MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9972 1244

July 2, 2008

Del Sand, Administrator
River Birch Residence
231 Washington Avenue
Holdingford, MN 56340

Re: Amended Licensing Follow Up visit

Dear Mr. Sand:

On June 27, 2008, you were sent an Informational Memorandum, a MDH Correction Order and License Survey Form, and a Notice of Assessment for Noncompliance with Correction Orders, as the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. Subsequent to this mailing, on July 2, 2008, it was requested that MDH redirect the mailing to the above address.

The amended information is underscored and the stricken [~~stricken~~] information has been removed. Please return the green card on the envelope as verification that you received the survey information.

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

01/07 CMR1000AMMENDED

MINNESOTA
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DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail ~~# 7003 2260 0000 9972 1138~~
7003 2260 0000 9972 1244

June 27, 2008

Del Sand, Administrator
River Birch Residence
PO BOX 432
Cold Spring, MN 56320

Re: Licensing Follow Up visit

Dear Mr. Sand:

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 June 9, 10, 11, and 12, 2008.

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: Stearns County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Deb Peterson, Office of the Attorney General-MA Fraud
Mary Henderson, Program Assurance

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

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NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOLLOWING A SUBSEQUENT REINSPECTION FOR CLASS F HOME CARE PROVIDERS

June 27, 2008

Del Sand, Administrator
River Birch Residence
PO BOX 432
Cold Spring, MN 56320

RE: QL21266002

Dear Mr. Sand:

1. On June 9, 10, 11, and 12, 2008, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of follow up visits to an original survey completed on November 4, 7, 16, and 17 and December 19, 20, and 21, 2005, and subsequent follow up visits made on July 17, 18, 19, 20, and 21, 2006, November 15 and 16, 2006, August 20 and 21, 2007and May 19, 20 and 21, 2008, with correction orders received by you on March 9, 2006, August 19, 2006, January 4, 2007, October 30, 2007, and June 4, 2008, and found to be uncorrected during inspections completed on July 17, 18, 19, 20, and 21, 2006, November 15 and 16, 2006, August 20 and 21, 2007 and May 19, 20, and 21, 2008.

As a result of correction orders remaining uncorrected on the May 19, 20, and 21, 2008, re-inspection, a penalty assessment in the amount of **$7100.00** was imposed on May 30, 2008.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on June 9, 10, 11, and 12, 2008.

5. MN Rule 4668.0810 Subp. 6 **$1,600.00**

Based on record review and interview, the licensee failed to maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include:

On September 22, 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation

indicated client#1 returned from the hospital with a "fleets enema." On November 9, 2005, the "Communication Book" had an entry that stated, the client fell and hit her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to be called if any symptoms were noted. Neither of these incidents was documented in client #1's record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record.

Client #9 had two fall notations in the incident/accident reports and facility communication book. On November 1, 2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head. On November 10, 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

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

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

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

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

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $1,600.00.

8. MN Rule 4668.0815 Subp. 4 **$800.00**

Based on record review and interview, the licensee failed to provide a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include:

Client #1 and #2's service plans were authenticated on February 18, 2005 and August 12, 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete.

Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans.

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;

(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: $800.00.

9. MN Rule 4668.0825 Subp. 4 **$5,600.00**

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include:

Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the assisted living home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $5,600.00.

15. MN Rule 4668.0855 Subp. 9 **$4,800.00**

Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include:

Client #2's Service Plan, August 12, 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October 5, 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders.

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: $4,800.00.

2. On June 9, 10, 11, and 12, 2008, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on November 15 and 16, 2006, which were received by you on January 4, 2007.

5. MN Statute §626.557 Subd. 14(b) **No Fine**

Based on record review and interview the licensee failed to provide a complete vulnerable adult assessment for two of two new client's (#18 and #19) records reviewed. The findings include:

Clients #18 and 19's service plans indicated that the clients began receiving services from the licensee on October 26, 2006 and October 31, 2006, respectively. The clients' records contained an assessment entitled, "Assessment for Resident Vulnerability and Safety", which included areas of vulnerability and interventions if the client was assessed as vulnerable in that area. The assessment lacked the person's susceptibility to abuse by other individuals, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

On interview, November 16, 2006, the owner stated she was unaware the vulnerable adult assessment needed to include these vulnerabilities. The registered nurse (RN) who completed these assessments was no longer employed by the licensee.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of the person's susceptibility to abuse by other individuals, including other vulnerable adults, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: NO FINE.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **12,800.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

June 24, 2008

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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: Stearns County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Attorney General's Office – MA Fraud
Mary Henderson, Program Assurance

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

INFORMATIONAL MEMORANDUM

PROVIDER: RIVER BIRCH RESIDENCE

DATE OF SURVEY: June 9, 10, 11, and 12, 2008

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

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

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

NAMES AND TITLES OF PERSONS INTERVIEWED:
Bonnie Norgren, Acting Director
Cindi Kuehl, LPN
Stephanie Norstrom, LPN
Brianne Wolters, Acting Administrator
Beth Tepfer, RN
Joan Breth Gondringer, Resident Aide; Assistant Director
Amber Volkers, Resident Aide
Courtney Breth, Resident Aide
Crystal Wall, Resident Aide
Brad Klein, Resident Aide
William Hepler, Resident Aide
Kim Treadway, Resident Aide

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #5

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 November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005; and subsequent follow up visits made on July 17, 18, 19, 20 and 21, 2006; November 15 and 16, 2006; August 20 and 21, 2007; and May 19, 20 and 21, 2008. 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 November 4, 7, 8, 16, and 17, 2005, and December 19, 20 and 21, 2005, and not corrected at subsequent follow up visits conducted on July 17, 18, 19, 20 and 21, 2006; November 15 and 16, 2006; August 20 and 21, 2007; and May 19, 20 and 21, 2008, is as follows:

5. MN Rule 4668.0810 Subp. 6 Not corrected $1600.00

Based on record review and interview, the licensee failed to maintain a complete record for two of two clients' (# 23 and #29) records reviewed. The findings include:

The June Medication Administration Record (MAR) for client #23 lacked the documentation of administration of Plavix on June 7, 2008, at 8 AM. When interviewed, June 9, 2008, the licensed practical nurse (LPN) verified that the MAR lacked documentation of the occurrence of administration of this medication and after assessing the "bubble pack" that contained the Plavix for client #23, indicated that the "punch out" included the first through ninth of the month, which would indicate the medication had been given but not documented.

The medication record (MAR) for client #29 indicated oxygen was not recorded as administered on June 4, 6, 7, and 8, 2008. There was a notation on a yellow post-it note on the medication record which noted: "Please make sure you sign off on (client #29's) oxygen-he's been using everyday-Thank you!" The client record contained a fax dated, May 29, 2008, sent to client #29's physician requesting an order for continuous oxygen because the client was using oxygen at four liters per nasal cannula on a continuous basis. When interviewed, June 10, 2008, the licensed practical nurse (AD) verified that client #29 used oxygen continuously.

8. MN Rule 4668.0815 Subp. 4 Not corrected $800.00

Based on record review and interview, the licensee failed to provide a complete service plan for four of four clients' (#17, #23, #24, and #29) records reviewed. The findings include:

Client #17 began receiving services from the licensee on April 4, 2004. The client's service plan was signed by the client on May 25, 2008. The service plan lacked central storage of medications, the frequency of supervisory visits, and a plan for contingency actions.

Client #23 began receiving services from the licensee on April 29, 2008. The client record contained a service plan dated May 21, 2008. The service plan lacked the frequency of supervisory visits, the authentication by the licensee, provision of central storage of medications, and a contingency plan; and the fees on the service plan were not complete.

Client #24 began receiving services from the licensee on April 29, 2008. The client's service plan was signed by the client on May 29, 2008, but was unsigned by an employee of the licensee. The service plan lacked the central storage of medications, the frequency of supervisory visits, and a plan for contingency actions.

Client #29 began receiving services from the licensee on May 7, 2008. The client's service plan was signed by the client but did not contain the date the client signed the service plan. The service plan had not been signed by an employee of the licensee and lacked the central storage of medications, the frequency of supervisory visits, and a plan for contingency actions.

When interviewed, June 11, 2008, the acting administrator stated she felt that the missing items were contained in the housing with services contract and that this was part of the service plan.

9. MN Rule 4668.0825 Subp. 4 Not corrected $5600.00

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for two of three clients' (#26 and #29) records reviewed. The findings include:

Client # 26 received medication administration and central storage of medications. When interviewed, June 9, 2008, the licensed practical nurse (LPN) stated that she would set-up client #26's medications in "medi dose" containers and the unlicensed staff would administer the medications and initial each medication that was administered from the "medi dose" container. When observed, June 9, 2008, client #26's medications were set-up in two, seven day, medi dose boxes. Each day's box consisted of 4 separate boxes for 8 AM, 12 Noon, 4 PM and 8 PM doses.

According to the medication administration record (MAR), employee M administered medications from the "medi dose" container to client #26 on June 2, 4, 5, 7 and 8, 2008. When asked about the protocol for administration and documentation from the "medi dose" container, employee M stated, she had not been trained on the "medi dose" system, as it had been started while she was on leave. She stated she would count the medications that she gave and then document on the MAR to the corresponding time that was on the dose box. She stated she would count the medications to make sure that it was the same amount as was on the MAR, however, she had not been instructed to do so and she said she had no way of knowing what each medication was as there were not any descriptions on the MAR.

Client #29 began receiving services from the licensee on May 7, 2008. The client had a physician's order dated May 29, 2008, for one DuoNeb treatment every four hours as needed for shortness of breath. The client's medication administration record indicated unlicensed employee U administered the client a DuoNeb treatment on June 5, 2008. When interviewed on June 10, 2008, employee U stated she was shown how to administer a nebulizer treatment by another unlicensed staff member. When asked, she stated she had administered a nebulizer treatment to the client but she had not received any training from the registered nurse regarding how to administer the treatment. When interviewed June 10, 2008, the registered nurse (RN) A stated she had provided a training session for staff on June 3, 2008, which included training in the administration of nebulizer treatments. The attendance roster for June 3, 2008, did not contain the name of employee U. The RN indicated she thought she recalled U had attended the training on June 3, 2008. Employee U's time sheet was checked and it was noted she had not signed in for work on June 3, 2008. When interviewed on June 10, 2008, employee U verified she had not attended any training session on June 3, 2008.

When interviewed, June 10, 2008, the registered nurse stated the "medi dose" system had been started by the previous nurse. She stated she did not know what training the unlicensed personnel had on the system and she had not provided training on the system since she became the licensee's registered nurse in May 2008. She stated that the training that she provided for medication administration did not include the administration and documentation of the "medi dose" system.

15. MN Rule 4668.0855 Subp. 9 Not corrected $4800.00

Based on record review and interview the licensee failed to ensure that medications were administered and documented as prescribed for three of three clients' (#23, #24 and #29) records reviewed. The findings include:

The June MAR for client #23 lacked the documentation of administration of Plavix on June 7, 2008, at 8 AM. When interviewed, June 9, 2008, the LPN verified that the MAR lacked documentation of the occurrence of administration of this medication and after observing the bubble pack that contained the Plavix for client #23, she stated that the Plavix had been punched out for the first through ninth of the month, which would indicate the medication had been given but not documented. Client #23 also had a medication order dated June 11, 2008, to increase Metoprolol from 50 milligrams every day to 50 milligrams twice a day. The medication administration record indicated the Metoprolol was to be given at 8 AM and 5 PM. At 7:30 PM on June 11, 2008, this reviewer noted that the afternoon dose of the Metoprolol was not yet transcribed on the MAR, or signed as given in any way, however, on June 12, 2008, at 8:20 AM the MAR indicated that the Metoprolol was administered to client #23 at 5 PM on June 11, 2008. When interviewed, June 12, 2008, employee M, an unlicensed staff who had administered the Metoprolol on the evening of June 11, 2008, stated that the medication had arrived around 6 PM from the pharmacy and the LPN, AA, had instructed her to give the dose of Metoprolol at 8 PM on June 11, 2008. The record lacked documentation that the medication was not administered at 5 PM as indicated and lacked the actual time the medication had been administered.

On June 3, 2008, at 11:00 AM client #24's blood sugar reading was 158. And per the physician ordered sliding scale insulin, the client was to receive 2 units of Humalog insulin. The June 3, 2008, medication administration record signed by unlicensed employee B documented that 4 units of Humalog insulin were self-administered by the client. When interviewed on June 13, 2008, employee B stated the client drew up and administered his own insulin and the dosage was verified by a staff member. Employee B stated that she did not know why she had recorded 4 units of insulin on the medication record when 2 units were to be administered according to the sliding scale. In contrast progress notes dated, June 3, 2008, for the 6 AM to 2 PM shift entered by unlicensed employee Y, indicated that 2 units of insulin were administered for the 11 AM blood sugar reading. When interviewed, by phone, on June 13, 2008, employees B and Y could not determine what insulin dosage was actually administered for the 11 AM blood sugar reading on June 3, 2008.

Client #29's progress notes contained documentation that a PRN (as needed) DuoNeb nebulizer treatment had been administered by an unlicensed staff at noon on June 8, 2008, and again during the 2 PM to 10 PM shift on June 9, 2008. The client's June medication record contained spaces for documentation of the DuoNeb treatments and there was no documentation on the medication record that these nebulizer treatments had been administered.

The status of the correction orders issued as a result of a follow up visit made on November 15 and 16, 2006, and not corrected on subsequent follow up visits conducted on August 20 and 21, 2007; and May 19, 20 and 21, 2008, is as follows:

4. MN Statute § 144A.46 Subd. 5(b) Corrected

5. MN Statute § 626.557 Subd. 14(b) Not corrected No Fine

Based on record review and interview the licensee failed to assess all of the client's vulnerabilities and develop and implement an abuse prevention plan for one of three clients' (#23) records reviewed with a history of negative behaviors. The findings include:

Client #23 began receiving care on April 29, 2008. Discharge documentation information from the previous residence, dated April 1, 2008, indicated that the client was a "moderate" public safety risk due to his physical status. The document noted the client to staff ratio was to be 1:1 when off of the campus with close public contact. The vulnerable adult assessment from his previous residence, dated April 10, 2008, indicated he had some vulnerability in "his right sided weakness limits his mobility and the use of his right arm and hand. He also has some swallowing difficulties and limited insight into his circumstances. Short term memory problems can also leave him vulnerable to making unwise decisions."

Client #23's progress notes read: June 2, 2008, "hasn't been watching where he's been going on his scooter. At lunch hit another resident's walker and backed into roommate." A progress note June 3, 2008, read, "He (client #23) kept running into walls and doors and his bed. Also on the way back to the room, (client #23) had ripped the trim around the door off in the D.R. (dining room) door." The progress notes June 6, 2008, stated, "(client #23) ran wheel chair in wall again—some damage. (client #23) "had an argument with roommate (#29) about LIGHT being on----start HUGE fight-------staff had to intervene at which point (client #23) swung at staff. Staff (T) call for additional staff and we (staff) got (client #23) back to bed." A progress note June 8, 2008, 2 PM to 10 PM, read "(client #23) ran into wall RM #3---bathroom door #3, out-side entry door-----door frame-entry-D.R. -- door frame-entry RM #3". Progress note June 9, 2008, 8 AM to 2 PM: "staff also asked resident to watch where he backs up, he doesn't look to see. Resident was not happy with the requests." Progress note, May 28, 2008, stated, "(client #23) was cussing at Rm-mates today at lunch. Both Rm-mates did it back at (client #23). Staff stepped in and calmed the situation." Progress note, June 2, 2008, 6 AM to 2 PM: "(client #23) is having big attitude……. He is smoking in his rm. and was caught by staff."

A progress note in client #29's record read, "(Client #29) called (client #23) some bad names and words. Staff interrupted him and told him (client #29) to settle down. (Client #29) is fighting with (client #23)—roommate. At lunch today they both were cussing at each other and calling each other names, bad names. Staff stepped in and calmed (client #29) down. (Client #29) and rm-mates (clients #23 and #24) went outside for about ½ hr. Came back in and started in w/rm-mate (client #23) again. Staff interfered again and calmed the situation again."

Neither client #23's assessment for client vulnerability and safety nor his care plan addressed the client's use of his scooter, smoking in his room within six feet of roommate's oxygen concentrator, or verbal abuse to roommates. When interviewed, June 10, 2008, employee Y stated that on June 2, 2008, she observed client #23 run his scooter into his roommate, client #24's, feet. She stated client #24 had to raise his feet up off the floor in order to avoid being run over with the scooter. The same day, she observed client #23 hitting another resident's (#25) walker with his scooter. She stated client #23 does not watch where he is going and instead just backs up at a fairly fast speed. Again the same day, she also smelled smoke in client #23's room and observed that client #23 was the only client in the room at the time. She confronted client #23 about his smoking and had observed that the client had a cigarette in his mouth that he had just dipped in his pop can, to put out. She stated that client #23's roommate (client #29) had his oxygen concentrator on at the time. The concentrator was approximately six feet away from where client #23 was smoking. When questioned if employee Y had been trained on specific measures to be taken if she noted any of the above behaviors, she stated no, she hadn't. When interviewed June 11, 2008, the registered nurse (RN) stated the cigarettes were suppose to be taken away and put in the medication room after the above incident. The RN also stated she was not aware that the above behaviors needed to be

addressed on client #23's vulnerability assessment with specific measures to be taken to minimize the risk of abuse by this client or to this client. On June 9, 2008, client #23 was observed by this reviewer with cigarettes and a lighter in his pocket. When interviewed, June 11, 2008, the acting director stated she could not remember if staff had been educated on what to do if they found the clients smoking in their room. She stated she did not have any documentation of training. She also stated they did not have a behavior plan for client #23 for the use of his scooter or his smoking, and she felt client #23 would not be getting any more cigarettes as his source had been terminated.

The status of the correction orders issued as a result of a follow up visit made on August 20 and 21, 2007, and not corrected on subsequent follow up visits conducted on May 19, 20 and 21, 2008, is as follows:

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

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

The status of the correction orders issued as a result of a follow up visit made on May 19, 20 and 21, 2008, is as follows:

1. **MN Rule 4668.0065 Subp. 1 Corrected**

2. **MN Rule 4668.0805 Subp. 1 Corrected**

3. **MN Rule 4668.0805 Subp. 4 Corrected**

4. **MN Rule 4668.0815 Subp. 1 Corrected**

5. **MN Rule 4668.0860 Subp. 8 Corrected**

The status of the 24 hour correction order issued as a result of a follow up made on June 10, 2008 and not corrected at a subsequent follow up visit conducted on June 11, 2008 is as follows:

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

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

3) The following referral/s is/are being made:
i) OHFC- VAA

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: RIVER BIRCH RESIDENCE

HFID #: 21266

Date(s) of Survey: June 9, 10, 11 and 12, 2008

Project #: QL21266002

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 ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 5 X___New Correction Order issued X___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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

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 ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 5 X___New Correction Order issued X___Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. • Nurse licenses are current. • The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. • The process of delegation and supervision is clear to all staff and reflected in their job descriptions. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 5 X___New Correction Order issued X___Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 5 X___New Correction Order issued X___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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

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** ____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 4668.0810 Subp. 5

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

Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name, date and title of the person making the entry in three of three client's (#23, #24 and #29) records reviewed. The findings include:

Client #23's progress notes dated May 24, 2008; June 4, 2008; June 7, 2008; and June 8, 2008, lacked the name and title of the person making the entry.

Client #24's record contained narrative entries on progress notes that were not authenticated with the name and title of the person making the entries on the 6 AM and 2 PM shift for June 4, 6 and 8, 2008.

Client #29's record contained narrative entries on progress notes that were not authenticated with the name and title of the person making the entries on the 6 AM to 2 PM shift for June 4, 6, 7, 8, and 11, 2008.

When interviewed via phone, June 13, 2008, the assistant director verified that the entries on the above dates were not signed by the person making the entries; she also stated the resident aides were instructed to sign their entries in the medical records and she did not know why it had not been done.

2. MN Rule 4668.0840 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure core training was complete for one of three unlicensed employees' (U) records reviewed. The findings include:

Employee U was hired on May 6, 2008, to provide direct care. Employee U's core training record lacked documentation that the following topics were included in her training: observing, reporting, and documenting client status and care; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and physical, emotional and developmental needs of clients and ways to work with clients who have problems in these areas. When interviewed June 10, 2008, the Registered Nurse (RN) stated she had provided a training session for staff on June 3, 2008, which included the core training requirements. The attendance roster for June 3, 2008, did not contain the name of employee U. The RN indicated she thought she recalled U had attended the training on June 3, 2008. Employee U's time sheet was checked and it was noted she had not signed in for work on June 3, 2008. When interviewed on June 10, 2008, employee U stated she had not attended any training session on June 3, 2008.

3. MN Rule 4668.0845 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise unlicensed personnel who perform services that require supervision for three of four clients' (#14, #17 and #28) records reviewed. The findings include:

Client #28 received services including medication administration from the licensee which required supervision by a registered nurse. The client record contained a form titled, R.N/LPN SUPERVISORY VISIT FORM. Client #28's services were monitored by a licensed practical nurse (LPN) from a contracted home care agency on April 4, 2008, and by the licensee's LPN on June 2, 2008. There was no evidence of a supervisory visit from a registered nurse. When interviewed on June 11, 2008, the registered nurse stated she thought all of the contracted home care employees were registered nurses and she was unaware the contracted agency had sent a LPN to conduct supervisory visits.

Client #17's most recent documented supervisory visit was dated April 4, 2008. The client's record contained an undated, unsigned document titled RIVERBIRCH SUPERVISORY VISIT NOTES. Portions of the document had been filled out including the client's name, the name of the unlicensed staff member to supervise, services reviewed, and a notation that all the home care services were being performed adequately. The same undated and unsigned documents titled RIVERBIRCH SUPERVISORY VISIT NOTES were also noted in client records #14 and #28. Identical portions, except dressing were filled out on these two documents as noted above for client #17. When interviewed on June 11, 2008, the registered nurse stated she had performed supervisory visits for clients #14, #17 and #28 on June 4, 2008. She indicated she had only partially filled out the supervisory form and she had not finished filling out the forms. She stated the incomplete forms must have been placed in the filing bin and filed before she had a chance to complete the form.

4. MN Rule 4668.0855 Subp. 6

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to have qualified persons determine the dosage of insulin for one of one insulin dependent client (#24) record reviewed. The findings include:

Client #24 received sliding scale insulin. The June 3, 2008 medication administration record signed by unlicensed employee B documented that 4 units of Humalog insulin were self-administered by the client. When interviewed on June 13, 2008, employee B stated the client drew up and administered his own insulin however the dosage was verified by a staff member.

