services could not be provided. The service plan for client #B3 lacked the fees for services. When interviewed, December 7, 2005, the licensed practical nurse verified this information was not indicated on any of the clients' service plans and was unable to locate any information related to the cost of the services noted on the client's service plan. Client #D5's service plan dated January of 2004 indicated registered nurse (RN) supervision every 62 days and RN medication set up weekly. The fees for these services were not indicated on the service plan. When interviewed, December 7, 2005, the registered nurse confirmed the fees for these services had not been listed. **Education:** Provided
#1	MN Rule 4668.0845 Subp. 2 Services that require supervision by a registered nurse	X	X	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 nine of thirteen clients' (#A1, #A2, #B1, #B2, #B3, #C1, #C2, #D4, and #D5) records reviewed. The findings include: Clients' #A1, #A2, and #C1, began receiving services November of 2004. Clients #B1, #B2, #B3, #C2, #D4, and #D5 began receiving services July of 2004, October of 2004, June of 2004, August of 2004,

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				January of 2005, and January of 2004 respectively. Clients' #A1, #A2, #B1, #B2, #B3, #C1, #C2, #D4, and #D5 received services that required supervision which ranged from assistance with medication administration to assistance with activities of daily living skills. There was no evidence of nursing supervisory visits in their records. When interviewed on December 7, 2005, the registered nurse indicated that she and the licensed practical nurse alternately tried to visit the clients once a month. The RN stated she or the LPN would do monthly health assessments and asked how things were going. The RN was not aware that she had to supervise the unlicensed personnel. When interviewed, December 8, 2005, the director of nursing verified that the monthly visits being conducted did not meet the requirements of a supervisory visit. **Education:** Provided
#2	MN Rule 4668.0030 Subp. 2 Notification of client	X	X	Based on record review and interview, the licensee failed to provide the current Minnesota Home Care Bill of Rights to twelve of thirteen clients' (A1, A2, A3, B1, B2, B3, C1, C2, C3, D4, D5 and D6) records reviewed. The findings include: Clients' A1, A2, B1, B2, B3, C1, C2, C3, D4, D5 and D6 began receiving services between January 2003 and November 2004. The clients had been given a copy of the bill of rights that did not contain information added to Subd. 1 (16) in

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				2001. A review of the admission package provided to the clients upon their admission to the agency contained the bill of rights from 1999. When interviewed December 8, 2005, the Director of Corporate Affairs stated the 1999 version of the Minnesota Home Care Bill of Rights had been provided to all of the clients. She indicated she was unaware that there had been updates to the bill of rights. **Education:** Provided
#3	MN Rule 4668.0065 Subp. 3 Infection control in-service training	X	X	Based on record review and interview, the licensee failed to ensure annual infection control in-service training was provided for two of five employees (DD and DE) reviewed. The findings include: Employee DD and DE were hired as a home health aides on December of 1999 and February of 1998, respectively. Documentation indicated that employee DD last had infection control training on October of 2004. There was no documentation that infection control training was provided to employee DE. When interviewed December 8, 2005, employee DD stated that in March 2005 she attended an infection control inservice. During an interview December 8, 2005, the registered nurse said that an infection control inservice is usually offered once a year to the staff. She was unable to find further documentation of infection control

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				training for employees DD and DE. **Education:** Provided
#3	MN Statute §626.557 Subd. 14(b) Abuse prevention plans	X	X	Based on interview and record review the licensee failed to develop an individual abuse prevention plan for two of nine (#A1, and #A2) current clients reviewed. The findings include: Client #A1had a Home Health Aide Care Plan which contained an assessment area for "Vulnerability Status." This area was left blank Client #A1 was a bilateral amputee. There was no evidence in the record of an assessment and plan for abuse prevention. Client #A2's record contained a Kandiyohi County Services form with an area entitled, "Protective Oversight." This area contained a plan for abuse prevention. There was no evidence the licensee had developed the plan nor had the licensee signed the plan in acknowledgement. On interview, December 8, 2005, the registered nurse stated that the home care agency, which is also a company of the licensee, did a vulnerable adult assessment and plan for these clients. The records did not contain any plan for abuse prevention except as noted above. **Education:** Provided
#5	MN Rule 4668.0810 Subp. 5 Form of entries	X	X	Based on record review and interview, the licensee failed to ensure that entries in the client records were authenticated with the name and title of the persons making the entries for two of two (#A1, #A2 and #E1) current client records