5. MN Rule 4668.0865 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview the facility failed to establish a system to control medications for three of three clients' (#24, #26, and #29) records reviewed that receive central storage of medications. The findings include:

When interviewed, June 9, 2008, the licensed practical nurse (LPN) AB stated that client #26 received medication administration by the unlicensed personnel with the "medi dose" system which was kept in central storage. This system consisted of two, seven day, "medi dose" boxes. Each day's box consisted of four separate boxes for 8 AM, 12 Noon, 4 PM and 8 PM doses. Client #26 also had two "bubble packs" of medications in central storage. One "bubble pack" contained, Coumadin 4 milligrams and the other "bubble pack" contained Coumadin 2 milligrams. When interviewed, June 9, 2008, the LPN, AB, stated that the Coumadin for client #26 had come in bubble packs since June 5, 2008. She also stated that she set-up the "medi dose" containers for client # 26, fourteen days at a time and confirmed she did not document in the record that she had set-up the medications nor did she indicate in the record which medications she had set-up in the "medi dose" containers. The medication administration record (MAR), for client # 26, read that he was to receive 4 milligrams of Coumadin at 4 PM, Monday through Saturday and Coumadin 2 milligrams at 4 PM on Sunday. The bubble pack containing 4 milligrams of Coumadin had two tablets punched from it. One of the punch outs was dated "6/7" with the initials of the resident aide who administered the medication, employee M; and the other was just to the left of it and did not have a date or initials on it, however, the number on the punch out for the tablet that was missing was the number "6" for the 6th of the month. The bubble pack was filled with pills to be administered to the client from the 5th of the month to the 30th. The bubble pack which contained Coumadin 2 milligrams did not have any tablets punched out from it. When interviewed, June 9, 2008, the LPN stated that client #26's "medi dose" box also contained Coumadin in the 4 PM administration box. She stated that the bubble pack should not have been put into client #26's central storage until the previous pills that remained in the dose box had all been administered. She stated she had removed the Coumadin from the dose box during the morning of June 9, 2008. When asked which dates she had removed, she stated she could not remember which boxes had Coumadin remaining in them. When asked if the June 7, 2008, "medi box" still contained the Coumadin, she stated she did not know. When interviewed, June 9, 2008, employee M, the unlicensed staff who administered the Coumadin on June 7, 2008, and dated the punch out, stated she could not remember if the medi dose box for June 7, 2008, also contained the Coumadin or if she had just administered the Coumadin from the "bubble pack." When asked about the protocol for documentation, employee M stated, she had not been trained on the

medi dose system, as it had been started while she was on leave. She stated she would count the medications that she gave and then document on the Medication Administration Record (MAR) to the corresponding time that was on the dose box. She stated she would count the medications to make sure that it was the same amount as was on the MAR, however, she had not been instructed to do so and she said she had no way of knowing what each medication was as there were not any identifiers on the MAR.

When interviewed, June 10, 2008, the registered nurse stated the "medi dose" system had been started by the previous nurse. She had not done any of the training of the unlicensed personnel on the use, administration or documentation for the system. She stated she did not know what training the unlicensed personnel had on the system and she had not provided training on the system since she became the licensee's registered nurse in May, 2008. She stated that the training that she provided for medication administration did not train on the "medi dose" system. Neither the nurses nor the unlicensed staff could determine what actual dose of Coumadin client #26 received.

According to client #24's blood sugar documentation on June 3, 2008, at 11 AM the client's blood sugar reading was 158. According to the physician ordered sliding scale insulin, the client was to receive 2 units of Humalog insulin. A notation on the June medication administration record made by unlicensed employee B noted that 4 units of Humalog insulin were self-administered by the client. When interviewed on June 13, 2008, employee B stated the client drew up and administered his own insulin and the dosage is verified by a staff member. Employee B indicated that she did not know why she had recorded 4 units of insulin on the medication record when 2 units were to be administered according to the sliding scale. A notation in the progress notes dated, June 3, 2008, for the 6 AM-2 PM shift entered by unlicensed employee Y, indicated that 2 units of insulin were administered for the 11 AM blood sugar reading. When interviewed by phone on June 13, 2008, employees B and Y could not determine what insulin dosage was actually administered for the 11 AM blood sugar reading on June 3, 2008.

Client #29's narrative progress notes documented that a PRN (as needed) DuoNeb treatment had been administered by an unlicensed staff at noon on June 8, 2008, and again during the 2 PM to 10 PM shift on June 9, 2008. There was no documentation on the clients' June MAR that these nebulizer treatments had been administered.

The June MAR for client #23 lacked documentation of administration of Plavix on June 7, 2008, at 8 AM. When interviewed, June 9, 2008, the LPN verified that the MAR lacked documentation of the occurrence of administration of this medication and after observing the bubble pack that contained the Plavix for client #23, she stated that the Plavix had been punched out for the first through ninth of the month, which would indicate the medication had been given but not documented. Client #23 also had a medication order dated June 11, 2008, to increase Metoprolol from 50 milligrams every day to 50 milligrams twice a day. The medication administration record indicated the Metoprolol was to be given at 8 AM and 5 PM. At 7:30 PM on June 11, 2008, this reviewer noted that the afternoon dose of the Metoprolol was not yet transcribed on the MAR, or signed as given in any way, however, on June 12, 2008, at 8:20 AM the MAR indicated that the Metoprolol was administered to client #23 at 5 PM on June 11, 2008. When interviewed, June 12, 2008, employee M, an unlicensed staff who had administered the Metoprolol on the evening of June 11, 2008, stated that the medication had arrived around 6 PM from the pharmacy and the LPN, AA, had instructed her to give the dose of Metoprolol at 8 PM on June 11, 2008. The record lacked documentation that the medication was not administered at 5 PM as indicated and lacked the actual time the medication had been administered.

A draft copy of this completed form was faxed to Joan Breth Gondringer and Cindi Kuehl, LPN, at an exit conference via telephone on June 13, 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).

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 2500

June 13, 2008

Del Sand, Administrator
River Birch Residence
231 Washington Ave PO BOX
Holdingford, MN 56340

Re: Licensing Follow Up visit

Dear Mr. Sand:

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 June 11, 2008.

The documents checked below are enclosed.

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

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

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

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

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

Sincerely,

for Jean Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Stearns 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

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: RIVER BIRCH RESIDENCE

DATE OF SURVEY: June 12, 2008

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:
Joan Breth Gondringer, Assistant Director

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: Second on 24 hour order

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 one day order written during a visit on June 10, 2008 and a subsequent follow up visit made on June 11, 2008. 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 June 10, 2008 and June 11, 2008 is as follows:

1. MN. STATUTE §144A.44 Subd. 1. (2) CORRECTED

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Hand Delivered and Faxed

June 11, 2008

Del Sand, Administrator
River Birch Residence
231 Washington Ave PO BOX 10
Holdingford, MN 56340

Re: Licensing Follow Up visit

Dear Mr. Sand:

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 June 10, 2008.

The documents checked below are enclosed.

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

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

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

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

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

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Stearns 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

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # Faxed and Hand Delivered

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOLLOWING A SUBSEQUENT REINSPECTION FOR CLASS F HOME CARE PROVIDERS

June 11, 2008

Del Sand, Administrator
River Birch Residence
231 Washington Ave PO BOX 10
Holdingford, MN 56340

RE: 21266002

Dear Mr. Sand:

1. On June 11, 2008, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on June 10, 2008, with correction orders received by you on June 10, 2008, and found to be uncorrected during an inspection completed on June 11, 2008.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on June 11, 2008:

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

Based on record review, interview and observation, the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for one of one (#23) clients records reviewed with hypertension. The findings include:

Client 23 began receiving services from the facility on April 29, 2008 with diagnoses of cerebrovascular accident (stroke) with right side weakness, hypertension, hypertensive heart disease, and aortic stenosis. Client 23 was admitted with orders for Lisinopril 5 milligrams (mg) daily, and Tropral XL 25 mg daily. Blood pressure records from the client's prior placement for April 2008 indicated his blood pressure ranged from a low of 121/65 to a high of 183/78. The client had a physicians visit scheduled for May 27, 2008, to establish himself as a patient of a physician in the facility area. The facility began monitoring the clients' blood pressure daily on May 23, 2008, five days prior to the physician visit. The blood pressures were 178/78 and 180/97 on May 23, 2008; 196/104, 214/102 and 202/102 on May 24, 2008; 198/103 and 226/113 on May 25, 2008; 181/90 and 228/115 on May 26, 2008; they were 187/97 on May 27, 2008.

There was one nurses note from a licensed practical nurse (LPN) dated May 23, 2008 which read "Will monitor daily has an appointment 5-27, BP will be addressed with physician at that time." There was no other documentation by a nurse in the record related to blood pressure nor was there evidence of "monitoring" other than data collection.

On May 27, 2008 the physician ordered the client's blood pressure medication dosages be doubled to Lisinopril 10 mg daily and Topral XL 50mg daily. Additionally the physician ordered daily blood pressure checks.

Blood pressure checks for client 23 after the medication increase were 181/88 on May 28, 2008; 197/104 may 30, 2008; 190/98 and 196/102 May 31,2008; 184/86 June 1, 2008; 197/100 June 2, 2008; 201/97 on June 3, 2008; 168/86 on June 4, 2008; 181/88 on June 5, 2008; 207/97 June 6, 2008;168/77 and 190/97 on June 7, 2008; 188/84 June 8, 2008 and 209/91 on June 10, 2008. There was no evidence of nursing assessment or report to the physician of the clients' ongoing elevated blood pressures.

When interviewed June 9, 2008 the LPN stated she was aware of the elevated blood pressures but had not reported them to the physician. When interviewed June 10, 2008 about the blood pressures the registered nurse (RN) stated she "thought they were better than before the med. adjustment." She also stated they had not called the physician because they did not have ant order to notify the physician. She added that the facility protocol was to notify the LPN if the LPN was working if any blood pressure was greater than 150 systolic or greater than 90 diastolic. The LPN was then to notify the RN. She said she was aware they were elevated buy unable to remember if she had been notified. The facility was unable to locate any protocol on June 10, 2008 when asked to produce it for review.
When interviewed June 10, 2008 the LPN stated she did not know of any protocol for elevated blood pressure. She stated if she needed to she would tell staff to call her if a client's blood pressure was 20 points above or below their individual norm and that would vary from client to client. When interviewed June 10, 2008 employee B, an unlicensed care giver stated she did not know of any parameters for reporting blood pressure except that the RN had written in a sheet of paper that if client #26's blood pressure was more than 170/80 she should be called.

TO COMPLY: The right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **$250.00.** This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

June 11, 2008

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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

Sincerely,

for Jean Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Stearns 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: RIVER BIRCH RESIDENCE

DATE OF SURVEY: June 11, 2008

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:
Beth Tepler Registered Nurse

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: First on 24 hour order

ITEMS NOTED AND DISCUSSED:
An unannounced visit was made to follow up on the status of state licensing orders issued as a result of a one day order written during a visit made on June 10, 2008. 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 one day order written during a visit made on June 10, 2008 is as follows:

1. MN. STATUTE §144A.44 Subd. 1. (2) NOT CORRECTED $250.00

Based on record review, interview and observation, the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for one of one (#23) clients records reviewed with hypertension. The findings include:

Client 23 began receiving services from the facility on April 29, 2008 with diagnoses of cerebrovascular accident (stroke) with right side weakness, hypertension, hypertensive heart disease, and aortic stenosis. Client 23 was admitted with orders for Lisinopril 5 milligrams (mg) daily, and Toprol XL 25 mg daily. Blood pressure records from the client's prior placement for April 2008 indicated his blood pressure ranged from a low of 121/65 to a high of 183/78. The client had a physicians visit scheduled for May 27, 2008, to establish himself as a patient of a physician in the facility area. The facility began monitoring the clients' blood pressure daily on May 23, 2008, five days prior to the physician visit. The blood pressures were 178/78 and 180/97 on May 23, 2008; 196/104, 214/102 and 202/102 on May 24, 2008; 198/103 and 226/113 on May 25, 2008; 181/90 and 228/115 on May 26, 2008; they were 187/97 on May 27, 2008.

There was one nurses note from a licensed practical nurse (LPN) dated May 23, 2008 which read "Will monitor daily has an appointment 5-27, BP will be addressed with physician at that time." There was no other documentation by a nurse in the record related to blood pressure nor was there evidence of "monitoring" other than data collection.

On May 27, 2008 the physician ordered the client's blood pressure medication dosages be doubled to Lisinopril 10 mg daily and Toprol XL 50mg daily. Additionally the physician ordered daily blood pressure checks.

Blood pressure checks for client 23 after the medication increase were 181/88 on May 28, 2008; 197/104 may 30, 2008; 190/98 and 196/102 May 31,2008; 184/86 June 1, 2008; 197/100 June 2, 2008; 201/97 on June 3, 2008; 168/86 on June 4, 2008; 181/88 on June 5, 2008; 207/97 June 6, 2008;168/77 and 190/97 on June 7, 2008; 188/84 June 8, 2008 and 209/91 on June 10, 2008.

On June 11, 2008 client #23's physician ordered the Toprol XL 50 mg daily to be doubled to 50 mg twice daily. He also ordered "HCTZ 12.5 mg daily." The order was faxed from the facility to the pharmacy on June 11, 2008 at 11 am by the LPN.

When reviewed June 11, 2008 at 4:30 pm the medication order changes had not been placed on the medication administration record (MAR) of client #23. There was a note on the cover of the MAR book listing "All have new medication orders. Please read MAR" Client #23 was not included on this list. When interviewed June 11, 2008 the RN stated it was the facility protocol that when they received a new physician orders the LPN was to put them on the MAR.

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

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: RIVER BIRCH RESIDENCE

HFID #: 21266

Date(s) of Survey:

Project #: QL21266002

Indicators of Compliance	Outcomes Observed	Comments
2. 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 ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey ____New Correction Order issued ____Education Provided

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** ____Met _X_Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey _____ ____New Correction Order issued ____Education Provided
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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey _____ ____New Correction Order issued ____Education Provided

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 ____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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey _____ ____New Correction Order issued ____Education Provided

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

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** ____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 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.

<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. STATUTE §144A.44 Subd. 1. (2)

Based on record review, interview and observation, the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for one of one (#23) clients records reviewed with hypertension. The findings include:

Client 23 began receiving services from the facility on April 29, 2008 with diagnoses of cerebrovascular accident (stroke) with right side weakness, hypertension, hypertensive heart disease, and aortic stenosis. Client 23 was admitted with orders for Lisinopril 5 milligrams (mg) daily, and Tropral XL 25 mg daily. Blood pressure records from the client's prior placement for April 2008 indicated his blood pressure ranged from a low of 121/65 to a high of 183/78. The client had a physicians visit scheduled for May 27, 2008, to establish himself as a patient of a physician in the facility area. The facility began monitoring the clients' blood pressure daily on May 23, 2008, five days prior to the physician visit. The blood pressures were 178/78 and 180/97 on May 23, 2008; 196/104, 214/102 and 202/102 on May 24, 2008; 198/103 and 226/113 on May 25, 2008; 181/90 and 228/115 on May 26, 2008; they were 187/97 on May 27, 2008.

There was one nurses note from a licensed practical nurse (LPN) dated May 23, 2008 which read "Will monitor daily has an appointment 5-27, BP will be addressed with physician at that time." There was no other documentation by a nurse in the record related to blood pressure nor was there evidence of "monitoring" other than data collection.

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When interviewed June 9, 2008 the LPN stated she was aware of the elevated blood pressures but had not reported them to the physician. When interviewed June 10, 2008 about the blood pressures the registered nurse (RN) stated she "thought they were better than before the med. adjustment." She also stated they had not called the physician because they did not have ant order to notify the physician. She added that the facility protocol was to notify the LPN if the LPN was working if any blood pressure was greater than 150 systolic or greater than 90 diastolic. The LPN was then to notify the RN. She said she was aware they were elevated buy unable to remember if she had been notified. The facility was unable to locate any protocol on June 10, 2008 when asked to produce it for review.
When interviewed June 10, 2008 the LPN stated she did not know of any protocol for elevated blood pressure. She stated if she needed to she would tell staff to call her if a client's blood pressure was 20 points above or below their individual norm and that would vary from client to client. When interviewed June 10, 2008 employee B, an unlicensed care giver stated she did not know of any parameters for reporting blood pressure except that the RN had written in a sheet of paper that if client #26's blood pressure was more than 170/80 she should be called.

A draft copy of this completed form was faxed to Bonnie Norgren at an exit conference on June 10, 2008. 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)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 2289

May 30, 2008

Del Sand, Administrator
River Birch Residence
PO BOX 432
Cold Spring, MN 56320

Re: Licensing Follow Up visit

Dear Mr. Sand:

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 May 19, 20, and 21, 2008.

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,

for Jean Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Stearns 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

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #7004 1350 0003 0567 2289

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOLLOWING A SUBSEQUENT REINSPECTION FOR CLASS F HOME CARE PROVIDERS

May 30, 2008

Del Sand, Administrator
River Birch Residence
PO Box 432
Cold Spring, MN 56320

RE:QL21266002

Dear Mr. Sand:

1. On May 19, 20, and 21, 2008, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of follow up visits to an original survey completed on November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005, and subsequent follow up visits made on July 17, 18, 19, 20, and 21, 2006, November 15 and 16, 2006, and August 20 and 21, 2007, with correction orders received by you on March 9, 2006, August 19, 2006, January 4, 2007, and October 30, 2007, and found to be uncorrected during an inspections completed on July 17, 18, 19, 20, and 21, 2006, November 15 and 16, 2006, and August 20 and 21, 2007.

As a result of correction orders remaining uncorrected on the July 17, 18, 19, 20, and 21, 2006, November 15 and 16, 2006, and August 20 and 21, 2007 re-inspections, a penalty assessment in the amount of **$5,100.00** was imposed on October 25, 2007.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on May 19, 20, and 21, 2008.

5. MN Rule 4668.0810 Subp. 6 **$800.00**

Based on record review and interview, the licensee failed to maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include:

On September 22, 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation indicated client#1 returned from the hospital with a "fleets enema." On

May 30, 2008

November 9, 2005, the "Communication Book" had an entry that stated, the client fell and hit her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to be called if any symptoms were noted. Neither of these incidents was documented in client #1's record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record.

Client #9 had two fall notations in the incident/accident reports and facility communication book. On November 1, 2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head. On November 10, 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

F. documentation of each instance of assistance with self-administration of medication

and of medication administration, if any;

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

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

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

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $800.00.

8. MN Rule 4668.0815 Subp. 4 **$400.00**

Based on record review and interview, the licensee failed to provide a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include:

Client #1 and #2's service plans were authenticated on February 18, 2005 and August 12, 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete.

Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans.

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;

(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: $400.00.

9. MN Rule 4668.0825 Subp. 4 **$2,800.00**

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include:

Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the assisted living home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

TIME PERIOD FOR CORRECTION: Thirty (30) days

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $2,800.00.

15. MN Rule 4668.0855 Subp. 9 **$2,400.00**

Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include:

Client #2's Service Plan, August 12, 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October 5, 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders.

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: $2,400.00.

2. On May 19, 20, and 21, 2008, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on November 15 and 16, 2006, 2006, which were received by you on January 4, 2007.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on May 19, 20, and 21, 2008.

4. MN Statute §144A.46 Subd. 5(b) **No Fine**

Based on record review and interview the licensee failed to perform a background study on one of two new employee's (N) records reviewed. The findings include:

Employee N began providing direct patient care on November 6, 2006. Employee N's record lacked evidence of an application for a background study or a background study. On interview, November 16, 2006, the Department of Human Services background study representative confirmed that they had not received an application for a background study for employee N. On November 16, 2006, the Assistant Director stated they had not sent in an application for a background study for employee N, and that they would have employee N sign for it when she returned to work on November 18, 2006.

TO COMPLY: Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057. These individuals shall be disqualified under the provisions of chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

5. MN Statute §626.557 Subd. 14(b) **No Fine**

Based on record review and interview the licensee failed to provide a complete vulnerable adult assessment for two of two new client's (#18 and #19) records reviewed. The findings include:

Clients #18 and 19's service plans indicated that the clients began receiving services from the licensee on October 26, 2006 and October 31, 2006, respectively. The clients' records contained an assessment entitled, "Assessment for Resident Vulnerability and Safety", which included areas of vulnerability and interventions if the client was assessed as vulnerable in that area. The assessment lacked the person's susceptibility to abuse by other individuals, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

On interview, November 16, 2006, the owner stated she was unaware the vulnerable adult assessment needed to include these vulnerabilities. The registered nurse (RN) who completed these assessments was no longer employed by the licensee.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of the person's susceptibility to abuse by other individuals, including other vulnerable adults, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

3. On May 19, 20, and 21, 2008, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on August 20 and 21, 2007, which were received by you on October 30, 2007.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on May 19, 20, and 21, 2008.

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

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 assistance with medication administration for two of four (#20 and #21) current client's records reviewed. The findings include:

Client #20's care plan, dated August 10, 2007, indicated she received medication administration. The care plan had "Special Instructions" which read "Can do own Nebs-set out 4 solutions each morning for her to use PRN. Checks own Glucoscan 2-3 X wk." The medication administration records, for client # 21, indicated he received assistance with medication administration form August 10, 2007 through the survey review date of August 29, 2007. There was no evidence that the registered nurse (RN) had conducted a nursing assessment of the client's functional status and need for assistance with medication administration prior to providing the service. When interviewed, August 21, 2007, the director stated she was unaware the RN had not conducted an assessment of the client's functional status and need for medication administration.

Client #21's care plan, dated June 22, 2007, indicated he received medication administration. The medication administration records, for client # 21, indicated he received assistance with medication administration form June 19, 2007 through July 29, 2007. There was no evidence that the registered nurse (RN) had conducted a nursing assessment of the client's functional status and need for assistance with medication administration prior to providing the service. When interviewed, August 21, 2007, the Director stated she was unaware the RN had not conducted an assessment of the client's functional status and need for medication administration.

TO COMPLY: For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.

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

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

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) conducted 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 two of three client's (#21) records reviewed. The findings include:

Client #20's care plan, dated August 10, 2007, indicated she received medication administration. The care plan had "Special Instructions" which read "Can do own Nebs-set out 4 solutions each morning for her to use PRN. Checks own Glucoscan 2-3 X wk." The medication administration records, for client # 21, indicated he received assistance with medication administration form August 10, 2007 through the survey review date of August 29, 2007. There was no evidence that the registered nurse (RN) had conducted a nursing assessment of the client's functional status and need for assistance with medication administration prior to providing the service. When interviewed, August 21, 2007, the director stated she was unaware the RN had not conducted an assessment of the client's functional status and need for medication administration.

Client # 21's record indicated he received administration of medications from June 19, 2007 through July 29, 2007. On interview, August 20, 2007, the Director indicated that client # 21 had central storage of medications from June 19, 2007 through July 29, 2007. The record lacked an assessment for the need for central storage of medications, nor did client # 21's service plan include central storage of medications. On interview, August 20, 2007, the director stated she was unaware the registered nurse (RN) had not conducted an assessment for the need for central storage of medications and was unaware it needed to be included on the service plan.

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

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

May 30, 2008

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **$7100.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Stearns 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: RIVER BIRCH RESIDENCE

DATE OF SURVEY: May 19, 20 and 21, 2008

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

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Courtney Breth, RA
Bonnie Norgren, Acting Program Director
Beth Tepler, RN
Del Sands, Owner
Marie Koopmeiners, RA
William Hepler, RA
Bonnie Loni, Visitor
Joan Breth Gondringer, Assistant Director
Brianne Wolters, Adm. Lexington Commons (assisting with administration at River Birch/ Acting Adminestrator)
Ben Byker, Stearns County LSW
Amber Wolkers, RA
Stephinie Norstrom, LPN

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

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow up on the status of state licensing orders issued as a result of a visit made on November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005 and subsequent follow up visits made on July 17, 18, 19, 20 and 21, 2006, November 15 and 16, 2006 and August 20 and 21, 2007. 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 November 4, 7, 8, 16, and 17, 2005, and December 19, 20, and 21, 2005, and not corrected at subsequent follow up visits conducted on July 17, 18, 19, 20 and 21, 2006, November 15 and 16, 2006, and August 20 and 21, 2007, is as follows:

5. MN Rule 4668.0810 Subp. 6 Not corrected $800.00

Based on record review and interview, the licensee failed to maintain a complete record for two of two current clients' (#23 and #24) records reviewed. The findings include:

Client #23's record indicated he began receiving services from the license on April 29, 2008. The client's record lacked a nursing evaluation of the client's needs, a complete service plan, a nursing assessment for the need for assistance with administration of medication, an assessment for the need for central storage of medications and a vulnerable adult assessment.

Client #24 began receiving services from the licensee on April 29, 2008. The client's record lacked a nursing evaluation of the client's needs, a complete service plan, a nursing assessment for the need for assistance with administration of medication, an assessment for the need for central storage of medications and a vulnerable adult assessment.

When interviewed May 20, 2008, the acting administrator stated a county registered nurse (RN) had completed assessments of each client's needs prior to their admission to the facility for the county and the licensee was waiting for the county RN to send the assessments she had completed. The acting administrator verified that the clients' records lacked the afore mentioned documents.

8. MN Rule 4668.0815 Subp. 4 Not corrected $400.00

Based on record review and interview, the licensee failed to provide a complete service plan for one of two client's (#24) records reviewed. The findings include:

Client #24 began receiving services from the licensee on April 30, 2008. The client record contained an undated, unsigned service plan. The service plan lacked: a description of the services to be provided based on an individualized evaluation completed by a registered nurse, the fees for services, the method for the client to contact a representative of the licensee whenever staff were providing services, the name and telephone number of a person to contact in case of an emergency or a significant change in the client's condition, the method for the licensee to contact a responsible person of the client and the circumstances in which emergency medical services were not to be summoned. When interviewed on May 20, 2008, the acting administrator verified the client's service plan was incomplete.

9. MN Rule 4668.0825 Subp. 4 Not corrected $2,800.00

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for one of two client's (#24) records reviewed. The findings include:

Client #24 began receiving services from the licensee on April 29, 2008. The client had a physician order dated April 23, 2008 for Capsaicin cream apply every day needed for pain; One month supply, no refills. Client #24's April medication administration record read "Capsaisin Cream 0.035% every day as needed." There were no specific instructions in writing by the RN for application of the cream or to which part (s) of the client body for this client. On April 29, 2008 at 9:30 pm, unlicensed employee T documented the client was given a foot-treatment of "Capsaicin." When interviewed on May 21, 2008, employee T stated he applied the Capsaicin ointment to the client's feet on April 29, 2008. He stated before he applied the ointment he checked with licensed nurse AA. He stated nurse AA informed him that he could apply the ointment since it "was not a medication." Employee T's record indicated that he was trained by the registered nurse on medication administration and passed medication/treatment administration competency on May 13, 2008. When interviewed on May 20, 2008, the RN verified that employee T had performed this procedure prior to being trained.

15. MN Rule 4668.0855 Subp. 9 Not corrected $2,400.00

Based on record review and interview the licensee failed to ensure that medications were administered and documented as prescribed for two of four client's (#10 and #26) records reviewed. The findings include:

Client # 10's record contained a physician order April 24, 2008 for Warfarin 2 milligrams every Monday, Wednesday and Friday and Warfarin 2.5 milligrams the other 4 days. The medication administration record lacked evidence of administration of Warfarin on May 12, 2008; and it lacked documentation why the medication was not administered as ordered. On interview, May 21, 2008, the acting director verified that the medication had not been documented as administered on May 12, 2008. She stated it would be difficult to ascertain if the medication was given and not documented or not given and not documented.

Client #23's record contained a physician order dated March 20, 2008 for Coumadin 5 mg. to be alternated with 2.5 mg of Coumadin every day. The client's medication administration record was documented that Coumadin 2.5 mg. was administered to the client for three consecutive days on March 26, 27 and 28, 2008. The Coumadin was not alternated with a 5mg. dose on March 27th as ordered by the physician. When interviewed on May 20, 2008, registered nurse A stated she did not know why the Coumadin was not alternated as ordered by the physician and that a medication error had occurred.

16. MN Rule 4668.0860 Subp. 2 Corrected

The status of the correction orders issued as a result of a follow up visit made on July 17, 18, 19, 20 and 21, 2006, and not corrected at subsequent follow up visits conducted on November 15 and 16, 2006, and August 20 and 21, 2007, is as follows:

2. MN Rule 4668.0815 Subp. 2 Corrected

The status of the correction orders issued as a result of a follow up visit made on November 15 and 16, 2006, and not corrected at subsequent follow up visits conducted on August 20 and 21, 2007, is as follows:

4. MN Statute §144A.46 Subd. 5(b) Not corrected No Fine

Based on record review and interview the licensee failed to have a background study preformed on one of three new employees' (S) records reviewed. The findings include:

Employee S's record indicated that he was hired May 8, 2008. There was no evidence that a background study had been done. Client #23's record contained documentation by employee S on May 13, 2008, that he was client #23's resident aide for the 10:00 p.m. to 6:00 a.m. shift. When interviewed, May 20, 2008, the acting administrator stated that employee S's background study had not been done.

5. MN Statute §626.557 Subd. 14(b) Not corrected No Fine

Based on record review and interview the licensee failed to assess, develop and implement an abuse prevention plan for three of three clients' (#23, #24, and #29) records reviewed, with a history of abuse of vulnerable individuals. The findings include:

Client #23's record indicated the client was admitted to the care of the licensee on April 29, 2008. Discharge information from a previous placement, dated April 1, 2008, indicated that the client was a "moderate" public safety risk due to his physical status. The document noted the client to staff ratio was to be 1:1 when off of the campus and in close public contact. A vulnerable adult assessment from his previous placement, dated April 10, 2008, indicated he had some vulnerability in "his right sided weakness limits his mobility and the use of his right arm and hand. He also has some swallowing difficulties and limited insight into his circumstances. Short term memory problems can also leave him vulnerable to making unwise decisions." A progress note on May 12, 2008 by a resident aid stated, staff "came in and talked to him regarding his BM's and attitude. He constantly turns up the volume on his TV. Annoying!!!" On interview, May 20, 2008, the acting administrator stated the vulnerable adult assessment had not been completed.

Client #24's record indicated the client was admitted to the care of the licensee on April 29, 2008. A document dated April 1, 2008, and titled "Resident Security Status" from the former placement of client #24, noted the client was a "high" public safety risk due to his history. The document noted when #24 was a client at the former residence; the staff ratio was to be 1:1 when the client was off the campus and with close public contact. Client #29's record indicated the client was admitted to the care of the licensee on May 7, 2008. A document dated April 1, 2008, and titled "Resident Security Status" from the former placement of client #29, noted the client was a "high" public safety risk due to his history. The document noted when #29 was a client at the former placement; the staff ratio was to be 1:1 when the client was off the campus and with close public contact.

At 10:15 am on May 19, 2008, employee U, an unlicensed care aide, was observed in a room with clients # 23, #24 and #29. When interviewed, employee U stated she was assigned to the three clients in the room (here after identified as the "apartment") and that she was to "keep her eyes on them at all times." With further inquiry, a document dated April 30, 2008 and titled, "GENERAL FLOOR STAFF INFORMATION REGARDING RESIDENTS OF (Apartment)" was given to the reviewers. The document noted clients #23 and #24 were confined to their apartment for a few days until they got settled in the facility. This document indicated these clients had to meet the steps of a written program in order to gain access to other areas of the facility. The document noted that client's #23 and #24 were to be accompanied and visually supervised by their assigned staff. (Since April 30, 2008, a third client, #29, had been admitted to this apartment).

Numerous interviews on all days of the on site survey with administrative staff, licensed and unlicensed staff, established it was the policy of the facility to provide direct visual supervision of these three clients at all times and/or visually observe the entrance to their apartment when all three of the clients were present in their apartment.

On May 19, 2008 at 11:45 am, employee U was observed leaving the dining room with client #29. At 11:50 am client #23 was observed leaving the facility dining room, unattended, in his electric scooter. The client proceeded down the hallway, past two vacant client rooms, then into his own apartment. It was observed that there were no staff members visually present observing the client as he proceeded to his apartment. At 11: 55 am, client #24 exited the dining room in his electric wheelchair, and proceeded down the hallway toward his apartment. There was no staff visually observing the client as he proceeded down the hallway. As client #24 proceeded to his apartment, he passed client #27 standing in the hallway. At 1:38 pm, client #24 was observed exiting his apartment in his electric wheelchair, there were no staff visually present either in the hallway or in the client's apartment. Client #14 was observed sitting in a chair in the hallway directly across from the doorway to client #24's apartment as client #24 exited. Client #24 sat in the hallway for approximately two minutes, until another client of the facility held open the front doors of the facility so the client could exit outside in his electric wheelchair. Once outside, it was observed that there was another facility employee outside with other clients in the general vicinity of client #24. Client #24 stayed outside for a few minutes and as he came back into the building he was visibly agitated, swearing and saying he "needed to get out of here." He maneuvered his electric chair approximately fifteen feet past the door to his room and sat in the hallway. His assigned staff member, employee U, came into the hallway and sat in the hallway. She was able to see into the clients' apartment and see client #24 seated in the hallway. After a few minutes, client #24, still visibly agitated went into his apartment and loudly called his roommate, client #23, an "asshole" and a "shithead." Employee U did not speak to, or address this comment from client #24. Client #24 transferred himself into another chair in his room and covered his head with a towel.

When interviewed on May 19, 2008, employee U stated she had been trained, the previous week, by shadowing another aide. She stated she had no idea what to expect from the three clients she was assigned to because she had been informed that they had not had any behaviors for "so many years." When queried, she stated she had no training from the facility concerning the clients' behavior and she had no idea the behaviors she should "be aware of that will set them off." Employee U stated she had left the dining room at lunchtime because client #29 had to use the bathroom. She stated she left the dining room expecting the other staff member, X, to watch the other two clients. When interviewed on May 21, 2008, employee X stated it was her understanding that the three clients were the responsibility of their assigned staff member and she would only keep an eye on them in the dining room as she would any other client, for example, for choking or needing help with their meal.

The facility document titled, "GENERAL FLOOR STAFF INFORMATION REGARDING RESIDENTS OF (Apartment)" dated April 30, 2008, indicated there was a written behavior program for the clients of the apartment to follow. It was noted in the document that the written program was posted in the staff office, in each client's chart and posted in the clients' room. When interviewed on May 20, 2008, the owner stated there were no written behavior programs for any of the three clients because no behaviors had occurred since they had been discharged from a former placement in early April 2008 and since their admission to this facility. He indicated his off site staff, behavioral analyst staff at another business he has, were writing up behavior modification

programs, but none were currently available for the River Birch facility staff. It was verified through interview with the administrator that staff assigned solely to the three clients in the room, received the same training as any staff member hired for the facility. The administrator referred the reviewer to the acting director, employee V, for the content of the training. When interviewed on May 20, 2008, she was unable to provide any documentation of any behavioral training for any of the facility staff.

Client #24 had a history of exhibiting negative behaviors. Some behaviors had occurred since he was admitted to the facility on April 29, 2008. Discharge information and information received from a previous placement of client #24, included information related to the client's behaviors. A discharge summary dated April 2, 2008 read, "In past has exhibited some threatening behaviors towards others, gesturing with his cane. (The client) verbalizes superiority over peers, calling them "rum-dums" and other demeaning, sarcastic, or racist names. Exhibits behaviors that show him to be better than others or above the rules." In the summary of an assessment, completed by a psychiatrist, dated April 4, 2008, it was noted the client "does have a life-long history of irresponsible, illegal, and dangerous behavior with repeated violation of the law and the rights of other people…" The summary noted the client did not have any significant degree of cognitive deterioration, his memory was intact, and he had excellent command of the English language, could concentrate, communicated well and had good command of general information. A therapeutic recreation discharge summary dated April 25, 2008, noted client #24 displayed some intolerance for the other residents and at times he was unwilling to follow staff directions. An individual program plan from a former placement of the client dated January 8, 2008, indicated problems areas of altered behaviors including, verbal threats to use his cane on other peers and verbally abusive and demanding to peers. Other documented behaviors were: On April 12, 2007, he ran into a peer with his power chair, after telling the peer "get out of my way." On October 26, 2007 he threw a cup of water on a peer, unprovoked, and on January 1, 2008, he threw hot coffee on a peer, unprovoked.

Facility progress notes indicated on May 10, 2008, client #24 yelled "asshole" to client #23 "because (client #23) had turned on his T.V. loudly this am. It seems (client #24) is becoming increasely angrier at (client #24) for some of his behaviors." On May 11, 2008, progress notes documented, client #24 "seems to get more irritated by his roommate (#23). (Client #24) swears at (client #23) when the TV's up to loud." On May 17, 2008, progress notes documented he swore at staff because he was upset that the drinking cups tasted and smelled like chlorine. When May 19, 2008, client #24 observed was swearing at client #23. Employee U was present during the swearing but this was not documented in the progress notes. Client #23 did not have a vulnerability assessment completed at the time of the site visit.

As noted above, client #24 was observed on two separate occasions on May 19, 2008, not under the direct supervision of a facility staff member and in the presence of two of the vulnerable clients at the facility. Client #27 is a female client at the facility. She had an assessment for her vulnerability and safety completed by facility staff on March 22, 2007. The assessment indicated that she would be unable to report abuse if it occurred. Client #14 is a female client at the facility. She had an assessment for her vulnerability and safety completed by facility staff on March 26, 2007. It indicated she would be unable to report abuse if it occurred.

Concerns regarding the vulnerability of the clients in the facility in regard to the history of the three clients in the apartment and the current display of behaviors specifically related to client #24 were relayed to the owner and other administrative staff on May 20, 2008. At the end of the meeting, the

acting administrator posted a typed document to the attention of all staff that read "You need to assure that the residents in Apartment… are always supervised 24/7, they need to leave the dining room together and go to the dining room together, if one needs to use the restroom in their apartment then the main door needs to be shut for security, if one needs to use the restroom while in the dining room then another staff member needs to supervise them, there is no exceptions for this rule, these are the conditions of their stay here, they need to be supervised at all times!!!!!!!!!!!!!!!!!!, or you will be terminated on the spot. Please feel free to ask questions if you are unclear, we are here for you." The posted document was observed on May 21, 2008. It was noted there were some hand written comments on the document: "You need to provide training!!! Have enough staff to provide that!; Which one dining room or the apartment door." When interviewed on May 21, 2008, a staff member stated there were concerns related to the supervision of the clients in the apartment. The staff member stated on a recent weekend there was one staff member assigned to the clients in the apartment and another staff member assigned to the other fifteen clients of the facility. The staff member stated it expected that the staff member assigned to the fifteen clients of the facility was also to relieve the staff member assigned to the apartment, for their breaks. The staff member expressed concern that while providing the supervision of the clients of the apartment, when the assigned apartment staff member was on break, it was impossible to be in both places at once if something would have happened to the other fifteen clients, i.e. a fall. The staff member was concerned, that if the staffing was not increased for the weekend coverage, a situation could occur that would leave the apartment clients unsupervised. On interview, May 20, 2008, the acting administrator stated a vulnerable adult assessment had not been completed for clients #23, 24 and 29.

The status of the correction orders issued as a result of a follow up visit made on August 20 and 21, 2007, is as follows:

1. MN Rule 4668.0855 Subp. 2 Not corrected $350.00

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 assistance with medication administration for two of two (#23 and #24) current client's records reviewed. The findings include:

Client #23's record contained a progress noted that indicated the client began receiving services at the facility on April 29, 2008. The record also contained medication administration records which indicated that the client received assistance with medication administration since his admission. On record review, May 19, 2008, the record lacked a nursing assessment of the client's functional status and need for assistance with medication administration. On interview, May 20, 2008, the acting administrator stated that the county registered nurse had done an assessment of the client prior to admission to River Birch and that since the county's assessment form was the same as their assessment they were waiting for the county RN to send them the assessment she had completed. The acting administrator verified that the record lacked an assessment.

Client #24 began receiving services from the licensee on April 29, 2008. The client's record indicated he received medication administration. There was no evidence that the RN conducted a nursing assessment of the client's functional status and need for assistance with medication administration. When interviewed, May 20, 2008, the facility RN verified a nursing assessment had not been completed.

2. MN Rule 4668.0865 Subp. 2 Not Corrected $350.00

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) conducted an assessment of the client's functional status and need for central storage of medication and develop a service plan for the provision of central storage of medications for two of two current clients' (#23 and #24) records reviewed. The findings include:

Client #23's record contained medication administration records which indicated that the client had received assistance with medication administration from unlicensed staff, since his admission to the facility on April 29, 2008. On interview, May 19, 2008, the assistant director stated that all of the clients received central storage of their medications in a locked medication cart. Client #23's record lacked an assessment for the need for central storage of medications and a service plan for this provision. On interview, May 20, 2008, the acting administrator indicated that the record lacked an assessment for the need for central medication storage.

Client #24 began receiving services from the licensee on April 29, 2008. The client's record indicated he received daily medication administration since April 29, 2008. There was no evidence that the registered nurse (RN) conducted an assessment of the client's functional status and need for central storage of medications. When interviewed, May 20, 2008, the facility registered nurse verified an assessment had not been completed.

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

3) The following referral/s is/are being made:

i) OHFC- VAA
ii) Local County-MOM
iii) Attorney General-HWS

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: RIVER BIRCH RESIDENCE

HFID #: 21266

Date(s) of Survey: May 19, 20 and 21, 2008

Project #: QL21266002

Indicators of Compliance	Outcomes Observed	Comments
3. 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 ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 4 X New Correction Order issued X 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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided
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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ _X_New Correction Order issued _X_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 ____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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 4 X___New Correction Order issued X___Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 4 X New Correction Order issued X 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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided

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** ____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: # 5</u>

Based on record review and interview, the licensee failed to ensure tuberculosis screening was completed prior to direct client contact for two of two employees' (S and T) records reviewed. The findings include:

Employee S was hired May 8, 2008 as a direct care staff. Progress notes for client #23 indicated that employee S provided direct client contact on May 13, 2008 from 10PM to 6AM. A Mantoux form for employee S indicated that he received a Mantoux test on May 13, 2008 at 12:00PM, after direct client contact. The Mantoux was read as negative on May 15, 2008.

Employee T was hired April 29, 2008 as a direct care staff. Progress notes for client #23 indicated that employee T provided direct client contact on April 30, 2008 from 10PM to 10 AM. A Mantoux form for employee T indicated that he received a Mantoux test on May 13, 2008 at 12:10PM after direct client contact. The Mantoux was read as negative on May 15, 2008. On interview, May 20, 2008, the acting administrator confirmed that the employees were providing direct client contact prior to providing evidence of having received a negative reaction to a Mantoux test.

2. MN Rule 4668.0805 Subp. 1

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that each employee received orientation to home care requirements prior to providing direct care for one of two employees' (U) records reviewed. The findings include:

Employee U was hired May of 2008 as a direct care staff. Employee U's personnel file lacked evidence of orientation to home care. When interviewed May 21, 2008, employee U stated she began "shadowing" with another resident care aide on May 12, 2008, and on May 19, 2008, began providing client cares. Employee U stated she had not yet received orientation on the contents of the orientation to home care requirements. When interviewed May 21, 2008, the assistant director stated that the training and orientation received by employees was to be documented in their personnel files. She verified that employee U's file lacked documentation of the training.

3. MN Rule 4668.0805 Subp. 4

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to retain documentation that each employee had completed orientation to home care for one of two employees' (T) records reviewed. The findings include:

Employee T was hired April of 2008, and he began providing direct client care on May 3, 2008. His personnel record did not contain documentation that he had completed the orientation to home care. When interviewed May 21, 2008, employee T stated he had been given a book with the contents of orientation to home care and was asked to read the information, which he stated he had done. When interviewed May 21, 2008, the assistant director stated that the training and orientation received by employees was to be documented in their personnel files. She verified that employee T's file lacked documentation of the training.

4. MN Rule 4668.0815 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to have a registered nurse (RN) complete an individualized evaluation of the client's needs no later than two weeks after initiation of assisted living home care services and establish a suitable and up-to-date service plan for one of two clients' (#23) records reviewed. The findings include:

Client #23 began receiving services, including medication administration, central storage of medications and assistance with activities of daily living April of 2008. The client's record lacked documentation of an assessment by the RN of the client's needs. When interviewed, May 20, 2008, the interim administrator indicated that a Stearns County nurse had completed an assessment of the client's needs prior to admission to River Birch Residence and they were awaiting the county assessment. The client's record contained a form entitled "Service Plan" which included the components required in a service plan, however the form was blank and was not signed by the licensee or the client. The client's record

also contained a "Service Agreement/Assisted Living" form that listed all services and charges provided by River Birch Residence; however, it did not indicate the individualized services or charges for client #23. All individual areas on the form remained blank except the "Service Agreement/Assisted Living" form was signed by the client and dated, April of 2008. When interviewed, May 20, 2008, the interim administrator verified the assessment and the service plan had not been completed for client #23.

5. MN Rule 4668.0860 Subp. 8

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure action was taken to implement an order for medication within 24 hours of receipt of the order for one of three clients' (#10) records reviewed. The findings include:

Client #10's record contained a faxed order form, dated April 10, 2008, with an order to omit the next dose of Warfarin (Coumadin – an anticoagulant medication) and then to change the dose of Warfarin to 2.0 milligrams (mg.) alternating with 2.5 mg. orally, daily. The faxed order had been sent to the registered nurse (RN) at the contracting home care agency for the licensee. The faxed form also indicated that the order had also been faxed to the pharmacy and the licensee on April 10, 2008. According to the medication administration record the order was implemented on April 14, 2008, at which time the Warfarin was held and on April 15, 2008, the medication was resumed with the new dosage schedule. When interviewed, May 21, 2008, the interim RN confirmed there had been a problem with the implementation of orders for the Warfarin in a timely manner.

Client #10's record also contained a note from the contracted RN, dated April 14, 2008, which indicated the pharmacy did not send the new dose of Warfarin 2 mg. to River Birch Residence when the order was faxed on April 10, 2008, and the client therefore, continued receiving 2.5 mg. daily rather than alternating with 2 mg. The note also indicated the Coumadin would be held "today" and started 2 mg. alternating with 2.5 mg. "tomorrow."

An exit conference was held on May 21, 2008, with Beth Telper,RN; Bonnie Norgren, Interim Director; Brianne Wolters, Administrator; Stephanie Nordstrom, LPN and JoAnn Gondringer, Assistant Director and a faxed draft copy of this completed form was (faxed to) JoAnn Breth Gondringer, Assistant Director; Stephanie Norstrom, LPN; Bonnie Norgren, Interim Director on May 27, 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).

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 0350 0003 0567 0360

October 25, 2007

Del Sand, Administrator
Riverbirch Residence
PO BOX 432
Cold Spring, MN 56320

Re: Licensing Follow Up visit

Dear Mr. Sand:

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 20 and 21, 2007.