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				reviewed at site A and one of one client records reviewed at site E. The findings include: Client #A1's Home Health Aide Notes, Blood Sugar Record, Home Health Aide Log and Medication Administration Record for December, 2005, and Client #A2's Home Health Aide Log, Home Health Aide Notes for December, 2005 lacked the names of staff making entries in the records. On interview, December 7, 2005, the registered nurse (RN), stated the medication administration record was to have the full names and titles of the staff administering the medications and providing cares. Client # E1's weekly care records dated, December of 2005, lacked the titles of the staff providing daily cares and the competency evaluations for delegated nursing services in the client's record were signed but did not have titles of staff with the signatures. When interviewed, December 8, 2005, the RN stated she did not realize titles needed to be included on the weekly record or the signature list for competency evaluations. Education: **Provided**
#5	MN Rule 4668.0810 Subp. 6 Content of client record	X	X	Based on record review and interview the licensee failed to have a significant change in the client's status and any actions by staff in response to the change documented document in the client record for one of two (#A1) current client's records reviewed at site A. The findings include:

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				When interviewed, December 6, 2005, client #A1, stated she had had an occurrence of chest pain, during the night, about a week prior to the interview. Client A1 had a prescription for Nitroglycerin as needed for chest pain. She had summoned help at the time. A home health aide (HHA) responded to the call and checked the client's pulse and blood pressure. Client #A1 asked the HHA what her pulse was and to ensure her Nitroglycerin was available if needed. The HHA stated her pulse was 40 and the Nitroglycerin was available. Client #A1 stated that the HHA repeated the pulse check and told client #A1that her pulse at that time was 80. Client #A1 stated that eventually the pain subsided without Nitroglycerin. The record lacked any documentation of the incident or notification of the registered nurse or the clients' physician. **Education:** Provided
#8	MN Rule 4668.0855 Subp. 5 Administration of medications	X	X	Based on record review and interview, the licensee failed to ensure that the registered nurse (RN) was notified, within twenty-four hours after it's administration, or within a time period that was specified by a registered nurse prior to the administration, when an unlicensed person administered a pro re nata (PRN/ as needed) medication to a client for one of one discharged client (#C3) records reviewed at site C and two of two current client (#D4, and #D6) records reviewed at site D. The findings include:

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				Client # C3 received Milk of Magnesia 15-30 cc PRN on February 5, 16, and 19, 2005. Client # C3 received TUMS 1-2 tablet on February 9, 2005 for upset stomach. Also Client # C3 received Asprin 650 milligrams (mg) PRN for a headache and Tylenol 650 mg PRN on February 13, 2005. Client #D4 received Darvocet 100/650 1 tablet PRN on September 8, 2005. Client #D6 received Tylenol 500 mg 1 tablet PRN on July 8, 13, and 15, 2005. There was no documentation that the RN was notified when the PRN medications were given or at a time period that was specified by a registered nurse prior to the administration. When interviewed December 6, 2005, the registered nurse, indicated that the licensed practical nurse (LPN) checks the PRN log sheet once a week when she sets up the weekly medications. The LPN wrote a memo to the staff with regards to PRN medications, which stated she (LPN) would check the medication sheets once a week for PRN use and would notify the RN. There was no facility's policy on PRN use. **Education**: Provided
#8	MN Rule 4668.0855 Subp. 6 Limitations on administering medications	X	X	Based on record review and staff interview, the licensee failed to assure licensed persons drew insulin injections for two of two clients who had insulin drawn by the facility staff, (#A1, #B1) records reviewed. The findings include: Client #A1's medication

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				administration record indicated that unlicensed staff administered Lantus insulin by pen daily, and Novolog insulin by pen at each meal, with the dosage depending on the number of carbohydrates the client ingested. On December 6, 2005, employee AA, a home health aide (HHA), stated that she dialed up the Lantus dosage prior to injecting the insulin into client #A1 and at the time she injected the Novolog insulin, employee AA counted the carbohydrates the client had ingested and then called the on-call registered nurse, who then told employee AA how many units of Novolog insulin to dial up and inject. Client #B1 received an injection of Lantus insulin every evening. When interviewed, December 6, 2005, regarding the procedure for the Lantus insulin injection HHA, BA stated an insulin pen was used to administer the Lantus. She stated she dialed up the dosage and then administered the insulin to client #B1. The HHA showed the reviewer the insulin pen stored in the kitchen refrigerator. When interviewed, December 8, 2005, the director of nursing stated the HHAs' were instructed to call the nurse on call before they administered insulin using the insulin pen. She stated the insulin pens were being used for the Lantus insulin due to the instability of Lantus insulin. She was unaware the HHA were unauthorized to draw insulin by dialing a dosage on

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				the insulin pens. **Education:** Provided
#8	MN Rule 4668.0855 Subp. 7 Performance of routine procedures	X	X	Based on interview and record review, the licensee failed to ensure that the registered nurse (RN), specified in writing, specific instructions for performing the procedures for medication administration for one of one (#E1) current client records reviewed at site E. The findings include: Client E1 received assistance with medication administration from unlicensed staff. When interviewed, December 7, 2005, the RN stated client E1's medications were crushed and mixed in applesauce before giving them to the client to self-administer. The client's record lacked instructions in writing on how to crush the medications and mix them in applesauce. On, December 8, 2005, the RN verified the lack of instruction in writing for this procedure. **Education:** Provided
#8	MN Rule 4668.0855 Subp. 9 Medication records	X	X	Based on record review and interview, the licensee failed to ensure medication administration records were complete for one of two current clients (#A1) records reviewed at site A. The findings include: Client #A1 had physician orders, November of 2005, which indicated the client was to receive Lovenox 60 milligrams (mg) subcutaneously (SQ) every day and one Nephrocap at bedtime. Client #A1 had weekly