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: Stearns 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

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 0360

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

October 25, 2007

Del Sand, Administrator
Riverbirch Residence
PO BOX 432
Cold Spring, MN 56320

RE: QL21266002

Dear Mr. Sand:

1. On August 20 and 21, 2007, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of follow up visits to an original survey completed on November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005 and subsequent follow up visits made on July 17, 18, 19, 20, and 21, 2006 and November 15 and 16, 2006, with correction orders received by you on March 9, 2006, August 19, 2006, and January 4, 2007, and found to be uncorrected during an (inspection/s) completed on July 17, 18, 19, 20, and 21, 2006 and November 15 and 16, 2006.

As a result of correction orders remaining uncorrected on the November 15 and 16, 2006 re-inspection, a penalty assessment in the amount of **$3350.00** was imposed on December 28, 2006.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on August 20 and 21, 2007.

5. MN Rule 4668.0810 Subp. 6 **$400.00**

Based on record review and interview, the licensee failed to maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include:

On September 22, 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation indicated client#1 returned from the hospital with a "fleets enema." On November 9, 2005, the "Communication Book" had an entry that stated, the client fell and hit

her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to be called if any symptoms were noted. Neither of these incidents was documented in client #1's record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record.

Client #9 had two fall notations in the incident/accident reports and facility communication book. On November 1, 2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head. On November 10, 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

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

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

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G; *(MDH Added note to surveyors: Refer to MN Statute 144A.4605, Subd. 2(d)(1) for citation or education regarding this requirement).*

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

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $400.00.

8. MN Rule 4668.0815 Subp. 4 **$200.00**

Based on record review and interview, the licensee failed to provide a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include:

Client #1 and #2's service plans were authenticated on February 18, 2005 and August 12, 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete.

Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans.

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;

(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: $200.00.

9. MN Rule 4668.0825 Subp. 4 **$1400.00**

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include:

Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the assisted living home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $1400.00.

15. MN Rule 4668.0855 Subp. 9 **$1200.00**

Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include:

Client #2's Service Plan, August 12, 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October 5, 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders.

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: $1200.00

16. MN Rule 4668.0860 Subp. 2 **$1400.00**

Based on record review and interview the licensee failed to have written prescriber orders for medications for two of six (#1and #2) current clients' records reviewed. The findings include:

Client #1 was readmitted to the facility February 18, 2005 after a two-month stay in a hospital and a nursing home. The nursing home had transferred a current copy of client #1's medication administration record, but had not included any orders signed by the physician, a physician assistant, a nurse practitioner, or other prescriber. Subsequent to admission on February 18, 2005, client#1s' physician had faxed some orders, however, several medications the client was receiving did not have physician orders. After this reviewer questioned the orders during the survey, the licensee attempted to obtain signed orders on November 8, 2005. The physician assistant refused to sign the medication orders citing that the client had left the nursing home against medical advice. When interviewed November 8, 2005, the director, stated the agency was providing assistance with all medication administration for client #1. She stated the agency was unaware that the medication administration record from the nursing home was not considered orders for the medications.

Client #2's service plan, dated August 12, 2004, indicated client #2 received medication administration. Client #2s' medication administration record indicated that on October 2, and 3, 2005; client #2 received a PRN (as needed) pain medication. There was no order for this medication. When interviewed, November 8, 2005, the director stated she was unaware they lacked an order for the analgesic. The director then called the pharmacy and requested a faxed copy of the physician order for the pain medication. When interviewed December 21, 2005, the registered nurse stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $1400.00

2. On August 20 and 21, 2007, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on July 17, 18, 19, 20, and 21, 2006, which were received by you on August 19, 2006.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on August 20 and 21, 2007:

2. MN Rule 4668.0815 Subp. 2 **$500.00**

Based on record review and interview the licensee failed to have a registered nurse (RN) review each client's evaluation annually for two of two client's (#1 and #2) records reviewed who resided in the facility for a year or more. The findings include:

Client #1 was admitted to the facility on October 2, 2004. The "RN Evaluation/Baseline Assessment was dated September 13, 2004. There was no evidence of an annual review of the client's initial evaluation. When interviewed, July 18, 2006, the RN verified that the record did not contain a more current evaluation.

Client #2 was admitted to the facility July 9, 2002. The "RN Evaluation/Baseline Assessment dated August 1, 2004. When interviewed July 18, 2006, the RN verified that the record did not contain a more current client evaluation.

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

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

3. On August 20 and 21, 2007, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on November 15 and 16, 2006, which were received by you on January 4, 2007.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on August 20 and 21, 2007:

4. MN Statute §144A.46 Subd. 5(b) **No Fine**

Based on record review and interview the licensee failed to perform a background study on one of two new employee's (N) records reviewed. The findings include:

Employee N began providing direct patient care on November 6, 2006. Employee N's record lacked evidence of an application for a background study or a background study.

On interview, November 16, 2006, the Department of Human Services background study representative confirmed that they had not received an application for a background study for employee N. On November 16, 2006, the Assistant Director stated they had not sent in an application for a background study for employee N, and that they would have employee N sign for it when she returned to work on November 18, 2006.

TO COMPLY: Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057. These individuals shall be disqualified under the provisions of chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

5. MN Statute §626.557 Subd. 14(b) **No Fine**

Based on record review and interview the licensee failed to provide a complete vulnerable adult assessment for two of two new client's (#18 and #19) records reviewed. The findings include:

Clients #18 and 19's service plans indicated that the clients began receiving services from the licensee on October 26, 2006 and October 31, 2006, respectively. The clients' records contained an assessment entitled, "Assessment for Resident Vulnerability and Safety", which included areas of vulnerability and interventions if the client was assessed as vulnerable in that area. The assessment lacked the person's susceptibility to abuse by other individuals, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

On interview, November 16, 2006, the owner stated she was unaware the vulnerable adult assessment needed to include these vulnerabilities. The registered nurse (RN) who completed these assessments was no longer employed by the licensee.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of the person's susceptibility to abuse by other individuals, including other vulnerable adults, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: $5100.00. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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: Stearns 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: RIVER BIRCH RESIDENCE

DATE OF SURVEY: November 15, and 16, 2006

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

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Linda Sand, Owner
Beth Tepfer, RN
Karen Klaphake, Resident Aid
Judy Roering, Resident Aid
Kelly Miller, Resident Aid
Kim Freyman, Resident Aid
Joann Breth, Resident Aid

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

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 November 4, 7, 8, 16, and 17, 2005 and December 19, 20 and 21, 2005 and a subsequent follow up visit made on July 17, 18, 19, 20 and 21, 2006. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the correction orders issued as a result of a visit made on November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005 is as follows:

5. MN Rule 4668.0810 Subp. 6 **Not corrected** **$200.00**

Based on record review and interview, the licensee failed to maintain a complete record for two of two (#1 and #15) client's records reviewed. The findings include:

An entry in the facility "communication book" a cumulative log for any/all clients dated November 5, 2006, documented that client #15 was "walking funny… and said he couldn't walk and that he fell out of bed…He said he was dizzy when he stood up… and he told me his left arm felt heavy when he lifted it. …He said he didn't have pain but said he just didn't feel right." There was no documentation in the client's permanent record that he had experienced the fall and the other aforementioned symptoms.

An entry in the facility "communication book" " a cumulative log for any/all clients dated November 5, 2006, documented that client #1 "had a really hard time walking all night…she was up two other times and very unsteady. She didn't sleep much and just didn't seem to know what was going on." There was no documentation in the client's permanent record about the aforementioned symptoms.

When interviewed on November 15, 2006, the registered nurse verified the agency staff documented these events in a log of multiple clients that was not a permanent part of the client record and not in the client record.

7. MN Rule 4668.0815 Subp. 3 **Corrected**

8. MN Rule 4668.0815 Subp. 4 **Not corrected** **$100.00**

Based on record review and interview, the licensee failed to provide a complete service plan for three of five current clients' (#15, #18 and #19) records reviewed. The findings include:

Client #15's service plan was signed April 18, 2006, by the "Director of the Facility." It was also signed by client #1; however, the date line after the client signature remained blank. Client #15's service plan stated, "services provided for a monthly rate with payment from" (county name) "County include: …" The service plan then enumerated different services that could be provided to the client with the rate the county would pay for each service. The area on the service plan which indicated the actual cost for services remained blank for all services listed. The service plan did not indicate which services were actually utilized by the client nor did it indicate the frequency.

Client's #18 and #19 had service plans dated October 26, 2006 and October 31, 2006, respectively. The contingency plan section stated "Services Provided, Contingency Plan: Essential services: if services are essential for medical or safety reasons, arrangements acceptable to the client or client's responsible person shall be made to complete the service as follows:

"County contact:_____; Family Contact_____." These areas were blank. The service plans lacked the action to be taken by the client or the client's responsible person and the assisted living home care provider licensee if scheduled services could not be provided. Client #18 and 19's service plans also lacked the schedule or frequency of sessions of supervision for the services or the persons providing those services. Both client #18 and #19's records contained November, 2006 medication administration records which indicated both clients were receiving assistance with medication administration from the unlicensed personnel. When interviewed, November 16, 2006, the owner indicated she had been unaware that the service plans lacked these items.

9. MN Rule 4668.0825 Subp. 4 **Not corrected** **$700.00**

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for two of five current clients (#1 and #10)) records reviewed. The findings include:

Client #10's daily care sheets for November 2006 indicated employees N and O provided AM cares and showers for client #10. The records for employees N and O lacked documentation of training or demonstrated competency for activities of daily living for employees N and O. When interviewed November 15, 2006, employee N stated she had started providing cares on November 6, 2006. She stated she had not been trained by the RN nor had she demonstrated competencies on any delegated nursing tasks to the RN. She stated she had been working with another resident aid. Employee O stated on November 16, 2006 that she had not had any training from the RN other than medication administration. She stated she had not demonstrated any competencies to the RN and she had been doing vital signs, medication administration, and activities of daily living. On interview, November 16, 2006 the assistant director stated that "AM cares" for client #10 consisted of total dressing, and grooming.

Client #1's medication administration record for November 2006, indicated employee O applied her C-PAP machine on November 2, 2006. Employee O's competency evaluation for "correct usage of C-PAP machine and correct cleaning procedure" was blank. On interview, November 16, 2006, employee O stated she had not been trained by the RN on the usage or application of the C-PAP nor demonstrated a competency on the correct application, usage and cleaning of the C-PAP to the RN.

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

14. MN Rule 4668.0855 Subp. 5 **Not corrected** **$700.00**

Based on record review and interview, the licensee failed to ensure that the registered nurse (RN) was notified, either 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 three of three clients (#10, #15 and #18) reviewed that received PRN medications after the follow up correction date of October 19, 2006. The findings include:

Client #10's medication administration record (MAR) indicated unlicensed personnel B administered a PRN medication to the client on October 20, 2006. Client #15 was administered PRN medications on November 8, 10, and 12, 2006, by other unlicensed employees. Client #18 was administered PRN medications daily from November 1 through 14, 2006 by unlicensed employees, including employee O. There was no evidence the RN had been informed within twenty-four hours after the administration of PRN medication.

When interviewed November 16, 2006, concerning the facility's PRN medication policy, unlicensed employee B stated she had been instructed at a staff meeting held on Monday, November 13, 2006, by registered nurse #A, that a form would be sent to the facility to document all PRN medications when administered. Employee B indicated the PRN form was to be faxed to the RN once every 24 hours but as of November 16, 2006 the form had not yet been received at the facility. Employee B

indicated she had been employed by the agency around three years and Monday, November 13, 2006 was the first time she had ever been instructed a RN had to be notified when a PRN medication was administered. Employee B stated she routinely administered medications to the clients in the facility.

On interview, November 16, 2006, employee O stated she had not informed the registered nurse of the administration PRN medications she had administered for client #18. She stated that she had not been informed by the RN she needed to notify the RN when she administered a PRN medication.

15. MN Rule 4668.0855 Subp. 9 **Not corrected** **$600.00**

Based on record review and interview the licensee failed to administer medications as prescribed for two of five (#5, and #10) current clients' records reviewed. The findings include:

Client #5 received central storage and medication administration by facility unlicensed staff. The November 2006 medication administration record indicated client #5 was to receive Detrol 4 mg. every night at 8:00 pm. On November 13, 2006, the 8 pm dose was not initialed as given. The medication administration record lacked documentation of the reason why it was not administered as ordered or any follow up procedures taken if any.

Client #10 received central storage of medications and medication administration by the unlicensed staff. The medication record indicated the client was to receive Fentanyl 37 micrograms every three days. On November 11, 2006, the 8PM dose was not initialed as given. The medication administration record lacked documentation of the reason it was not administered as ordered or any follow up procedures taken if any. Employee O had administered medications to client # 10 on the evening shift on November 11, 2006. On interview, November 16, 2006, employee O stated she had been instructed by the registered nurse to circle the date any time a medication was not given and document on the back of the medication administration record why the medication had not been given. She was unaware that the Fentanyl was not documented as given.

16. MN Rule 4668.0860 Subp. 2 **Not corrected** **$700.00**

Based on record review the licensee failed to have written prescriber orders for medications for two of five current client's (#1 and #18) records reviewed. The findings include:

Client #1 was administered one tablet of Cefzil at 8:00 pm on November 4, 2006 at 8:00 pm. The client's record did not contain a physician's order for this medication. The client had been seen in the emergency room earlier in the day and at that time the physician had ordered Augmentin to be administered. However, the client was allergic to Augmentin. A review of all the available documentation did not indicate if/how the order for the Cefzil was obtained.

Client #18 was admitted by the licensee on October 26, 2006. Client #18 brought along, from his previous residence, all of his medications which included: Lopressor; aspirin; Zantac; Ditropan; Copaxone; Effexor; Elavil; and ibuprofen. Client #18's record lacked priscriber orders for any of his medications until October 31, 2006, when a psychiatrist ordered Elavil and Effexor. On November 13, 2006, his primary physician ordered: Lopressor; Prilosec, discontinued the Zantac; and changed the ibuprofen to 800mg, three times a day. The record still lacked prescriber orders for the aspirin, Copaxone; and Ditropan at the time of the survey.

On interview, November 16, 2006, the assistant director stated that unlicensed personnel took the medications, from central storage, to the client, observed him taking the medications and then documented on the medication administration record the medications taken by the client. On interview, November 15, 2006, the registered nurse (RN) stated on admission they did not have any physician orders for client #18's medications. The RN stated that they were trying to get the pharmacy to fax the medication orders to them. At the end of the survey the orders had not yet been faxed to the licensee.

17. MN Rule 4668.0860 Subp. 8 **Corrected**

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

The status of the correction orders issued as a result of a visit made on July 17, 18, 19, 20, and 21, 2006 is as follows:

1. MN Rule 4668.0805 Subp. 2 **Not corrected** **$100.00**

Based on record review and interview the licensee failed to provide the required contents of orientation to home care for one of two, newly hired employee's (N) records reviewed. The findings include:

Employee N began providing direct client care on November 6, 2006 as an unlicensed staff. Employee N's record indicated that she did not have any of the topics included in orientation to home care. On interview, November 15, 2006, employee N stated that she had not had any training or orientation by the registered nurse. She stated she had been working with another resident aid, who was instructing her.

2. MN Rule 4668.0815 Subp. 2 **Not Corrected** **$250.00**

Based on record review and interview, the licensee failed to ensure that the client or the client's responsible person agreed in writing to a service plan modification for one of one (#15) client's records reviewed. The findings include:

Client #15's October 2006 medication administration record indicated client #15 received medication administration from facility staff. Client #15's service plan was signed April 18, 2006, by the "Director of the Facility" and by client #15; however, the date line after the client signature remained blank. Client #15's service plan stated, "services provided for a monthly rate with payment from" (county name) "County include: …" The service plan then enumerated the different services that could be provided to the client with the rate the county would pay for each service. The service plan did not identify medication administration as a service. The service plan stated that the "current fee for housing and services: Private Room $2400; Double Occupancy Room $1800." The last page of the service plan included an area for amendments to contractor checklist. This area remained blank for client #15's service plan. When interviewed, November 16, 2006, the owner stated she had found a stack of "Assisted Living Contractor Checklist" forms from Stearns County Human Services which indicated that client #15 had fee increases on July 1, 2006 and October 1, 2006 and that client #15 received assist with medication administration and supervision 24 hours. The owner confirmed client #15's service plan had not been modified to include the changes.

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: RIVER BIRCH RESIDENCE

HFID #: 21266

Date(s) of Survey: November 15, 16, 2006

Project #: QL21266002

Indicators of Compliance	Outcomes Observed	Comments
4. 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 ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 ____New Correction Order issued X___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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 X New Correction Order issued X 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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 X New Correction Order issued X 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 ____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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 X___New Correction Order issued X___Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 ____New Correction Order issued X___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 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided

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** ____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 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.

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

Based on record review and interview, the licensee failed to ensure that employees had tuberculosis screening prior to providing direct care to clients for one of two newly hired employee's (N) records reviewed. The findings include:

Employee N began working as a direct care staff November of 2006. There was no documentation of tuberculosis screening in her record. When interviewed November 15, 2006, employee N stated she had a Mantoux, in either July or August of 2006, at a previous employer which was read as negative. She indicated she had been instructed to get a copy of the Mantoux for her record; however, she had not done this yet.

2. MN Rule 4668.0840 Subp. 3

AREA OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure complete training for two of two, newly hired, unlicensed employees' (N and O) records reviewed. The findings include:

Employee N was hired November of 2006, and started to provide direct care five days later in November of 2006. Employee N's training record lacked documentation of any of the core training topics. Her training forms were blank. When interviewed November 15, 2006, employee N stated she had not received any training on any of the core training topics.

Employee O was hired August of 2006. Employee O's competency evaluation record indicated employee O had passed competencies in "a guide to Home Care"; "Communication skills"; "Medication administration/assistance with self administration of medications"; and "hand washing". The other core training topics were blank on the record. On interview, November 16, 2006, employee O stated the registered nurse had not provided the training on the other core topics.

3. MN Statute §144A.44 Subd. 1(2)

AREA OF COMPLIANCE: # 2

Based on record review and interviews, the licensee failed to provide nursing care subject to acceptable nursing standards for one of one client's (#1) records reviewed. The findings include:

Client #1's record noted she was seen at an emergency room (ER) November of 2006. When interviewed on November 16, 2006, employee K, an unlicensed employee, stated she transported the client to the ER at approximately 6:15 am on the date in November of 2006 after the client had been complaining during the night of trouble with breathing. Employee K stated she was unable to recall the time client #1 started to complain of trouble with her breathing, but she did note the client's breathing sounded "raspy" with every breath. Employee K stated she applied the client's oxygen machine to see if that would provide the client any relief, but that did not help. Employee K stated she could not recall if the facility RN (employee I) had instructed her to apply the oxygen but she had called the RN to report to her the client's complaints of trouble with breathing. Employee K indicated the client told her she wanted an ambulance summoned to take her to the hospital. Employee K stated she notified the facility registered nurse (RN) with a second phone call of the client's request, and was instructed by the RN to locate someone to take the client to the emergency room (there were no other staff working in the building). Employee K stated initially the client thought a friend would be able to take her to the ER, but that arrangement did not work out, so employee K volunteered to take her to the ER at the end of her night shift at the facility. Employee K relayed during the interview, the client was alert and oriented and able to walk independently without any problems when she was taken to the ER. Employee K stated at the ER the client was diagnosed with pneumonia in one lung. Instructions from the ER contained in the client record were: "(1) Do a nebulizer breathing treatment 2 times a day; (2) take an antibiotic one pill 2 times a day with food for 10 days; (3) Return to see" (the client's doctor) "this week; and (4) Follow up at the hospital if worse."

The facility communication book contained an unsigned entry which noted, "Went to ER this morning, has pneumonia? New med to be given, Call (facility RN) with any questions." When interviewed on

November 17, 2006, unlicensed employee H stated she was on-duty when the client returned from the ER and she verified she wrote the entry in the communication book. She stated the RN was not in the facility the date in November of 2006, and she faxed the ER orders to the pharmacy. She stated the facility RN called the facility "maybe" around 12 noon, but she was uncertain of the exact time. Employee H indicated at the time she spoke with the RN she informed the RN the client meds had not arrived yet, and she was unable to pick them up because she was the only one in the facility. Employee H stated the meds had not arrived at the facility when she went off duty at 2:00 pm. The medication administration record in the client's record noted the client was administered the nebulizer at 4:00 pm. A dose of a different antibiotic one tablet (no dosage noted) was documented as administered at 8:00 pm, approximately eleven hours after the client's return from the ER. The client's record did not contain an order for the different antibiotic. A notation on the instructions sheet from the ER noted the client was allergic to the antibiotic that was initially ordered and the pharmacy was notified. The notation related to the allergy was dated November of 2006, with the initials of the facility RN.

The facility communication book contained a note written by employee K dated November of 2006, at 5am that indicated; "(Client #1) had a tough night. At a little after 1 she was half ways off her bed. She had a really hard time walking all night. She was really shaky so we checked her blood sugar and it was 142. Also, took vitals BP 157/61, p 74, temp 99.7 Called (facility RN employee I), gave (client #1) a neb treatment and Tylenol. She was up two other times and very unsteady. She didn't sleep much and just didn't seem to know what was going on. The lights also went out."

When interviewed on November 16, 2006, employee K was queried about her entry in the communication book. She stated when she arrived at work at 10 pm on November of 2006 the client was doing "fine." At about 1 am she found her half off the bed and she helped the client to the bathroom. The client had "a lot of trouble walking" and she called the facility RN and reported to the RN the client's difficulty walking. She stated the RN instructed her to obtain the vital signs, administer a nebulizer treatment, and check the client's blood sugar. According to the client's medication administration the client was administered a nebulizer treatment at 1:40 am on November of 2006 for "trouble breathing." When queried, employee K stated the client normally was able to walk without difficulty, and the previous day, the client had walked into the ER without any difficulty. At 3 am employee K "thinks" the client blew her whistle to get her attention because she needed to go to the bathroom. At 3 am the client still had difficulty walking, was not really herself as exhibited by "being quiet and saying mama." After 3 am she continued to check on the client approximately every 15 minutes, and she also was checking on the other clients in the facility at the same frequency because the lights in the facility were out (reportedly due to a car hitting an electrical pole in the town.) Employee K reported she had no further direct interaction with the client after 3 am on November of 2006.

The progress notes in the client record documented as 7:45 am on November of 2006 entered by unlicensed employee H recorded: "Went to get (client #1) up for breakfast. Found her on floor between bed and dresser. Very unaware of what was happening, left arm bleeding, and bruise on left knee cap. Called RN and took vitals BP 157/61, P74, T 99.7 and blood sugar 142 was brought to ER". When interviewed on November 15 and 16, 2006, employee H stated she had checked on the client at 7:10 am and the client was in her bed at that time but when she went back to her room to get her up for breakfast, she found the client on the floor. She stated she called the facility RN and reported to the RN the client was on the floor, mumbling, not making sense and was "totally out of it" and was bleeding from her left arm. The RN instructed her to call another resident care assistant at their home, to come in and help her. Employee H indicated she called employee B at her home and employee B questioned her on the client's fall. Employee B instructed her to call 911 but employee H stated she informed employee B the facility

RN had instructed her to call a facility employee to come in to help her get the client off the floor and take the client to the ER. Employee H indicated she did not want to call the facility RN back and talk with her about calling 911 as employee B had instructed her, because she had "issues" with the RN. Employee H stated she just wanted employee B to come in and help her. Employee H indicated she stayed with the client, holding her, until employee B arrived at the facility.

When interviewed on November 15, 2006, employee B stated she arrived at the facility at 8:15 am. Employee B provided a written statement regarding the occurrences of the morning of November 5, 2006. The document indicated when she arrived at the facility she obtained the client's vital signs, and "(client#1) was laying on the floor opening and shutting her eyes and would mumble something I couldn't understand when I ask questions. I called 911." Employee B indicated the first responders arrived at the facility within minutes.

According to the ambulance report, the call was received at 8:33 am (about 45 minutes after the client had been found on the floor) and arrived at the scene at 8:56 am. The emergency room record noted the client arrived at the ER around 9:35 am. The ER record documented the client: "At present starting to speak, speech slurred-resp shallow-deep and blowing type-suctioned x2 in route-throat congested noted-generalized bruising throughout upper chest around pacemaker, left knee, left should, chin, (this reviewer unable to read the entry at this point)." The examination portion of the ER record noted the client also had a large laceration on her left forearm. During the ER visit the client had a CT scan of her head which revealed she had an intracranial bleed. She was transferred to another hospital where she died the next day.

4. MN Statute §144A.46 Subd. 5(b)

AREA OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to perform a background study on one of two new employee's (N) records reviewed. The findings include:

Employee N began providing direct patient care on November of 2006. Employee N's record lacked evidence of an application for a background study or a background study. On interview, November 16, 2006, the Department of Human Services background study representative confirmed that they had not received an application for a background study for employee N. On November 16, 2006, the Assistant Director stated they had not sent in an application for a background study for employee N, and that they would have employee N sign for it when she returned to work on November 18, 2006.

5. MN Statute §626.557 Subd. 14(b)

AREA OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to provide a complete vulnerable adult assessment for two of two new client's (#18 and #19) records reviewed. The findings include:

Clients #18 and 19's service plans indicated that the clients began receiving services from the licensee in October of 2006. The clients' records contained an assessment entitled, "Assessment for Resident Vulnerability and Safety", which included areas of vulnerability and interventions if the client was assessed as vulnerable in that area. The assessment lacked the person's susceptibility to abuse by other

individuals, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

On interview, November 16, 2006, the owner stated she was unaware the vulnerable adult assessment needed to include these vulnerabilities. The registered nurse (RN) who completed these assessments was no longer employed by the licensee.

A draft copy of this completed form was left (faxed to) with Linda Sand at an exit conference on November 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).

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail: # 7005 0390 0006 1220 4685

March 5, 2007

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

Re: Amended Licensing Follow Up visit

Dear Mr. Sand:

On August 16, 2006, you were sent an Informational Memorandum and a Notice of Assessment for Non-Compliance Letter as the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. Subsequent to that mailing, an error was noted in the information that was mailed. Enclosed are the corrected documents. The amended information in these documents that has been corrected is underscored and the stricken [~~stricken~~] information has been removed. Corrections have been made to **MN Rule 4668.0825 Subp.4** in the Informational Memorandum and the Notice of Assessment for Non-Compliance letters.

Since you have already paid **$3050.00** of the assessed amount, you will only need to pay the balance of **$300.00** related to the Notice of Assessment for Non-Compliance, originally dated August 16, 2006, and modified on December 29, 2006. Please make the check payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

06/06 FPC1000CMRAMMENDED

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1220 4685

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

March 5, 2007

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

RE: QL21266002

Dear Mr. Sand:

1. On November 15 and 16, 2006, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on November 4, 7, 8, 16, and 17, and December 19, 20, and 21, 2005, with correction orders received by you on March 9, 2006, and found to be uncorrected during an inspection completed on July 17, 18, 19, 20, and 21, 2006.

As a result of correction orders remaining uncorrected on the July 17, 18, 19 20, and 21, 2006 re-inspection, a penalty assessment in the amount of **$2900.00** was imposed on August 16, 2006.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on November 15 and 16, 2006:

5. MN Rule 4668.0810 Subp. 6 **$200.00**

Based on record review and interview, the licensee failed to maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include:

On September 22, 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation indicated client#1 returned from the hospital with a "fleets enema." On November 9, 2005, the "Communication Book" had an entry that stated, the client fell and hit her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to

be called if any symptoms were noted. Neither of these incidents was documented in client #1's record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record.

Client #9 had two fall notations in the incident/accident reports and facility communication book. On November 1, 2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head. On November 10, 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

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

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

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

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

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $200.00.

8. MN Rule 4668.0815 Subp. 4 **$100.00**

Based on record review and interview, the licensee failed to provide a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include:

Client #1 and #2's service plans were authenticated on February 18, 2005 and August 12, 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete.

Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans.

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;

(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: $100.00.

9. MN Rule 4668.0825 Subp. 4 **$700.00**

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include:

Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the assisted living home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00.

14. MN Rule 4668.0855 Subp. 5 **$700.00**

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) was informed within 24 hours of administration, or within a time period that was specified by a RN prior to the administration, when unlicensed personnel administered pro re nata (PRN, as needed) medications for two of six current clients' (#1 and #2) records reviewed. The findings include:

Client #1's medication administration record for November 2005 indicated that unlicensed personnel, including employee E, administered several PRN medications to the client on November 1, 2, 3, and 4, 2005. When interviewed, November 16, 2005, employee E stated she did not inform the registered nurse of the "PRN" medications given to client #1 November of 2005. Employee E stated that if the "PRN" medications are listed on the medication administration record, unlicensed employees could give these "PRN" medications to the clients without informing the registered nurse. However, if the clients were sick she would call the RN for assistance.

Client #2's medication administration record for October of 2005 indicated that unlicensed personnel administered an analgesic to client #2 on October 2, and 3, 2005, for complaints of ankle pain. When interviewed on November 4, 2005, employee B, an unlicensed staff the administers medication to client #2, stated that if "PRN" medications are given, the unlicensed personnel need to document on the back side of the medication administration record the name of medication given, date and time given, reason given and results. She also stated the unlicensed personnel do not notify the registered nurse, unless the client has a problem that requires a "PRN" that is not listed on the medication administration record. Then they would call the RN and she would advise them if they could use a standing order. On November 16, 2005, unlicensed employees E and F, who give medications, confirmed the above information provided by unlicensed employee B. When interviewed, November 7, 2005, the RN stated she reviewed the medication administration record monthly. She stated she had not specified a time period for informing her or established a protocol for her being informed of PRN medication administration.

TO COMPLY: A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

A. the medications are regularly scheduled; and

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $700.00.

15. MN Rule 4668.0855 Subp. 9 **$600.00**

Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include:

Client #2's Service Plan, August 12, 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October 5, 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders.

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: $600.00.

16. MN Rule 4668.0860 Subp. 2 **$700.00**

Based on record review and interview the licensee failed to have written prescriber orders for medications for two of six (#1and #2) current clients' records reviewed. The findings include:

Client #1 was readmitted to the facility February 18, 2005 after a two-month stay in a hospital and a nursing home. The nursing home had transferred a current copy of client #1's medication administration record, but had not included any orders signed by the physician, a physician assistant, a nurse practitioner, or other prescriber. Subsequent to admission on February 18, 2005, client#1s' physician had faxed some orders, however, several medications the client was receiving did not have physician orders. After this reviewer questioned the orders during the survey, the licensee attempted to obtain signed orders on November 8, 2005. The physician assistant refused to sign the medication orders citing that the client had left the nursing home against medical advice. When interviewed November 8, 2005, the director, stated the agency was providing assistance with all medication administration for client #1. She stated the agency was unaware that the medication administration record from the nursing home was not considered orders for the medications.

Client #2's service plan, dated August 12, 2004, indicated client #2 received medication administration. Client #2s' medication administration record indicated that on October 2, and 3, 2005; client #2 received a PRN (as needed) pain medication. There was no order for this medication. When interviewed, November 8, 2005, the director stated she was unaware they lacked an order for the analgesic. The director then called the pharmacy and requested a faxed copy of the physician order for the pain medication. When interviewed December 21, 2005, the registered nurse stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $700.00.

2. On November 15 and 16, 2006, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on July 17, 18, 19, 20, and 21, 2006, which were received by you on August 19, 2006.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on November 15 and 16, 2006:

1. MN Rule 4668.0805 Subp. 2 **$100.00**

Based on record review and interview the licensee failed to provide the complete required contents of orientation to home care for two of eight (I and E) employee's records reviewed. The findings include:

Employee E and I were hired on July 6, 2004, and March 2, 2006 respectively. Employee E's record indicated she had received orientation to reporting the maltreatment of vulnerable adults; the Home Care Bill of Rights; the handling of emergencies; the handling of client complaints and reporting to the office of Health of Health Facility Complaints. The orientation lacked the overview of the home care Statute and Rules, and the services of the Ombudsman. Employee I's record indicated she had received orientation to reporting the maltreatment of vulnerable adults and the home care bill of rights. Employee I had not received orientation to the overview of the home care Statute and Rules; the handling of emergencies; the handling of clients' complaints; or the services of the Ombudsman.

When interviewed, July 18, 2006, employee I stated she was not given this orientation and was not aware she needed to orientate staff on this rule. When interviewed, July 18, 2006, employee E stated she thought she may have had orientation to the home care Statute and Rules by the previous director, however, she stated she could not be sure.

TO COMPLY: The orientation required under subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling emergencies and using emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. the home care bill of rights, Minnesota Statutes, section 144A.44;

E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00.

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

Based on record review and interview the licensee failed to have a registered nurse (RN) review each client's evaluation annually for two of two client's (#1 and #2) records reviewed who resided in the facility for a year or more. The findings include:
Client #1 was admitted to the facility on October 2, 2004. The "RN Evaluation/Baseline Assessment was dated September 13, 2004. There was no evidence of an annual review of the client's initial evaluation. When interviewed, July 18, 2006, the RN verified that the record did not contain a more current evaluation.

Client #2 was admitted to the facility July 9, 2002. The "RN Evaluation/Baseline Assessment dated August 1, 2004. When interviewed July 18, 2006, the RN verified that the record did not contain a more current client evaluation**.**

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: ~~**$3050.00**~~ **$3350.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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: Stearns 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 MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1220 3114

December 28, 2006

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

Re: Licensing Follow Up visit

Dear Mr. Sand:

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 November 15 and 16, 2006.

The documents checked below are enclosed.

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

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

06/06 FPC1000CMR

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1220 3114

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

December 28, 2006

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

RE: QL21266002

Dear Mr. Sand:

1. On November 15 and 16, 2006, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on November 4, 7, 8, 16, and 17, and December 19, 20, and 21, 2005, with correction orders received by you on March 9, 2006, and found to be uncorrected during an inspection completed on July 17, 18, 19, 20, and 21, 2006.

As a result of correction orders remaining uncorrected on the July 17, 18, 19 20, and 21, 2006 re-inspection, a penalty assessment in the amount of **$2900.00** was imposed on August 16, 2006.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on November 15 and 16, 2006:

5. MN Rule 4668.0810 Subp. 6 **$200.00**

Based on record review and interview, the licensee failed to maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include:

On September 22, 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation indicated client#1 returned from the hospital with a "fleets enema." On November 9, 2005, the "Communication Book" had an entry that stated, the client fell and hit her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to be called if any symptoms were noted. Neither of these incidents was documented in client #1's

record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record.

Client #9 had two fall notations in the incident/accident reports and facility communication book. On November 1, 2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head. On November 10, 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

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

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

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

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

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $200.00.

8. MN Rule 4668.0815 Subp. 4 **$100.00**

Based on record review and interview, the licensee failed to provide a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include:

Client #1 and #2's service plans were authenticated on February 18, 2005 and August 12, 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete.

Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans.

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;

(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: $100.00.

9. MN Rule 4668.0825 Subp. 4 **$700.00**

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include:

Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the assisted living home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00.

14. MN Rule 4668.0855 Subp. 5 **$700.00**

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) was informed within 24 hours of administration, or within a time period that was specified by a RN prior to the administration, when unlicensed personnel administered pro re nata (PRN, as needed) medications for two of six current clients' (#1 and #2) records reviewed. The findings include:

Client #1's medication administration record for November 2005 indicated that unlicensed personnel, including employee E, administered several PRN medications to the client on November 1, 2, 3, and 4, 2005. When interviewed, November 16, 2005, employee E stated she did not inform the registered nurse of the "PRN" medications given to client #1 November of 2005. Employee E stated that if the "PRN" medications are listed on the medication administration record, unlicensed employees could give these "PRN" medications to the clients without informing the registered nurse. However, if the clients were sick she would call the RN for assistance.

Client #2's medication administration record for October of 2005 indicated that unlicensed personnel administered an analgesic to client #2 on October 2, and 3, 2005, for complaints of ankle pain. When interviewed on November 4, 2005, employee B, an unlicensed staff the administers medication to client #2, stated that if "PRN" medications are given, the unlicensed personnel need to document on the back side of the medication administration record the name of medication given, date and time given, reason given and results. She also stated the unlicensed personnel do not notify the registered nurse, unless the client has a problem that requires a "PRN" that is not listed on the medication administration record. Then they would call the RN and she would advise them if they could use a standing order. On November 16, 2005, unlicensed employees E and F, who give medications, confirmed the above information provided by unlicensed employee B. When interviewed, November 7, 2005, the RN stated she reviewed the medication administration record monthly. She stated she had not specified a time period for informing her or established a protocol for her being informed of PRN medication administration.

TO COMPLY: A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

A. the medications are regularly scheduled; and

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $700.00.

15. MN Rule 4668.0855 Subp. 9 **$600.00**

Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include:

Client #2's Service Plan, August 12, 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October 5, 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders.

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: $600.00.

16. MN Rule 4668.0860 Subp. 2 **$700.00**

Based on record review and interview the licensee failed to have written prescriber orders for medications for two of six (#1and #2) current clients' records reviewed. The findings include:

Client #1 was readmitted to the facility February 18, 2005 after a two-month stay in a hospital and a nursing home. The nursing home had transferred a current copy of client #1's medication administration record, but had not included any orders signed by the physician, a physician assistant, a nurse practitioner, or other prescriber. Subsequent to admission on February 18, 2005, client#1s' physician had faxed some orders, however, several medications the client was receiving did not have physician orders. After this reviewer questioned the orders during the survey, the licensee attempted to obtain signed orders on November 8, 2005. The physician assistant refused to sign the medication orders citing that the client had left the nursing home against medical advice. When interviewed November 8, 2005, the director, stated the agency was providing assistance with all medication administration for client #1. She stated the agency was unaware that the medication administration record from the nursing home was not considered orders for the medications.

Client #2's service plan, dated August 12, 2004, indicated client #2 received medication administration. Client #2s' medication administration record indicated that on October 2, and 3, 2005; client #2 received a PRN (as needed) pain medication. There was no order for this medication. When interviewed, November 8, 2005, the director stated she was unaware they lacked an order for the analgesic. The director then called the pharmacy and requested a faxed copy of the physician order for the pain medication. When interviewed December 21, 2005, the registered nurse stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $700.00.

2. On November 15 and 16, 2006, a re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on July 17, 18, 19, 20, and 21, 2006, which were received by you on August 19, 2006.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on November 15 and 16, 2006:

1. MN Rule 4668.0805 Subp. 2 **$100.00**

Based on record review and interview the licensee failed to provide the complete required contents of orientation to home care for two of eight (I and E) employee's records reviewed. The findings include:

Employee E and I were hired on July 6, 2004, and March 2, 2006 respectively. Employee E's record indicated she had received orientation to reporting the maltreatment of vulnerable adults; the Home Care Bill of Rights; the handling of emergencies; the handling of client complaints and reporting to the office of Health of Health Facility Complaints. The orientation lacked the overview of the home care Statute and Rules, and the services of the Ombudsman. Employee I's record indicated she had received orientation to reporting the maltreatment of vulnerable adults and the home care bill of rights. Employee I had not received orientation to the overview of the home care Statute and Rules; the handling of emergencies; the handling of clients' complaints; or the services of the Ombudsman.

When interviewed, July 18, 2006, employee I stated she was not given this orientation and was not aware she needed to orientate staff on this rule. When interviewed, July 18, 2006, employee E stated she thought she may have had orientation to the home care Statute and Rules by the previous director, however, she stated she could not be sure.

TO COMPLY: The orientation required under subpart 1 must contain the following topics:

A. an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

B. handling emergencies and using emergency services;

C. reporting the maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

D. the home care bill of rights, Minnesota Statutes, section 144A.44;

E. handling of clients' complaints and how clients and staff may report complaints to the Office of Health Facility Complaints; and

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00.

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

Based on record review and interview the licensee failed to have a registered nurse (RN) review each client's evaluation annually for two of two client's (#1 and #2) records reviewed who resided in the facility for a year or more. The findings include:
Client #1 was admitted to the facility on October 2, 2004. The "RN Evaluation/Baseline Assessment was dated September 13, 2004. There was no evidence of an annual review of the client's initial evaluation. When interviewed, July 18, 2006, the RN verified that the record did not contain a more current evaluation.

Client #2 was admitted to the facility July 9, 2002. The "RN Evaluation/Baseline Assessment dated August 1, 2004. When interviewed July 18, 2006, the RN verified that the record did not contain a more current client evaluation**.**

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: ~~**$2750.00**~~ **$3050.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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: Stearns 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: RIVER BIRCH RESIDENCE

DATE OF SURVEY: November 15, and 16, 2006

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

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Linda Sand, Owner
Beth Tepfer, RN
Karen Klaphake, Resident Aid
Judy Roering, Resident Aid
Kelly Miller, Resident Aid
Kim Freyman, Resident Aid
Joann Breth, Resident Aid

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

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 November 4, 7, 8, 16, and 17, 2005 and December 19, 20 and 21, 2005 and a subsequent follow up visit made on July 17, 18, 19, 20 and 21, 2006. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the correction orders issued as a result of a visit made on November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005 is as follows:

5. MN Rule 4668.0810 Subp. 6 **Not corrected** **$200.00**

Based on record review and interview, the licensee failed to maintain a complete record for two of two (#1 and #15) client's records reviewed. The findings include:

An entry in the facility "communication book" a cumulative log for any/all clients dated November 5, 2006, documented that client #15 was "walking funny… and said he couldn't walk and that he fell out of bed…He said he was dizzy when he stood up… and he told me his left arm felt heavy when he lifted it. …He said he didn't have pain but said he just didn't feel right." There was no documentation in the client's permanent record that he had experienced the fall and the other aforementioned symptoms.

An entry in the facility "communication book" " a cumulative log for any/all clients dated November 5, 2006, documented that client #1 "had a really hard time walking all night…she was up two other times and very unsteady. She didn't sleep much and just didn't seem to know what was going on." There was no documentation in the client's permanent record about the aforementioned symptoms.

When interviewed on November 15, 2006, the registered nurse verified the agency staff documented these events in a log of multiple clients that was not a permanent part of the client record and not in the client record.

7. MN Rule 4668.0815 Subp. 3 **Corrected**

8. MN Rule 4668.0815 Subp. 4 **Not corrected** **$100.00**

Based on record review and interview, the licensee failed to provide a complete service plan for three of five current clients' (#15, #18 and #19) records reviewed. The findings include:

Client #15's service plan was signed April 18, 2006, by the "Director of the Facility." It was also signed by client #1; however, the date line after the client signature remained blank. Client #15's service plan stated, "services provided for a monthly rate with payment from" (county name) "County include: …" The service plan then enumerated different services that could be provided to the client with the rate the county would pay for each service. The area on the service plan which indicated the actual cost for services remained blank for all services listed. The service plan did not indicate which services were actually utilized by the client nor did it indicate the frequency.

Client's #18 and #19 had service plans dated October 26, 2006 and October 31, 2006, respectively. The contingency plan section stated "Services Provided, Contingency Plan: Essential services: if services are essential for medical or safety reasons, arrangements acceptable to the client or client's responsible person shall be made to complete the service as follows:

"County contact:_____; Family Contact_____." These areas were blank. The service plans lacked the action to be taken by the client or the client's responsible person and the assisted living home care provider licensee if scheduled services could not be provided. Client #18 and 19's service plans also lacked the schedule or frequency of sessions of supervision for the services or the persons providing those services. Both client #18 and #19's records contained November, 2006 medication administration records which indicated both clients were receiving assistance with medication administration from the unlicensed personnel. When interviewed, November 16, 2006, the owner indicated she had been unaware that the service plans lacked these items.

9. MN Rule 4668.0825 Subp. 4 **Not corrected** **$700.00**

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for two of five current clients (#1 and #10)) records reviewed. The findings include:

Client #10's daily care sheets for November 2006 indicated employees N and O provided AM cares and showers for client #10. The records for employees N and O lacked documentation of training or demonstrated competency for activities of daily living for employees N and O. When interviewed November 15, 2006, employee N stated she had started providing cares on November 6, 2006. She stated she had not been trained by the RN nor had she demonstrated competencies on any delegated nursing tasks to the RN. She stated she had been working with another resident aid. Employee O stated on November 16, 2006 that she had not had any training from the RN other than medication administration. She stated she had not demonstrated any competencies to the RN and she had been doing vital signs, medication administration, and activities of daily living. On interview, November 16, 2006 the assistant director stated that "AM cares" for client #10 consisted of total dressing, and grooming.

Client #1's medication administration record for November 2006, indicated employee O applied her C-PAP machine on November 2, 2006. Employee O's competency evaluation for "correct usage of C-PAP machine and correct cleaning procedure" was blank. On interview, November 16, 2006, employee O stated she had not been trained by the RN on the usage or application of the C-PAP nor demonstrated a competency on the correct application, usage and cleaning of the C-PAP to the RN.

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

14. MN Rule 4668.0855 Subp. 5 **Not corrected** **$700.00**

Based on record review and interview, the licensee failed to ensure that the registered nurse (RN) was notified, either 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 three of three clients (#10, #15 and #18) reviewed that received PRN medications after the follow up correction date of October 19, 2006. The findings include:

Client #10's medication administration record (MAR) indicated unlicensed personnel B administered a PRN medication to the client on October 20, 2006. Client #15 was administered PRN medications on November 8, 10, and 12, 2006, by other unlicensed employees. Client #18 was administered PRN medications daily from November 1 through 14, 2006 by unlicensed employees, including employee O. There was no evidence the RN had been informed within twenty-four hours after the administration of PRN medication.

When interviewed November 16, 2006, concerning the facility's PRN medication policy, unlicensed employee B stated she had been instructed at a staff meeting held on Monday, November 13, 2006, by registered nurse #A, that a form would be sent to the facility to document all PRN medications when administered. Employee B indicated the PRN form was

to be faxed to the RN once every 24 hours but as of November 16, 2006 the form had not yet been received at the facility. Employee B indicated she had been employed by the agency around three years and Monday, November 13, 2006 was the first time she had ever been instructed a RN had to be notified when a PRN medication was administered. Employee B stated she routinely administered medications to the clients in the facility.