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				medication set-up by licensed staff and daily medication administration by unlicensed staff. The Medication Administration Record for December 2005 lacked documentation of both of these medications being administered. The record also lacked documentation as to why the medication administration was not completed as prescribed. The licensed staff that performed the weekly set-up of medications did not document each medication set-up. Client A1's medication administration record had several medications for December 3, and 4, 2005 that were not documented as given and the record lacked evidence of any documentation as to why the medication administration was not completed as prescribed nor any follow up procedures that were provided. On December 3 and 4, 2005 the Medication Administration Record (MAR) was documented as "R." The record lacked any documentation why the medication was "refused" and lacked the initials of the staff that provided assistance with medication administration for the refused medication. There was a notation in the unlicensed staff notes for client #A1, dated December 4, 2005, that indicated the client was given an "Imodium AD." There was no documentation as to the time of administration of the Imodium or the signature and title of the person who provided assistance with administration of the medication. The Imodium was not listed on the MAR for December 2005 for client #A1.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				On interview, December 7, 2005, the licensed practical nurse (LPN) stated that unlicensed personnel could provide assist with "PRN"(as needed) medications if they were documented on the backside of the MAR, which listed the "PRN" medication, dosage, route of administration, and orders for use. The LPN also stated she did not know why the unlicensed staff had not documented the administration of all the medications administered. She indicated she thought the staff probably forgot to document on the MAR after giving the medications. Education: **Provided**
#8	MN Rule 4668.0865 Subp. 2 Nursing assessment and service plan	X	X	Based on record review and interview, the licensee failed to conduct an assessment of the client's functional status and need for central medication storage and develop a service plan for the provision of central storage of medications for one of two current clients (#A1) at site A and one of one current clients' at site E (#E1) who received central storage of medications. The findings include: Client #A1 and client #E1 began receiving central storage of medications November of 2004, and January of 2004, respectively. Client #A1 and # E1's records did not include an assessment for central storage of medications nor was the provision of that service indicated on the Service Plan. When interviewed, December 7, 2005, the registered nurse

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				confirmed that the licensee provided central storage of medications to these clients. She indicated that she was unaware of the need for the assessment and service plan. **Education:** Provided
#8	MN Rule 4668.0865 Subp. 8 Storage of drugs	X	X	Based on observation and interview, the licensee failed to store drugs in locked compartments for one of two (#B1) current clients reviewed at site B. The findings include: Client B#1 received central storage of medications. On December 6, 2005, insulin belonging to client #B1 was observed in an unlocked, covered container in an unlocked refrigerator located in kitchen. The program director was interviewed, December 6, 2005. She stated she was unaware the insulin should be in a locked location. It was observed that the kitchen area was an open area with no door available to lock to secure the area. **Education:** Provided
#8	MN Rule 4668.0865 Subp. 9 Storage of Schedule II drugs	X	X	Based on observation and interview, the agency failed to provide locked affixed storage for schedule II drugs in one of five storage areas observed. The findings include: On December 6, 2005, the storage area for schedule II drugs at Southview Manor was observed with the registered nurse. The registered nurse removed a locked black metal box from a locked kitchen cabinet. She placed the narcotic box on the counter in the

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				kitchen area. The box contained Tylenol # 3 pills. **Education**: Provided
#9	MN Rule 4668.0870 Subp. 2 Drugs given to discharged clients	X	X	Based on record review and interview, the licensee failed to ensure that the disposition of medications was documented for two of four discharged client records (#B3, and #C3) reviewed. The findings include: Client #3B was discharged April of 2005. He had received central storage of medications while at the facility. There was no documentation of to whom the medications were given upon discharge. When interviewed, December 7, 2005, the program director stated the medications were sent with the client's wife and confirmed that there was no documentation related to the disposition of the client's medication. Client #C3 was discharged February of 2005. She had received central storage of medications while at the facility. There was no documentation of to whom the medications were given upon discharge. When interviewed, December 6, 2005, the licensed practical nurse (LPN) stated the medications were sent with the client's family who accompanied the client upon discharge. The LPN verified that there was no documentation related to the disposition of the client's medication.

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				Education: Provided
#10	MN Rule 4668.0012 Subp. 17 Display of license		X	**Education:** Provided

A draft copy of this completed form was left with Pam Brede, RN and Deb Olson at an exit conference on December 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)