On interview, November 16, 2006, employee O stated she had not informed the registered nurse of the administration PRN medications she had administered for client #18. She stated that she had not been informed by the RN she needed to notify the RN when she administered a PRN medication.

15. MN Rule 4668.0855 Subp. 9 Not corrected $600.00

Based on record review and interview the licensee failed to administer medications as prescribed for two of five (#5, and #10) current clients' records reviewed. The findings include:

Client #5 received central storage and medication administration by facility unlicensed staff. The November 2006 medication administration record indicated client #5 was to receive Detrol 4 mg. every night at 8:00 pm. On November 13, 2006, the 8 pm dose was not initialed as given. The medication administration record lacked documentation of the reason why it was not administered as ordered or any follow up procedures taken if any.

Client #10 received central storage of medications and medication administration by the unlicensed staff. The medication record indicated the client was to receive Fentanyl 37 micrograms every three days. On November 11, 2006, the 8PM dose was not initialed as given. The medication administration record lacked documentation of the reason it was not administered as ordered or any follow up procedures taken if any. Employee O had administered medications to client # 10 on the evening shift on November 11, 2006. On interview, November 16, 2006, employee O stated she had been instructed by the registered nurse to circle the date any time a medication was not given and document on the back of the medication administration record why the medication had not been given. She was unaware that the Fentanyl was not documented as given.

16. MN Rule 4668.0860 Subp. 2 Not corrected $700.00

Based on record review the licensee failed to have written prescriber orders for medications for two of five current client's (#1 and #18) records reviewed. The findings include:

Client #1 was administered one tablet of Cefzil at 8:00 pm on November 4, 2006 at 8:00 pm. The client's record did not contain a physician's order for this medication. The client had been seen in the emergency room earlier in the day and at that time the physician had ordered Augmentin to be administered. However, the client was allergic to Augmentin. A review of all the available documentation did not indicate if/how the order for the Cefzil was obtained.

Client #18 was admitted by the licensee on October 26, 2006. Client #18 brought along, from his previous residence, all of his medications which included: Lopressor; aspirin; Zantac; Ditropan; Copaxone; Effexor; Elavil; and ibuprofen. Client #18's record lacked priscriber orders for any of his medications until October 31, 2006, when a psychiatrist ordered Elavil and Effexor. On November 13, 2006, his primary physician ordered: Lopressor; Prilosec, discontinued the Zantac; and changed the ibuprofen to 800mg, three times a day. The record still lacked prescriber orders for the aspirin, Copaxone; and Ditropan at the time of the survey.

On interview, November 16, 2006, the assistant director stated that unlicensed personnel took the medications, from central storage, to the client, observed him taking the medications and then documented on the medication administration record the medications taken by the client. On interview, November 15, 2006, the registered nurse (RN) stated on admission they did not have any physician orders for client #18's medications. The RN stated that they were trying to get the pharmacy to fax the medication orders to them. At the end of the survey the orders had not yet been faxed to the licensee.

17. MN Rule 4668.0860 Subp. 8 **Corrected**

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

The status of the correction orders issued as a result of a visit made on July 17, 18, 19, 20, and 21, 2006 is as follows:

1. MN Rule 4668.0805 Subp. 2 **Not corrected** **$100.00**

Based on record review and interview the licensee failed to provide the required contents of orientation to home care for one of two, newly hired employee's (N) records reviewed. The findings include:

Employee N began providing direct client care on November 6, 2006 as an unlicensed staff. Employee N's record indicated that she did not have any of the topics included in orientation to home care. On interview, November 15, 2006, employee N stated that she had not had any training or orientation by the registered nurse. She stated she had been working with another resident aid, who was instructing her.

2. MN Rule 4668.0815 Subp. 2 **Not Corrected** **$250.00**

Based on record review and interview, the licensee failed to ensure that the client or the client's responsible person agreed in writing to a service plan modification for one of one (#15) client's records reviewed. The findings include:

Client #15's October 2006 medication administration record indicated client #15 received medication administration from facility staff. Client #15's service plan was signed April 18, 2006, by the "Director of the Facility" and by client #15; however, the date line after the client signature remained blank. Client #15's service plan stated, "services provided for a monthly rate with payment from" (county name) "County include: …" The service plan then enumerated the different services that could be provided to the client with the rate the county would pay for each service. The service plan did not identify medication administration as a service. The service plan stated that the "current fee for housing and services: Private Room $2400; Double Occupancy Room $1800." The last page of the service plan included an area for amendments to contractor checklist. This area remained blank for client #15's service plan. When interviewed, November 16, 2006, the owner stated she had found a stack of "Assisted Living Contractor Checklist" forms from Stearns County Human Services which indicated that client #15 had fee increases on July 1, 2006 and October 1, 2006 and that client #15 received assist with medication administration and supervision 24 hours. The owner confirmed client #15's service plan had not been modified to include the changes.

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: RIVER BIRCH RESIDENCE

HFID #: 21266

Date(s) of Survey: November 15, 16, 2006

Project #: QL21266002

Indicators of Compliance	Outcomes Observed	Comments
5. 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 ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 ____New Correction Order issued X___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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 X New Correction Order issued X 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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 X New Correction Order issued X 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 ____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** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 X___New Correction Order issued X___Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey # 2 ____New Correction Order issued X___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 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided

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** ____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 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.

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

Based on record review and interview, the licensee failed to ensure that employees had tuberculosis screening prior to providing direct care to clients for one of two newly hired employee's (N) records reviewed. The findings include:

Employee N began working as a direct care staff November of 2006. There was no documentation of tuberculosis screening in her record. When interviewed November 15, 2006, employee N stated she had a Mantoux, in either July or August of 2006, at a previous employer which was read as negative. She indicated she had been instructed to get a copy of the Mantoux for her record; however, she had not done this yet.

2. MN Rule 4668.0840 Subp. 3

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

Based on record review and interview, the licensee failed to ensure complete training for two of two, newly hired, unlicensed employees' (N and O) records reviewed. The findings include:

Employee N was hired November of 2006, and started to provide direct care five days later in November of 2006. Employee N's training record lacked documentation of any of the core training topics. Her training forms were blank. When interviewed November 15, 2006, employee N stated she had not received any training on any of the core training topics.

Employee O was hired August of 2006. Employee O's competency evaluation record indicated employee O had passed competencies in "a guide to Home Care"; "Communication skills"; "Medication administration/assistance with self administration of medications"; and "hand washing". The other core training topics were blank on the record. On interview, November 16, 2006, employee O stated the registered nurse had not provided the training on the other core topics.

3. MN Statute §144A.44 Subd. 1(2)

AREA OF COMPLIANCE: # 2

Based on record review and interviews, the licensee failed to provide nursing care subject to acceptable nursing standards for one of one client's (#1) records reviewed. The findings include:

Client #1's record noted she was seen at an emergency room (ER) November of 2006. When interviewed on November 16, 2006, employee K, an unlicensed employee, stated she transported the client to the ER at approximately 6:15 am on the date in November of 2006 after the client had been complaining during the night of trouble with breathing. Employee K stated she was unable to recall the time client #1 started to complain of trouble with her breathing, but she did note the client's breathing sounded "raspy" with every breath. Employee K stated she applied the client's oxygen machine to see if that would provide the client any relief, but that did not help. Employee K stated she could not recall if the facility RN (employee I) had instructed her to apply the oxygen but she had called the RN to report to her the client's complaints of trouble with breathing. Employee K indicated the client told her she wanted an ambulance summoned to take her to the hospital. Employee K stated she notified the facility registered nurse (RN) with a second phone call of the client's request, and was instructed by the RN to locate someone to take the client to the emergency room (there were no other staff working in the building). Employee K stated initially the client thought a friend would be able to take her to the ER, but that arrangement did not work out, so employee K volunteered to take her to the ER at the end of her night shift at the facility. Employee K relayed during the interview, the client was alert and oriented and able to walk independently without any problems when she was taken to the ER. Employee K stated at the ER the client was diagnosed with pneumonia in one lung. Instructions from the ER contained in the client record were: "(1) Do a nebulizer breathing treatment 2 times a day; (2) take an antibiotic one pill 2 times a day with food for 10 days; (3) Return to see" (the client's doctor) "this week; and (4) Follow up at the hospital if worse."

The facility communication book contained an unsigned entry which noted, "Went to ER this morning, has pneumonia? New med to be given, Call (facility RN) with any questions." When interviewed on November 17, 2006, unlicensed employee H stated she was on-duty when the client returned from the ER and she verified she wrote the entry in the communication book. She stated the RN was not in the facility the date in November of 2006, and she faxed the ER orders to the pharmacy. She stated the facility RN called the facility "maybe" around 12 noon, but she was uncertain of the exact time. Employee H indicated at the time she spoke with the RN she informed the RN the client meds had not arrived yet, and she was unable to pick them up because she was the only one in the facility. Employee H stated the meds had not arrived at the facility when she went off duty at 2:00 pm. The medication

administration record in the client's record noted the client was administered the nebulizer at 4:00 pm. A dose of a different antibiotic one tablet (no dosage noted) was documented as administered at 8:00 pm, approximately eleven hours after the client's return from the ER. The client's record did not contain an order for the different antibiotic. A notation on the instructions sheet from the ER noted the client was allergic to the antibiotic that was initially ordered and the pharmacy was notified. The notation related to the allergy was dated November of 2006, with the initials of the facility RN.

The facility communication book contained a note written by employee K dated November of 2006, at 5am that indicated; "(Client #1) had a tough night. At a little after 1 she was half ways off her bed. She had a really hard time walking all night. She was really shaky so we checked her blood sugar and it was 142. Also, took vitals BP 157/61, p 74, temp 99.7 Called (facility RN employee I), gave (client #1) a neb treatment and Tylenol. She was up two other times and very unsteady. She didn't sleep much and just didn't seem to know what was going on. The lights also went out."

When interviewed on November 16, 2006, employee K was queried about her entry in the communication book. She stated when she arrived at work at 10 pm on November of 2006 the client was doing "fine." At about 1 am she found her half off the bed and she helped the client to the bathroom. The client had "a lot of trouble walking" and she called the facility RN and reported to the RN the client's difficulty walking. She stated the RN instructed her to obtain the vital signs, administer a nebulizer treatment, and check the client's blood sugar. According to the client's medication administration the client was administered a nebulizer treatment at 1:40 am on November of 2006 for "trouble breathing." When queried, employee K stated the client normally was able to walk without difficulty, and the previous day, the client had walked into the ER without any difficulty. At 3 am employee K "thinks" the client blew her whistle to get her attention because she needed to go to the bathroom. At 3 am the client still had difficulty walking, was not really herself as exhibited by "being quiet and saying mama." After 3 am she continued to check on the client approximately every 15 minutes, and she also was checking on the other clients in the facility at the same frequency because the lights in the facility were out (reportedly due to a car hitting an electrical pole in the town.) Employee K reported she had no further direct interaction with the client after 3 am on November of 2006.

The progress notes in the client record documented as 7:45 am on November of 2006 entered by unlicensed employee H recorded: "Went to get (client #1) up for breakfast. Found her on floor between bed and dresser. Very unaware of what was happening, left arm bleeding, and bruise on left knee cap. Called RN and took vitals BP 157/61, P74, T 99.7 and blood sugar 142 was brought to ER". When interviewed on November 15 and 16, 2006, employee H stated she had checked on the client at 7:10 am and the client was in her bed at that time but when she went back to her room to get her up for breakfast, she found the client on the floor. She stated she called the facility RN and reported to the RN the client was on the floor, mumbling, not making sense and was "totally out of it" and was bleeding from her left arm. The RN instructed her to call another resident care assistant at their home, to come in and help her. Employee H indicated she called employee B at her home and employee B questioned her on the client's fall. Employee B instructed her to call 911 but employee H stated she informed employee B the facility RN had instructed her to call a facility employee to come in to help her get the client off the floor and take the client to the ER. Employee H indicated she did not want to call the facility RN back and talk with her about calling 911 as employee B had instructed her, because she had "issues" with the RN. Employee H stated she just wanted employee B to come in and help her. Employee H indicated she stayed with the client, holding her, until employee B arrived at the facility.

When interviewed on November 15, 2006, employee B stated she arrived at the facility at 8:15 am. Employee B provided a written statement regarding the occurrences of the morning of November 5, 2006. The document indicated when she arrived at the facility she obtained the client's vital signs, and "(client#1) was laying on the floor opening and shutting her eyes and would mumble something I couldn't understand when I ask questions. I called 911." Employee B indicated the first responders arrived at the facility within minutes.

According to the ambulance report, the call was received at 8:33 am (about 45 minutes after the client had been found on the floor) and arrived at the scene at 8:56 am. The emergency room record noted the client arrived at the ER around 9:35 am. The ER record documented the client: "At present starting to speak, speech slurred-resp shallow-deep and blowing type-suctioned x2 in route-throat congested noted-generalized bruising throughout upper chest around pacemaker, left knee, left should, chin, (this reviewer unable to read the entry at this point)." The examination portion of the ER record noted the client also had a large laceration on her left forearm. During the ER visit the client had a CT scan of her head which revealed she had an intracranial bleed. She was transferred to another hospital where she died the next day.

4. MN Statute §144A.46 Subd. 5(b)

AREA OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to perform a background study on one of two new employee's (N) records reviewed. The findings include:

Employee N began providing direct patient care on November of 2006. Employee N's record lacked evidence of an application for a background study or a background study. On interview, November 16, 2006, the Department of Human Services background study representative confirmed that they had not received an application for a background study for employee N. On November 16, 2006, the Assistant Director stated they had not sent in an application for a background study for employee N, and that they would have employee N sign for it when she returned to work on November 18, 2006.

5. MN Statute §626.557 Subd. 14(b)

AREA OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to provide a complete vulnerable adult assessment for two of two new client's (#18 and #19) records reviewed. The findings include:

Clients #18 and 19's service plans indicated that the clients began receiving services from the licensee in October of 2006. The clients' records contained an assessment entitled, "Assessment for Resident Vulnerability and Safety", which included areas of vulnerability and interventions if the client was assessed as vulnerable in that area. The assessment lacked the person's susceptibility to abuse by other individuals, including other vulnerable adults; the person's risk of abusing other vulnerable adults; and statement of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults.

On interview, November 16, 2006, the owner stated she was unaware the vulnerable adult assessment needed to include these vulnerabilities. The registered nurse (RN) who completed these assessments was no longer employed by the licensee.

A draft copy of this completed form was left (faxed to) with Linda Sand at an exit conference on November 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).

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail: # 7005 0390 0006 1220 3121

December 28, 2006

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

Re: Amended Licensing Follow Up visit

Dear Mr. Sand:

On August 16, 2006, you were sent an Informational Memorandum and a Notice of Assessment for Non-Compliance Letter as the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. Subsequent to that mailing, an error was noted in the information that was mailed. Enclosed are the corrected documents. The amended information in these documents that has been corrected is underscored and the stricken [~~stricken~~] information has been removed. Corrections have been made to **MN Rule 4668.0825 Subp.4** in the Informational Memorandum and the Notice of Assessment for Non-Compliance letters.

Since you have already paid **$50.00** of the assessed amount, you will only need to pay the balance of **$300.00** related to the Notice of Assessment for Non-Compliance, originally dated August 16, 2006, and modified on December 29, 2006. Please make the check payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

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

06/06 FPC1000CMRAMMENDED

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 2443

August 16, 2006

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

Re: Licensing Follow Up visit

Dear Mr. Sand:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on July 17, 18, 19, and 20, and 21, 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: Stearns County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

06/06 FPC1000CMR

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # ~~7005 0390 0006 1222 2443~~
7005 0390 0006 1220 3121

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

August 16, 2006 (Modified December 28, 2006)

Del Sand, Administrator
River Birch Residence
231 Washington Avenue Po Box 10
Holdingford, MN 56340

RE QL21260002:

Dear Mr. Sand:

On July 17, 18, 19, 20, and 21, 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 a survey completed on November 4, 7, 8, 16, and 17, and December 19, 20, and 21, 2005, with correction orders received by you on March 9, 2006.

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

5. MN Rule 4668.0810 Subp. 6 **$100.00**

Based on record review and interview, the licensee failed to maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include:

On September 22, 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation indicated client#1 returned from the hospital with a "fleets enema." On November 9, 2005, the "Communication Book" had an entry that stated, the client fell and hit her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to be called if any symptoms were noted. Neither of these incidents was documented in client #1's record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record.

Client #9 had two fall notations in the incident/accident reports and facility communication book. On November 1, 2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head.

On November 10, 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

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

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

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

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

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

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00.

7. MN Rule 4668.0815 Subp. 3 **$250.00**

Based on record review and interview, the licensee failed to ensure that the client or the client's responsible person agreed in writing to a service plan modification for one of five current clients (#2) records reviewed for service plans. The findings include:

Client #2's service plan was signed by the personal representative August 12, 2004 and indicated a "Double Occupancy Room" fee of $1700. On November 8, 2005, the director stated client #2 had had an increase in her fees from $1700 to $1800 in 2005. The director stated she did not know the exact date of the fee increase as the corporate office takes care of the billing and had sent out the letter to the clients and families. On November 8, 2005, client #2's personal representative stated s/he thought the fee increase was for February 1, 2005 and that s/he had received a letter indicating the fee increase approximately four to six weeks prior to receiving the bill with the $1800 fee. S/he said s/he had not authenticated any fee increase to the service plan. When interviewed November 8, 2005, the director confirmed that the client's service plan had not been modified to reflect the rate increase nor had the client's responsible person agreed in writing to the modification.

TO COMPLY: A modification of the service plan must be in writing and agreed to by the client or the client's responsible person before the modification is initiated. A modification must be authenticated by the client or the client's responsible person and must be entered into the client's record no later than two weeks after the modification is initiated.

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

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

Based on record review and interview, the licensee failed to provide a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include:

Client #1 and #2's service plans were authenticated on February 18, 2005 and August 12, 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete.

Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans.

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;

(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.

9. MN Rule 4668.0825 Subp. 4 ~~**$50.00**~~ **$350.00**

Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include:

Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the assisted living home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

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

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

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 assistance with medication administration for one of six current clients' (#1) records reviewed. The findings include:

Client #1's service plan, dated February 18, 2005, indicated she received daily medication administration. There was no evidence that the RN conducted a nursing assessment of the client's functional status and need for assistance with medication administration prior to providing the service. When interviewed, November 7, 2005, the RN verified that the assessment had not been conducted.

TO COMPLY: For each client who will be provided with assistance with self-administration of medication or medication administration, a registered nurse must conduct a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration, and develop a service plan for the provision of the services according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845, and must be maintained as part of the service plan required under part 4668.0815.

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

14. MN Rule 4668.0855 Subp. 5 **$350.00**

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) was informed within 24 hours of administration, or within a time period that was specified by a RN prior to the administration, when unlicensed personnel administered pro re nata (PRN, as needed) medications for two of six current clients' (#1 and #2) records reviewed. The findings include:

Client #1's medication administration record for November 2005 indicated that unlicensed personnel, including employee E, administered several PRN medications to the client on November 1, 2, 3, and 4, 2005. When interviewed, November 16, 2005, employee E stated she did not inform the registered nurse of the "PRN" medications given to client #1 November of 2005. Employee E stated that if the "PRN" medications are listed on the medication administration record, unlicensed employees could give these "PRN" medications to the clients without informing the registered nurse. However, if the clients were sick she would call the RN for assistance.

Client #2's medication administration record for October of 2005 indicated that unlicensed personnel administered an analgesic to client #2 on October 2, and 3, 2005, for complaints of ankle pain. When interviewed on November 4, 2005, employee B, an unlicensed staff the administers medication to client #2, stated that if "PRN" medications are given, the unlicensed personnel need to document on the back side of the medication administration record the name of medication given, date and time given, reason given and results. She also stated the unlicensed personnel do not notify the registered nurse, unless the client has a problem that requires a "PRN" that is not listed on the medication administration record. Then they would call the RN and she would advise them if they could use a standing order. On November 16, 2005, unlicensed employees E and F, who give medications, confirmed the above information provided by unlicensed employee B. When interviewed, November 7, 2005, the RN stated she reviewed the medication administration record monthly. She stated she had not specified a time period for informing her or established a protocol for her being informed of PRN medication administration.

TO COMPLY: A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

A. the medications are regularly scheduled; and

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration.

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

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

Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include:

Client #2's Service Plan, August 12, 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October 5, 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders.

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.

16. MN Rule 4668.0860 Subp. 2 **$350.00**

Based on record review and interview the licensee failed to have written prescriber orders for medications for two of six (#1and #2) current clients' records reviewed. The findings include:

Client #1 was readmitted to the facility February 18, 2005 after a two-month stay in a hospital and a nursing home. The nursing home had transferred a current copy of client #1's medication administration record, but had not included any orders signed by the physician, a physician assistant, a nurse practitioner, or other prescriber. Subsequent to admission on February 18, 2005, client#1s' physician had faxed some orders, however, several medications the client was receiving did not have physician orders. After this reviewer questioned the orders during the survey, the licensee attempted to obtain signed orders on November 8, 2005. The physician assistant refused to sign the medication orders citing that the client had left the nursing home against medical advice. When interviewed November 8, 2005, the director, stated the agency was providing assistance with all medication administration for client #1. She stated the agency was unaware that the medication administration record from the nursing home was not considered orders for the medications.

Client #2's service plan, dated August 12, 2004, indicated client #2 received medication administration. Client #2s' medication administration record indicated that on October 2, and 3, 2005; client #2 received a PRN (as needed) pain medication. There was no order for this medication. When interviewed, November 8, 2005, the director stated she was unaware they lacked an order for the analgesic.

The director then called the pharmacy and requested a faxed copy of the physician order for the pain medication. When interviewed December 21, 2005, the registered nurse stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders.

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

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

17. MN Rule 4668.0860 Subp. 8 **$500.00**

Based on record review and interview, the facility failed to implement orders for one of three discharged clients' (#9) records reviewed. The findings include:

Client #9 was admitted to the facility on October 6, 2004 from another healthcare facility. A telephone order October 6, 2004, from the physician, stated to discharge client #9 to the assisted living with current medications and treatments and to discontinue the client's Lantus insulin. The nursing discharge summary, dated October 6, 2004, included the following medication and treatments: Blood pressure checks every other day for two weeks and then update the physician, oxygen at 3-5 liters to keep oxygen saturation levels more than 90%, and glucometer (blood

sugar) checks twice daily with sliding scale insulin with meals. There was no evidence the orders had been implemented.

When interviewed December 21, 2005, the registered nurse (RN) stated she "felt the doctor was called" to clarify the orders related to the insulin, glucometer checks and oximeter readings and verified that there was no evidence the orders had been verified. She said that client #9 had an oxygen concentrator, managed her own oxygen, and that the facility did not have an oximeter to check her oxygen saturation levels. She stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders. The RN verified that there was no documentation of the blood pressure checks or physician notification related to blood pressure checks.

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

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

20. MN Rule 4668.0865 Subp. 3 **$300.00**

Based on observation, record review and interview the facility failed to establish a system for control of medications for four of five (#1, #2, #4 and #5) current clients reviewed that received central storage of medications. The findings include:

The medication administration record for client #1 indicated s/he received Lorazepam 0.5 milligrams November 1, 2005 as a "PRN" (as needed). Employee H, an unlicensed employee, administered the medication. Client #1's medication administration record indicated the resident was to receive "Lorazepam 0.5 mg. every 8 hours as needed." Documentation for this medication administration lacked the time, route, and reason for administration. When interviewed November 16, 2005 the registered nurse confirmed the documentation was incomplete. She stated that at the end of the month she reviewed the medication administration record and then had employees complete any documentation that was lacking for "PRN" medications given.

Client #2 had a September 25, 2005, prescriber order for Advil 200 milligrams (mg) one to two tablets every four hours PRN (as needed) for pain and fever. The medication administration record for client #2's "Advil" order read "Ibuprofen 200mg tab, Take 1-2 tablets every 4 hours as needed for pain and fever-Generic Advil." When observed, November 8, 2005, it was noted that the container of "ibuprofen" which was in central storage in the medication cart, had an expiration date of July 26, 2005. Client #2 had received ibuprofen 200mg, two tablets on October 2, and 3, 2005. When interviewed, November 8, 2005, the director stated that client #2 also had a new bottle of ibuprofen that was filled on September 25, 2005; however, the agency was unable to locate any other bottle of ibuprofen.

During observation of central storage of medications, November 8, 2005, it was noted that client #4's medications which were in central storage locked in the medication cart were in "dose

boxes" with medications set up for four weeks for each of the administrative times the client received medications. When interviewed, employee B, an unlicensed employee who assisted with medication administration, stated that client #4 received his medications from the Veterans Administration in bottles. This differed from the other clients, who received their medications in "bubble packs." When asked who set up the medications in the "dose boxes" employee B stated that the director, who is not a nurse set the medications up in the dose boxes. During an interview, November 16, 2005, employees E and F, unlicensed employees who assisted with medication administration, also stated that the director set up the medications for client #4 in the dose boxes. Once set up, the medications in the dose boxes were administered to client#4 by the unlicensed resident aids. When interviewed, November 8, 2005, the director denied setting up medications. The director stated the registered nurse, set up the medications into the dose boxes.

During observation of medication administration, November 8, 2005, for clients #1 and #5 employee B an unlicensed employee who assisted with medication administration**,** set the medication cups along side of the client's #1 and #5 plates and left the room before observing if the clients took their medications or not.

TO COMPLY: A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

B. The system must contain at least the following provisions:

(1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;

(2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;

(3) the procedures for recording medications that clients are taking;

(4) the procedures for storage of legend and over-the-counter drugs;

(5) a method of refrigeration of biological medications; and

(6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.

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~~:~~ ~~$2600.00~~ $2900.00.** 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.

August 18, 2006

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

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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

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

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

INFORMATIONAL MEMORANDUM

PROVIDER: RIVER BIRCH RESIDENCE

DATE OF SURVEY: July 17, 18, 19, 20 and 21, 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:
Melissa Olson, RN
Becky Roering, Resident Care Assistant
Joann Breth, Resident Care Assistant
Judy Roering, Resident Care Assistant

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 November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 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 is as follows:

1. MN Rule 4668.0065 Subp. 1 **Corrected**

2. MN Rule 4668.0805 Subp. 4 **Corrected**

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

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

5. MN Rule 4668.0810 Subp. 6 Not Corrected $100.00

Based on record review and interview, the licensee failed to maintain a complete record for two of ten (#13 and #15) current client's records reviewed. The findings include:

An entry in the facility "communication book" dated July 13, 2006 documented that Client # 15 was exhibiting "weird behavior" such as "asking for pop three times in two minutes, went to laundry room, came out, went out the exit doors, came back out, then walked down the hallway. A few minutes later he was trying to get into the staff restroom. During snack time he sat for about ten minutes moving his feet up and down while banging his spoon in his ice cream dish." Client # 15 had a diagnosis of Paranoid Schizophrenia. There was no documentation in the client permanent record that he had exhibited these behaviors.

An incident report dated June 15, 2006 indicated Client # 13 had fallen off the toilet and said she hit her head. There was no documentation of this incident in Client # 13's permanent record.

When interviewed, July 19, 2006, the registered nurse, indicated she had ongoing education of staff regarding documenting incidents in the permanent record.

6. MN Rule 4668.0815 Subp. 1 Corrected

7. MN Rule 4668.0815 Subp. 3 Not corrected $250.00

Based on record review and interview, the licensee failed to ensure that the client or the client's responsible person agreed in writing to a service plan modification for one of ten (#16) current client records reviewed. The findings include:

Client #16 had a service plan dated May 26, 2006 and a contractor checklist dated July 1, 2006 that added incidental nursing monthly to his services. The client was his own responsible party and had not agreed to this modification of the service plan in writing.

When interviewed, July 18, 2006, the registered nurse, stated that she was unaware she needed to have the modification from the county added to the service plan and authenticated by the client or the client's responsible person.

8. MN Rule 4668.0815 Subp. 4 Not corrected $50.00

Based on record review and interview, the licensee failed to provide a complete service plan for four out of ten (#1, #2, #13, and #14) current client's records reviewed. The findings include:

Client's #1 and # 2 had service plans dated April 18, 2006. Client # 13's and #14's service plans were dated June 1, 2006 and June 25, 2006, respectively. Client's #1's, #2's, #13's and #14's contingency plans lacked the action to be taken by the clients responsible person if essential services could not be met. Clients # 1, #13 and # 14's service plans also lacked the frequency of services.

When interviewed by phone, July 20, 2006, the registered nurse (RN) stated she had the frequency of services on the private pay service plans but not on service plans for clients with county payment contracts.

9. MN Rule 4668.0825 Subp. 4 **Not corrected** ~~**$50.00**~~ **$350.00**

Based on record review and interview the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed and written instructions for performing the procedures for each client, for five of five unlicensed employees' (B, H, J, L and M) records reviewed who performed delegated nursing tasks. The findings include:

Client #10's medication administration record for June and July, 2006 indicated employees H, J and L provided assistance with medication administration of a trans dermal administered drug. The records lacked documentation of training or demonstrated competency for the delegated nursing task of administration of trans dermal medications for employees H, J and L. Client #10's Care Record for June, 2006, indicated employees B and H had assisted client #10 with application of a back brace. The records lacked documentation of training or demonstrated competency for the delegated nursing task of back brace application for unlicensed employees B and H.

The facility's "Communication Book" had an entry dated June 8, 2006, by the registered nurse (RN) which stated, Client #10 "has a back brace. I want each shift to train in the next shift on it so we all know how to use it." When interviewed, July 20, 2006, the RN stated she had the unlicensed employees verbally demonstrate competency for the administration of the trans dermal medication, prior to the administration of the medications, however, she had not documented the competency and had not specified in writing specific instructions for performing the administration of the trans dermal medication. The RN also stated she had instructed employees B and H on the application of the back brace for client #10 and that they had demonstrated to her their competency in performing the application, however, she had not documented the competency. When interviewed, July 20, 2006, employee H stated that she had received verbal training from the RN on the administration of the trans dermal medication and application of the back brace. She stated she had verbally demonstrated to the registered nurse how she would apply the medication and back brace.

Client #16 returned from the Emergency Room on July 9, 2006, with physician orders to cleanse, apply ointment, 4x4's and Kerlix to the areas of cellulitis on his legs. The client's record lacked specific written instructions for the procedure. When interviewed, July 19, 2006, the RN stated that on July 19 and 20, 2006, she had demonstrated the dressing change procedure to employees B, J, L, and M, but she did not provide any written instructions for the dressing change. The RN indicated she did not document the training she provided to the employees. Employee B was interviewed on July 20, 2006, and verified the RN had demonstrated the dressing change procedure to her.

10. MN Rule 4668.0835 Subp. 3 **Corrected**

11. MN Rule 4668.0840 Subp. 3 **Corrected**

12. MN Rule 4668.0845 Subp. 2 **Corrected**

13. MN Rule 4668.0855 Subp. 2 **Not corrected** **$350.00**

Based on record review and interview the licensee failed to ensure a registered nurse (RN) conducted a nursing assessment of the client's functional status and need for assistance with medication administration for one of ten (#11) current client records reviewed. The findings include:

Client #11's service plan dated March 30, 2006, indicated she received daily medication administration. There was no evidence the RN conducted a nursing assessment of the client's functional status and the need for assistance with medication administration. When interviewed, July 19, 2006, the RN verified an assessment had not been completed.

14. MN Rule 4668.0855 Subp. 5 **Not corrected** **$350.00**

Based on record review and interview the licensee failed to ensure a registered nurse (RN) was informed within 24 hours of administration when an unlicensed personnel administered a pro re nata (PRN) medication for one of ten (#10) current clients records reviewed. The findings include:

When interviewed July 19, 2006, concerning the facility's PRN medication policy, the RN stated unlicensed staff members are to call her before they administer any PRN medications that are not listed on the facility's standing orders. The RN indicated she was working with staff to educate them to contact her before they administer a client's PRN medication which is not contained on the facility's standing orders.

Client #10's medication administration record indicated unlicensed personnel administered PRN medications to the client approximately 70 times during the month of June 2006. During the course of the follow up site visit conducted July 17th through the July 21, 2006, several unlicensed staff were interviewed. One unlicensed staff member interviewed stated she administered numerous PRN medications to client #10, but she did not call the RN each time she administered a PRN because the client receives PRN medications so frequently. Another unlicensed staff member who also administered client #10 numerous PRN medications during the month of June 2006 was interviewed during the course of the follow up site visit. The staff member stated she routinely called the RN anytime she administered a PRN medication that was not on the client's standing orders. The staff member stated each time she contacted the RN she documented this in the staff communication book or in the client's record. Client #10's medication administration record indicated she had received Percocet, Oxycontin 10 mg, Oxycodone 5mg., and Tylenol #3, forty-seven times as a "PRN" medication, from June 1, 2006 through July 19, 2006. Client's #10's medical record and the communication book for the month of June were reviewed and there was no documentation in either document indicating the RN had been notified when client #10 was administered a PRN medication.

15. MN Rule 4668.0855 Subp. 9 Not corrected $300.00

Based on record review and interview the licensee failed to administer medications as prescribed to two of ten (#5 and #10) current clients reviewed. The findings include:

Client #5's service plan dated April 18, 2006, indicated the client was to have assistance with medication administration and central storage of medications. The July 2006 medication administration record indicated client #5 was to receive Acetaminophen 325 mg. two tablets (650mg.) four times daily. On July 9, 2006, the 5PM dose was not initialed as given. The medication administration record lacked documentation of the reason why it was not administered as ordered. When interviewed, July 19, 2006, the registered nurse (RN) indicated that she reviewed the medication administration records at the end of the month and informed the staff of the need to document medications that were not documented.

Client #10's medication administration record for July 10, 2006 indicated, by the initials of the unlicensed personnel administering the medications being circled, that Ranitidine 300mg. was not administered, as ordered. The back of the medication administration record for July 10, 2006, stated, "7/10/06; 8PM; Zantac; not given; forgot-sorry!" and the name of the unlicensed personnel administering medications for that shift. When interviewed, July 19, 2006, the RN stated all of the current clients received central storage of medications and assistance with administration of medications. On July 19, 2006, when asked for the medication error reports for the past three months, the registered nurse stated that there have not been any medication errors since March of 2006 when she has began employment at the facility.

16. MN Rule 4668.0860 Subp. 2 Not corrected $350.00

Based on record review and interview the licensee failed to have written prescriber orders for medications for two of twelve (#10 and #12) clients' records reviewed. The findings include:

Client #10 was readmitted to the facility July 1, 2006 after a 2-day hospital stay. On June 28, 2006, the physician had written orders to give the client "Prevacid, ASA, and Synthroid as ordered morning of surgery 6/30/06. Hold all other meds ordered on MAR" (medication administration record) On return, from the hospital, the hospital sent a "Discharge Medication Instruction Sheet" which included a list of the client's medications and when they had last been administered. The sheet was signed by the hospital's registered nurse and the client's responsible person but did not include any physician's signature. On July 6, 2006, the licensee's registered nurse, faxed the primary physician and stated, client #10 "Had surgery on 6/30/06. May we resume current meds? Copies of current meds are attached." The signed, fax order was returned from the physician July 7, 2006, contained an order for "ASA EC 325 mg. Q AM" and no comment on resuming the previous medications. When phone interviewed by phone, July 20, 2006, the registered nurse (RN) stated that the licensee's unlicensed staff was providing assistance with medication administration for client #10. According to the RN, upon return from the hospital, client #10 also received home care services from another agency, and the unlicensed staff had been instructed by the RN to call the on-call RN from the other agency upon the client's return from the hospital. The licensee's registered nurse stated that on July 1, 2006, the registered nurse from the home care agency told the licensee's unlicensed staff that they could administer the medications as listed from the hospital's "Discharge Medication Instruction

Sheet" even though they did not have a signed physician order to resume these medications. The July 2006 medication administration record for client #10 indicated the client had received ASA, Furosemide, Levothyroxin, Plavix, Potassium, Prevacid, Warfarin, Ranitidine, Acetaminophen, Duragesic, and Tylenot #3 since her , July 1, 2006 return from the hospital.

Client #12 was admitted to the facility on May 26, 2006. The client was administered Ciprofloxacin and Tylenol May 26 through May 30, 2006, the five days he resided in the facility before he was admitted to the hospital. There were no prescriber's orders for the medications the licensee had administered. The client's record contained a fax sent to the client's physician dated May 26, 2006, but the fax ordering the medications had not been signed by the physician and returned to the licensee. When interviewed July 19, 2006, the RN verified there were no physician orders for client #12's medications the licensee had administered.

17. MN Rule 4668.0860 Subp. 8 Not corrected $500.00

Based on record review and interview the facility failed to implement orders within twenty-four hours for one of ten (#5) current client records reviewed. The findings include:

The facility "Communication Book" had an entry by the registered nurse (RN) dated, May 22, 2006 which stated, "Please be sure to check all papers that come back with residents after appointments and from fax machine for new orders." It further stated client #5 "had orders from 5/16/06 that were sitting on my desk. I need to be called about them." A physician order dated May 16, 2006, indicated, "Hot compress to both eyes, 2 times each week, ongoing." The medication administration record for May 2006 indicated the client did not receive "hot compresses" to the eyes until May 23, 2006 seven days later. The medication administration record did not indicate any reason why the compresses were not administered until May 23, 2006. When interviewed by phone, July 20, 2006, the RN stated she could not remember the circumstances of the incident and would have to look into it.

18. MN Rule 4668.0860 Subp. 9 Corrected

19. MN Rule 4668.0865 Subp. Corrected

20. MN Rule 4668.0865 Subp. 3 Not corrected $300.00

Based on observation, record review, and interview the licensee failed to establish and maintain a system for control of medications for three of ten current clients (#1, #2 and #10) reviewed. The findings include:

Client #1 had a physician order dated May 23, 2006, to change her Coumadin to a 3mg, 3mg, and 2mg. rotation every three days. The client's 2 mg. and 3 mg. Coumadin medication bubble packs were observed July 20, 2006, and did not reflect the current physician's order. The prescription label on the medication bubble pack containing Coumadin 2 mg. indicated the 2 mg. of Coumadin was to be administered daily alternating with 3 mg. of Coumadin. The prescription label on the medication bubble pack containing Coumadin 3 mg. indicated the 3 mg. of Coumadin was to be administered daily alternating with 2 mg. of Coumadin. On July 20, 2006, employee B verified the mislabeled Coumadin prescription labels. Employee B stated the

Coumadin orders changed frequently and often the prescriptions labels were not the same as the current physician's orders.

Client #1's July 2006 medication administration record (MAR) noted the client was scheduled to receive Coumadin 3 mg. at 5:00 pm on July 18, 2006, but this space was blank. The client's 3 mg. Coumadin dated medication bubble pack still contained 3 mg. tablets of Coumadin in the slots of the bubble pack dated July 17, 18 and 19, 2006. When interviewed July 20, 2006, employee B stated the administration of the Coumadin from the dated bubble packs do not coincide with the dates on the bubble packs because of the frequent changes in the Coumadin orders. Employee B indicated it was the licensee's policy to check each client's dated medication bubble packs at the end of each shift to assure all medications had been administered for the shift. In this instance it could not be determined if the Coumadin had been administered since the prescription label did not reflect the current physician's order.

Client #1's record indicated client #1 was receiving Ativan 0.5 mg. every night from April through the survey review July 19, 2006. A physician's order in the client's record at the time of the review indicated the current order was Ativan 0.5 mg at the time of sleep "as needed." When interviewed, July 19, 2006, the registered nurse (RN) stated she had just received a signed fax from the physician ordering the Ativan to be administered every night. The RN stated she received a verbal order from the physician March 12, 2006, to administer the client's Ativan every night. She was unable to locate documentation of the verbal order.

Client #2's medication administration dated bubble packs were observed July 20, 2006. There were two tablets of Tylenol Arthritis 650 mg. were in the medication bubble packs dated July 14, 2006 and July 16, 2006. The client's medication administration record was documented that the Tylenol had been administered as ordered on July 14 and 16, 2006. When interviewed on July 20, 2006, employee H stated she had previously noted the Tylenol in the bubble packs in dates past due for administration and reported this to the RN. Employee H stated she was informed by the RN, due to the client's frequent leave of absences from the facility that medications would be left in the bubble packs. The client's record did not contain any indication that the client had been absent from the facility on July 14 and 16, 2006. When interviewed, July 21, 2006, the RN indicated she had been educating staff to always document the reason when a medication was not administered as ordered.

Client #10's physician orders dated July 14, 2006,ordered a Coumadin change from Coumadin 2 mg. daily to Coumadin 2 mg. alternate with 1 mg. When observed, July 19, 2006, client #10's Coumadin 2 mg. "Bubble Pack" directions for use stated, "Take 1 tablet daily. GENERIC FOR COUMADIN. Warfarin 2 mg. TAB." When interviewed July 19, 2006 employee E stated that when there is a change in dosage of medications the label is not changed until it is refilled.

Client #10's medication administration record for July 10, 2006 indicated, by the initials of the unlicensed personnel, administering the medications, being circled, that the Ranitidine 300mg. was not administered. The back of the medication administration record for July 10, 2006, stated "7/10/06; 8PM; Zantac; not given; forgot-sorry!" and the name of the unlicensed personnel administering medications for that shift. On July 19, 2006, when asked for the Medication Error Reports for the past three months, the registered nurse stated that there have not been any medication errors since March of 2006 when she began employment at the facility.

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

22. MN Statute §144A.46 Subd. 5(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 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: RIVER BIRCH RESIDENCE
HFID # (MDH internal use): 21266
Date(s) of Survey: July 17, 18, 19, 20, and 21, 2006
Project # (MDH internal use): QL21266002

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 Follow Up #1

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 ___ Correction Order(s) issued ___ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff observe infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	___ Met _X_ Correction Order(s) issued _X_ Education Provided Follow Up #1
4. The agency has a system to receive, investigate, and resolve complaints from its clients and/or their representatives. (MN Rule 4668.0040)	There is a formal system for complaints. Clients and/or their representatives are aware of the complaint system. Complaints are investigated and resolved by agency staff.	___ Met ___ Correction Order(s) issued ___ Education provided
5. The clients' confidentiality is maintained. (MN Statute 144A.44; MN Rule 4668.0810)	**Client personal information and records are secure.** **Any information about clients is released only to appropriate parties.** Permission to release information is obtained, as required, from clients and/or their representatives.	___ Met ___ Correction Order(s) issued ___ Education provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	____ Met ____ Correction Order(s) issued ____ Education provided
7. The agency employs (or contracts with) qualified staff. (MN Statutes 144D.065; 144A.45, Subd. 5; MN Rules 4668.0070, 4668.0820, 4668.0825, 4668.0030, 4668.0835, 4668.0840)	Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff who are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	____ Met ____ Correction Order(s) issued ____ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	____ Met ____ Correction Order(s) issued ____ Education provided ____ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	____ Met ____ Correction Order(s) issued ____ Education provided ____ N/A

Indicators of Compliance	Outcomes Observed	Comments
10. The agency has a current license. (MN Statutes 144D.02, 144D.04, 144D.05, 144A.46; MN Rule 4668.0012 Subp.17) Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	The ALHCP license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. The agency operates within its license(s).	____ Met ____ Correction Order(s) issued ____ Education provided

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
1	MN Rule 4668.0815 Subp. 2 Service Plan Reevaluation	X	X	Based on record review and interview the licensee failed to have a registered nurse (RN) review each client's evaluation annually for two of two client's (#1 and #2) records reviewed who resided in the facility for a year or more. The findings include: Client #1 was admitted to the facility on October of 2004. The "RN Evaluation/Baseline Assessment was dated September 13, 2004. There was no evidence of an annual review of the client's initial evaluation. When interviewed, July 18, 2006, the RN verified that the record did not contain a more current evaluation. Client #2 was admitted to the facility

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				July 9, 2002. The "RN Evaluation/Baseline Assessment dated August of 2004. When interviewed July 18, 2006, the RN verified that the record did not contain a more current client evaluation. **Education:** Provided
3	MN Rule 4668.0805 Subp. 2 Orientation to Home Care, Content	X	X	Based on record review and interview the licensee failed to provide the complete required contents of orientation to home care for two of eight (I and E) employee's records reviewed. The findings include: Employee E and I were hired July of 2004, and March of 2006 respectively. Employee E's record indicated she had received orientation to reporting the maltreatment of vulnerable adults; the Home Care Bill of Rights; the handling of emergencies; the handling of client complaints and reporting to the office of Health of Health Facility Complaints. The orientation lacked the overview of the home care Statute and Rules, and the services of the Ombudsman. Employee I's record indicated she had received orientation to reporting the maltreatment of vulnerable adults and the home care bill of rights. Employee I had not received orientation to the overview of the home care Statute and Rules; the handling of emergencies; the handling of clients' complaints; or the services of the Ombudsman. When interviewed, July 18, 2006, employee I stated she was not given this orientation and was not aware she needed to orientate staff on this rule. When interviewed, July 18, 2006, employee E stated she thought she may have had orientation to the home care

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				Statute and Rules by the previous director, however, she stated she could not be sure. **Education:** Provided

A draft copy of this completed form was left with Melissa Olson, RN at an exit conference on July 21, 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 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) 201-4301. 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 3/06)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 9014

March 6, 2006

Del Sand, Administrator
River Birch Residence
231 Washington Avenue PO Box 10
Holdingford, MN 56340

Re: Results of State Licensing Survey

Dear Mr. Sand:

The above agency was surveyed on November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 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: Del Sand, President of Governing Board
Stearns County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
CMR File

Assisted Living Home Care Provider

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

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Name of ALHCP: RIVER BIRCH RESIDENCE

HFID # (MDH internal use): 21266

Date(s) of Survey: November 4, 7, 8, 16, and 17, 2005 and December 19, 20, and 21, 2005

Project # (MDH internal use): QL21266002

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.	_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.	___ Met _X_ 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.	___ Met _X_ Correction Order(s) issued _X_ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	___ Met _X_ Correction Order(s) issued _X_ Education provided ___ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ___ Correction Order(s) issued ___ Education provided ___ N/A
10. The agency has a current license. (MN Statutes 144D.02, 144D.04, 144D.05, 144A.46; MN Rule 4668.0012 Subp.17) Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	The ALHCP license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. The agency operates within its license(s).	_X_ Met ___ Correction Order(s) issued ___ Education provided

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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. 1 Evaluation; documentation			Based on record review and interview, the facility failed to have a service plan for one of three discharged clients' (#9) records reviewed. The findings include: Client #9 was admitted to the facility on October of 2004, and discharged November of 2004. There was no service plan in the client's record. When interviewed December 21, 2005, the registered nurse and the director was unable to locate a service plan for the client. **Education:** Provided
1	MN Rule 4668.0815 Subp. 3 Modifications	X	X	Based on record review and interview, the licensee failed to ensure that the client or the client's responsible person agreed in writing to a service plan modification for one of two current clients (#2) records reviewed. The findings include: Client #2's service plan was signed by the personal representative August of 2004 and indicated a "Double Occupancy Room" fee of $1700. On November 8, 2005, the director stated client #2 had had an increase in her fees from $1700 to $1800 in 2005. The director stated she did not know the exact date of the fee increase as the corporate office takes care of the billing and had sent out the letter to the clients and families. On November 8, 2005, client #2's personal representative stated s/he thought the fee increase was for February of 2005 and that s/he had received a letter indicating the fee increase approximately four to six weeks prior to receiving the bill with the $1800 fee. S/he said s/he had not authenticated any fee increase to the service plan. When interviewed November 8, 2005, the director confirmed that the client's service plan had not been modified to reflect the rate increase nor had the

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				client's responsible person agreed in writing to the modification. **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 a complete service plan for two of five current clients' (#1, and #2) records reviewed for service plans. The findings include: Client #1 and #2's service plans were authenticated on February of 2005 and August of 2004, respectively. Both service plans lacked the identification of the persons or category of persons who were to provide housekeeping, laundry, nutritional services, and activities. Also, the frequency of activities was not indicated and the contingency plans were incomplete regarding the action to be taken by the client's responsible person if essential services could not be met. When interviewed, November 4, 2005, director confirmed the clients' service plans were incomplete. Client #1 and client #2 both received central storage of medication from the licensee. Neither client#1 nor client#2 had service plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the inclusion of central storage of medication in service plans. **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 two of six current clients (#1 and #2) and one of three discharged clients' (#9) records reviewed. The findings include: Client #1's "Resident Face Sheet"

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				indicated she was admitted to the facility on October of 2004. However, the medication administration record and care sheets indicated that the client was admitted and began receiving cares on October of 2004. During the initial review of client #1's record, November of 2005, there was no evidence of supervisory visits. This reviewer inquired about documentation and none was available for review. Upon return to the agency November of 2005 client #1s' record contained an "RN/LPN Supervisory Visit Form" that was signed to indicate the RN performed a supervisory visit on August 1, 2004 and October 1, 2004, (two months and one week respectively prior to the clients' admission and receipt of services) and had observed the delegated task of "meds" even though the client had not been admitted until October of 2005 with services beginning October of 2005. When interviewed November 16, 2005, the RN stated that she might have put the wrong date on the form related to the August 1, 2004 supervisory visit. The RN also stated she had done the supervisory visit for October 1, 2005, however, had pulled the supervisory form (which also included the August 1, 2005 visit) and had not yet returned it to the record. The RN also stated that even though the supervisory form was dated "August 1, 2005 and October 1, 2005" she might have done the supervisory visit on the 30th of the month or the 2nd. She confirmed that she predated the forms for the first of every other month in order to keep track of the requirement for the every 62 days visit. The RN added that when she was hired the clients lacked records; however there was a "stack of papers" with documentation for the clients in the facility. The RN stated she had to start somewhere for documenting the supervisory visits, so she picked a date to start the documentation. Client #2's service plan, dated August of 2004, indicated she was receiving medication administration and other delegated nursing duties. The only supervisory visit documented was August of 2005 (fifty one weeks after admission).

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				When interviewed November 16, 2005, the RN stated that supervisory visits had not been entered into the record. She stated that she saw clients more often than every 62 days and would observe "interactions" between the clients and staff. Client #2's record contained a ""RN/LPN Supervisory Visit Form" that contained predated documentation areas for three supervisory visits by the nurse. The RN had signed all three-signature areas, although only one of the areas had documentation of a supervisory visit on August of 2005. Client #9 was admitted to the facility October of 2004 and began receiving services, including medication administration, October of 2004. The client's record lacked documentation that a fourteen-day supervisory visit had been conducted. When interviewed December 21, 2005, the RN stated that fourteen day visits were not being done at the time the client was admitted. **Education:** Provided
2	MN Rule 4668.0030 Subp. 4 Content of notice		X	**Education:** Provided
2	MN Statute §144A.44 Subd. 1(2) Home care bill of rights	X	X	Based on record review and interview, the licensee failed to provide services according to acceptable medical and nursing standards for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include: Client #1 received central storage of medications and medication administration. The licensee received a faxed order on October 12, 2005, to hold the client's Coumadin (anticoagulant medication) and Aspirin one week preoperative. An additional order on the bottom of the fax stated to hold the Coumadin five days prior to surgery and that the client had an appointment with the doctor on October 25, 2005 with the time to be determined. The director's (a non-nurse) signature, with a date of October 12, 2005, was noted on the bottom of the faxed order.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				When interviewed November 18, 2005, the director stated that when she received the faxed order she had called the clinic to verify which order was correct. She stated she could not remember which new order was received, "but it must have been the five day order as they held the Coumadin from October 22, 2005 through October 27, 2005, according to the October medication administration record." The director stated that after returning from the October 25, 2005 appointment, client #1 told her that the surgery was canceled. The director stated that there was not a new order as to when to resume the Coumadin. An entry by employee G, an unlicensed employee, in the facility communication book, dated October 27, 2005, indicated s/he telephoned the director and asked if s/he should administer the Coumadin to client #1, since the client stated that s/he was not having the scheduled surgery. The documentation indicated that the director told employee G to go ahead and give client #1 the Coumadin "tonight." The record lacked orders as to how Coumadin administration was to take place after the surgery was canceled. The director, who is not a nurse, delegated to employee G, an unlicensed personnel, the delegated task of medication administration without a physician order. The record lacked any evidence the registered nurse (RN) had been notified of the discrepancy in orders after the surgery had been canceled. Client #9 was admitted to the facility on October of 2004 from another healthcare facility. Client #9's diagnoses included diabetes and severe chronic obstructive pulmonary disease (COPD). A telephone order from the physician, dated October 6, 2004, stated the client was to be discharged to the assisted living with current medications and treatments and to discontinue the Lantus insulin. The nursing discharge summary, dated October 6, 2004, included the following medication and treatments:

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				Blood pressure checks every other day for two weeks and then update the physician, oxygen at 3-5 liters to keep oxygen saturation levels more than 90%, and glucometer checks twice a day and sliding scale regular insulin with meals. The RN nursing assessment, dated October 6, 2004, indicated the client had diabetes and COPD. The assessment did not address the orders related to the client's blood pressure, oxygen and diabetic needs. Client #9 had two incidents based on a review of incident and accident reports and the facility communication book. On November 1, 2004 at 10:30 p.m. the client fell out of bed and stated she had hit her head. The incident report indicated the RN was not notified until November 4, 2004. On November 10, 2004 at 1:15 a.m. the client fell out of bed and complained of pain in her right shoulder and on the right side of her head by her ear. The incident report indicated the RN was not notified until November 11, 2004. The facility policy related to incidents indicated the RN was to be notified to assure the client received the proper treatment. When interviewed, December 21, 2005, the RN could not recall that she had been notified of the incidents. There was no evidence the RN was notified at the time of incident, the same shift or the same day of the incidents. The RN also stated that client #9 managed her own oxygen and verified that the nursing assessment did not address the client's needs. **Education:** Provided
3	MN Rule 4668.0065 Subp. 1 Tuberculosis screening	X	X	Based on record review and interview, the licensee failed to provide tuberculosis screening prior to direct client contact for two of four (C and D) employees reviewed. The findings include: Employee C, was hired March of 2004 and had direct client contact. Employee Cs' records contained documentation of a negative Mantoux test, dated May of 2005. There was no other documentation of tuberculosis testing in the record. During

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				an interview November 8, 2005 employee C stated a Mantoux test had been done during a previous employment and not ate the time of hire for this licensee. Employee C provided the reviewer with documentation of a negative Mantoux test dated November of 2002. Employee C's Mantoux tests were done 16 months prior to his/her employment and 30 months after the most recent Mantoux test. Employee D was hired Augustof 2005 as a direct caregiver. There was no documentation of tuberculosis screening in employee D's records. When interviewed November 8, 2005, the director stated that employee D had not had a Mantoux test done. **Education:** Provided
3	MN Statute §144A.46 Subd. 5(b) Background Study	X	X	Based on record review and interview the licensee failed to perform a background study for one of one (A) licensed employees reviewed. The findings include: Employee A's date of hire was listed as May of 2004. There was no background study on file. When interviewed, November 7, 2005, employee A stated s/he had had several background studies done for various counties but did not have a DHS background study done nor had there been a study done for this agency. During the survey, November 7, 2005 the licensee's corporate office requested a background study for employee A. **Education:** Provided
5	MN Rule 4668.0810 Subp. 3 Retention	X	X	Based on record review and interview, the licensee failed to retain records for one of two current clients' (#2) records reviewed. The findings include: Client #2 was admitted July of 2002 and the client's responsible person signed the service plan in the client's record on August of 2004. There was no evidence of a prior service plan. When interviewed November 16, 2005, the director stated that she did not know where the client's previous service plan was. **Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
5	MN Rule 4668.0810 Subp. 5 Form of entries	X	X	Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name and title of the person making the entry in one of two (#1) current client records reviewed. The findings include: Client #1's record contained "progress notes" with entries by care attendants in February of 2005, March of 2005, April of 2005, June of 2005, and September of 2005 that lacked the documenter's full name and title. When interviewed, November 7, 2005, the director confirmed that the documentation lacked the full names and titles of the staff making the entries. **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 maintain a complete record for one of six current clients (#1) and one of three discharged clients' (#9) records reviewed. The findings include: In September of 2005, Client #1 "complained of constipation and pain" and was taken to the hospital by the client's friend according to the "Communication Book." Communication book documentation indicated client#1 returned from the hospital with a "fleets enema." In November of 2005, the "Communication Book" had an entry that stated, the client fell and hit her/his head while at a doctor appointment. The client had a "pretty large bump" and was complaining of back pain. The client was taken to the hospital (by the director) for an evaluation. The client returned to the facility and was to be monitored for headache, increased confusion and pain. Ice and pain medication were also to be used. The registered nurse was to be called if any symptoms were noted. Neither of these incidents was documented in client #1's record. On interview, November 17, 2005, the director stated she had not had time to record the incidents in the record. Client #9 had two fall notations in the incident/accident reports and facility communication book. In November of

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				2004 at 10:30 p.m. client #9 fell out of bed and stated s/he had hit his/her head. Nine days later in November of 2004 at 1:15 a.m. the client #9 fell out of bed and complained of pain in his/her right shoulder and on the right side of his/her head by the ear. Neither of the incidents was documented in the client's record. When interviewed, December 19, 2005, the director stated the incidents should have been documented in the client's record. **Education:** Provided
7	MN Rule 4668.0805 Subp. 4 Verification and documentation	X	X	Based on record review and interview, the licensee failed to retain documentation that each employee had completed orientation to home care for two of four employees' (A and C) records reviewed. The findings include: Employee A and C were hired on May of 2004 and March of 2004, respectively. Their records did not contain documentation that they had completed the orientation to home care before providing home care services. When interviewed November 4, 2005, employees A and C stated that they had received this training, but confirmed there was no documentation of the training in their personnel records. **Education:** Provided
7	MN Rule 4668.0825 Subp. 4 Performance of routine procedures	X	X	Based on record review and interview, the licensee failed to retain documentation for demonstration of competency for delegated nursing tasks performed for two of five unlicensed employees' (B and D) records reviewed who preformed delegated nursing tasks. The findings include: Client #2's weekly documentation indicated employee D provided assistance with showers on August 7, 11, 15, 22, and 29, 2005 and employee B assisted the client with showers on August 4, and 7, 2005. The records lacked documentation of training or demonstrated competency for the delegated nursing task of showers for employees B and D.

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				When interviewed November 9, 2005, employee D stated that the registered nurse (RN) had trained her and observed her performing the shower task on a client. Employee B also confirmed she had been trained by the RN on the delegated task. On November 8, 2005, the director verified that there was no documentation of training and competency for this delegated nursing task for employees B and D. **Education:** Provided
7	MN Rule 4668.0835 Subp. 3 In-service training and demonstration of competency	X	X	Based on record review and interview, the licensee failed to assure eight hours of in-service training in topics relevant to the provision of home care services, in the past 12 months for one of five unlicensed staff (B) reviewed who provided direct client care. The findings include: Employee B was hired January 26, 2004. His/her in-service training records contained documentation of one in-service hour for July 7, 2004, August 9, 2004 and October 21, 2004. The records also indicated s/he had training on the topics of "Ethics; Safety; Death and Dying; TB (tuberculoses); BBP," however the records lacked the dates and length of time of the in-services. When interviewed November 7, 2005, employee B stated s/he did not have any other in-service hours other than what s/he had received at the facility. When interviewed, November 8, 2005, the director stated they generally include in-service training with their monthly meetings and confirmed employee B's records were incomplete regarding the length of time for the in-service training. **Education:** Provided
7	MN Rule 4668.0840 Subp. 3	X	X	Based on record review and interview, the licensee failed to ensure complete training for one of five unlicensed employees' (B) records reviewed who provided direct client care. The findings include: Employee B was hired January 26, 2004, to provide direct care. Employee B's core

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				training record lacked evidence that the following topics were included in her training and competency evaluation: communication skills; observing, reporting, and documenting client status and care; basic infection control; maintaining a clean, safe and healthy environment; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and physical, emotional and developmental needs of clients and ways to work with clients who have problems in these areas. When interviewed November 7, 2005, the director stated there was no additional information available related to employee B's training and indicated that the nurse who did the orientation with employee B was no longer employed by the provider. **Education:** Provided
8	MN Rule 4668.0855 Subp. 2 Nursing assessment and service plan	X	X	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 assistance with medication administration for one of six current clients' (#1) records reviewed. The findings include: Client #1's service plan, dated February of 2005, indicated she received daily medication administration. There was no evidence that the RN conducted a nursing assessment of the client's functional status and need for assistance with medication administration prior to providing the service. When interviewed, November 7, 2005, the RN verified that the assessment had not been conducted. **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 a registered nurse (RN) was informed within 24 hours of administration, or within a time period that was specified by a RN prior to the administration, when unlicensed personnel administered pro re nata (PRN, as needed) medications for two of six current clients' (#1 and #2) records reviewed. The findings include:

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				Client #1's medication administration record for November 2005 indicated that unlicensed personnel, including employee E, administered several PRN medications to the client on four different days in November of 2005. When interviewed, November 16, 2005, employee E stated she did not inform the registered nurse of the "PRN" medications given to client #1 November of 2005. Employee E stated that if the "PRN" medications are listed on the medication administration record, unlicensed employees could give these "PRN" medications to the clients without informing the registered nurse. However, if the clients were sick she would call the RN for assistance. Client #2's medication administration record for October of 2005 indicated that unlicensed personnel administered an analgesic to client #2 on two different days in October of 2005, for complaints of ankle pain. When interviewed on November 4, 2005, employee B, an unlicensed staff the administers medication to client #2, stated that if "PRN" medications are given, the unlicensed personnel need to document on the back side of the medication administration record the name of medication given, date and time given, reason given and results. She also stated the unlicensed personnel do not notify the registered nurse, unless the client has a problem that requires a "PRN" that is not listed on the medication administration record. Then they would call the RN and she would advise them if they could use a standing order. On November 16, 2005, unlicensed employees E and F, who give medications, confirmed the above information provided by unlicensed employee B. When interviewed, November 7, 2005, the RN stated she reviewed the medication administration record monthly. She stated she had not specified a time period for informing her or established a protocol for her being informed of PRN medication administration. **Education:** Provided

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8	MN Rule 4668.0855 Subp. 9 Medication records	X	X	Based on record review and interview the licensee failed to administer medications as prescribed to one of six (#2) current clients reviewed. The findings include: Client #2's Service Plan, August of 2004, indicated the resident was to have assistance with medication administration. The last physician orders for client #2, dated October of 2004, indicated the client was to receive "Tylenol Arthritis 650mg. BID" (twice a day). The medication administration records (MAR) for October 2005 and November 2005 listed "Tylenol Arthritis 650 mg. Take two tablets twice a day" (twice the prescribed amount). The MAR and record lacked documentation as to why the medication was not completed as prescribed. When interviewed, November 8, 2005, the director, confirmed the medication was not given as prescribed. She stated the pharmacy must have the correct orders as they fill the prescription from physician orders. **Education**: Provided
8	MN Rule 4668.0860 Subp. 2 Prescriber's order required	X	X	Based on record review and interview the licensee failed to have written prescriber orders for medications for two of six (#1and #2) current clients' records reviewed. The findings include: Client #1 was readmitted to the facility February of 2005 after a two-month stay in a hospital and a nursing home. The nursing home had transferred a current copy of client #1's medication administration record, but had not included any orders signed by the physician, a physician assistant, a nurse practitioner, or other prescriber. Subsequent to admission on February of 2005, client#1s' physician had faxed some orders, however, several medications the client was receiving did not have physician orders. After this reviewer questioned the orders during the survey, the licensee attempted to obtain signed orders on November 8, 2005. The physician assistant refused to sign the medication orders citing that the client had left the nursing home against medical advice. When interviewed November 8,

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				2005, the director, stated the agency was providing assistance with all medication administration for client #1. She stated the agency was unaware that the medication administration record from the nursing home was not considered orders for the medications. Client #2's service plan, dated August of 2004, indicated client #2 received medication administration. Client #2s' medication administration record indicated that on two days October of 2005; client #2 received a PRN (as needed) pain medication. There was no order for this medication. When interviewed, November 8, 2005, the director stated she was unaware they lacked an order for the analgesic. The director then called the pharmacy and requested a faxed copy of the physician order for the pain medication. When interviewed December 21, 2005, the registered nurse stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders. **Education:** Provided
8	MN Rule 4668.0860 Subp. 8 Implementation of order			Based on record review and interview, the facility failed to implement orders for one of three discharged clients' (#9) records reviewed. The findings include: Client #9 was admitted to the facility on October of 2004 from another healthcare facility. A telephone order the same day in October of 2004, from the physician, stated to discharge client #9 to the assisted living with current medications and treatments and to discontinue the client's Lantus insulin. The nursing discharge summary, dated the prior referred to date in October of 2004, included the following medication and treatments: Blood pressure checks every other day for two weeks and then update the physician, oxygen at 3-5 liters to keep oxygen saturation levels more than 90%, and glucometer (blood sugar) checks twice daily with sliding scale insulin with meals. There was no evidence the orders had been implemented.

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				When interviewed December 21, 2005, the registered nurse (RN) stated she "felt the doctor was called" to clarify the orders related to the insulin, glucometer checks and oximeter readings and verified that there was no evidence the orders had been verified. She said that client #9 had an oxygen concentrator, managed her own oxygen, and that the facility did not have an oximeter to check her oxygen saturation levels. She stated the current system was that physicians send the orders to the pharmacist and the facility did not retain a copy of orders. The RN verified that there was no documentation of the blood pressure checks or physician notification related to blood pressure checks. **Education:** Provided
8	MN Rule 4668.0860 Subp. 9 Renewal of orders	X	X	Based on record review and interview, the licensee failed to renew medication or treatment orders every 12 months for one of six current clients' (#2) records reviewed. The findings include: Client #2's last renewal of medications was October of 2004. When interviewed November 8, 2005, the director stated she was unaware that medication orders had to be renewed annually. **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 have the registered nurse (RN) 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 two of six current clients' (#1 and #2) who received central storage of medications. The findings include: Client #1 and client #2 both received central storage of medication from the licensee. There was no assessment for the need for central storage of medication for client #1. Client #2's record contained an assessment for the need for central storage of medication dated August of 2004. Neither client#1 nor client#2 had service

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				plans that included central storage of medications. When interviewed, November 4, 2005, the registered nurse stated that the licensee provided central storage of medications for clients' #1, #2, and all but one of their clients. She stated she was unaware of the need for the assessment of need for central storage of medication. **Education:** Provided
8	MN Rule 4668.0865 Subp. 3 Control of medications	X	X	Based on observation, record review and interview the facility failed to establish a system for control of medications for four of five (#1, #2, #4 and #5) current clients reviewed that received central storage of medications. The findings include: The medication administration record for client #1 indicated s/he received Lorazepam 0.5 milligrams November of 2005 as a "PRN" (as needed). Employee H, an unlicensed employee, administered the medication. Client #1's medication administration record indicated the resident was to receive "Lorazepam 0.5 mg. every 8 hours as needed." Documentation for this medication administration lacked the time, route, and reason for administration. When interviewed November 16, 2005 the registered nurse confirmed the documentation was incomplete. She stated that at the end of the month she reviewed the medication administration record and then had employees complete any documentation that was lacking for "PRN" medications given. Client #2 had a September of 2005, prescriber order for Advil 200 milligrams (mg) one to two tablets every four hours PRN (as needed) for pain and fever. The medication administration record for client #2's "Advil" order read "Ibuprofen 200mg tab, Take 1-2 tablets every 4 hours as needed for pain and fever-Generic Advil." When observed, November 8, 2005, it was noted that the container of "ibuprofen" which was in central storage in the medication cart, had an expiration date of July of 2005. Client #2 had received ibuprofen 200mg, two tablets on two days October of 2005. When interviewed,

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				November 8, 2005, the director stated that client #2 also had a new bottle of ibuprofen that was filled September of 2005; however, the agency was unable to locate any other bottle of ibuprofen. During observation of central storage of medications, November 8, 2005, it was noted that client #4's medications which were in central storage locked in the medication cart were in "dose boxes" with medications set up for four weeks for each of the administrative times the client received medications. When interviewed, employee B, an unlicensed employee who assisted with medication administration, stated that client #4 received his medications from the Veterans Administration in bottles. This differed from the other clients, who received their medications in "bubble packs." When asked who set up the medications in the "dose boxes" employee B stated that the director, who is not a nurse set the medications up in the dose boxes. During an interview, November 16, 2005, employees E and F, unlicensed employees who assisted with medication administration, also stated that the director set up the medications for client #4 in the dose boxes. Once set up, the medications in the dose boxes were administered to client#4 by the unlicensed resident aids. When interviewed, November 8, 2005, the director denied setting up medications. The director stated the registered nurse, set up the medications into the dose boxes. During observation of medication administration, November 8, 2005, for clients #1 and #5 employee B an unlicensed employee who assisted with medication administration**,** set the medication cups along side of the client's #1 and #5 plates and left the room before observing if the clients took their medications or not. **Education:** Provided
NA	CLIA Waiver		X	Based on interview and record review the licensee failed to have a CLIA waiver for one of two current clients reviewed. The findings include:

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				Client #1 had a blood sugar check done daily. On interview on November 4, 2005, employee A, the registered nurse stated she thought the Corporate office had a CLIA waiver, however, when she consulted with them she stated they did not have one for this facility. **Education:** Provided

A draft copy of this completed form was left with Kelly Johannes, Director at an exit conference on November 17, 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)