Protecting, maintaining and improving the health of all Minnesotans

October 1, 2007

Julie Osemeka
Mayfair Home Health Services
6019 West 39th Street
St. Louis Park, MN 55416

Dear Ms. Osemaka:

Enclosed are correction orders for your Class F home care license. Your license was suspended for sixty days commencing September 5, 2007. This suspension ends on November 3 and your time period for correction will therefore begin on November 4, 2007.

Sincerely,

Jean M. Johnston

Jean Johnston
Case Mix Review
Program Manager

Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7004 1350 0003 0567 0421

October 02, 2007

Julie Osemeka, Administrator
Mayfair HomeHealth Services
6019 West 39th Street
St. Louis, MN 55416

Re: Results of State Licensing Survey

Dear:Ms. Osemeka

The above agency was surveyed on August 29, 30, and 31, 2007, for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if found, are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me, or the RN Program Coordinator. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

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

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

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

Please feel free to call our office with any questions at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

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

01/07 CMR3199

Class F Home Care Provider

LICENSING SURVEY FORM

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

During an on-site visit, MDH nurses will interview staff, talk with clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class F Home Care services. Completing this Licensing Survey Form in advance may facilitate the survey process.

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

Name of CLASS F: MAYFAIR HOME HEALTH SERVICES

HFID #: 21533

Date(s) of Survey: August 29, 30, and 31, 2007

Project #: QL21533005

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

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** ____Survey not Expanded ____Met __X__Correction Order(s) issued __X__Education Provided Follow-up Survey __#___ ____New Correction Order issued ____Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. • Nurse licenses are current. • The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. • The process of delegation and supervision is clear to all staff and reflected in their job descriptions. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met __X__Correction Order(s) issued __X__Education Provided Follow-up Survey __#___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• The CLASS F license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. • The agency operates within its license(s) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided

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

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

SURVEY RESULTS: ___ All Indicators of Compliance listed above were met.

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

1. MN Rule 4668.0019

INDICATOR OF COMPLIANCE: # 7

Based on document review, observation and interview the agency failed to correctly represent the agency in the advertising flyer. The findings include:

On August 30, 2007, when asked for a copy of the advertising for the agency, employee B presented a flyer titled "Mayfair Meadows." The agency licensure and housing with services registration both list the business as Mayfair Home Health Services.

The advertising flyer stated
- "We provide 24-hour skilled nursing; provide safe services in a luxurious and quiet environment.
- Our interdisciplinary team applies special measures to monitor patient progress through daily recordings and weekly treatment meetings.
- We encourage family involvement
- Skilled nursing services by Registered Nurses (RNs), Licensed Practical Nurses (LPNs)
- Medication dispensation by RN's and Trained Medication Aides (TMAs,)
- Personal care services by Certified Nursing Assistants (CNAs,)

- Each resident referred to Mayfair Meadows is carefully evaluated for admission to assure that they meet the care criteria
- A physician order is required for admission and a preadmission screening is provided."

By comparison, interview, observation and record review reflected the following:

- There was no evidence of 24 hour skilled nursing.
- The building was unkempt and dirty.
- Some of the sheet rock in the bathroom was missing.
- The baseboard heating in the bathroom was falling off the wall.
- There was a hanging sticky fly trap in the kitchen above the sink.
- Unsafe practices including untrained staff performing services, unsafe medications set up and staff members observed working double shifts were observed.
- Only one licensed practical nurse was observed to be working during the 3 days and two nights of the survey.
- When interviewed, the owner stated that the registered nurse had not been working for months and was on a vacation.
- Medications were being dispensed by untrained personal attendants.
- There was only one unlicensed person who was identified as a CNA during the survey.
- There were no evaluations for admission found and no care criteria identified.
- Physician orders were not current for all clients and no preadmission screening was found.
- There was not evidence that trained medication aides or a registered nurse was employed by the licensee at the time of the survey.

2. MN Rule 4668.0030 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide the Minnesota Home Care Bill of Rights to clients for four of four current clients' (#1, #2, #3, and #4) records reviewed. The findings include:

Clients #1, #2, #3, and #4 began receiving services from the licensee on October 28, 2005, August 24, 2007, January 23, 2007, and June 29, 2005, respectively. There was no evidence in the clients' records that they received a copy of the Minnesota Home Care Bill of Rights. When interviewed on August 30, 2007, the licensed practical nurse stated she thought the clients were given a copy of the Bill of Rights on admission but was unable to verify for sure.

3. MN Rule 4668.0030 Subp. 4

INDICATOR OF COMPLIANCE: # 2

Based on record review, the licensee failed to ensure that in addition to the Minnesota Home Care Bill of Rights, clients were given information to make a complaint about the agency or the person providing home care services for four of four clients' (#1, #2, #3 and #4) records reviewed. The findings include:

When a copy of the information given to clients regarding their rights was requested, employee B, gave the reviewer a copy of the Minnesota Home Care Bill of Rights that was not complete. This copy did

not include additional content related to filing a complaint, the phone number, address of the Office of Health Facility complaints or office of the ombudsman, and the licensee's name, address, telephone number and name and title of the person to whom problems or complaints may be directed.

4. MN Rule 4668.0040 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on document review, the licensee failed to provide clients with a complete notice related to the procedure for making a complaint for four of four clients' (#1, #2, #2, and #4) records reviewed. The findings include:

The licensee's Grievance Procedure did not include a statement that the provider would in no way retaliate because of a complaint, and the phone number for the Minnesota Department of Health, Office of Health Facility Complaints was incorrect. In addition, there was no evidence that clients #1, #2, #3, and #4 were provided with a written notice of this procedure.

When interviewed regarding the complaint procedure, August 30, 2007, employee B stated, "This is all I have, there might be more, but I don't know."

5. MN Rule 4668.0050 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review, interview and observation, the licensee failed to ensure adequate staff was available to provide cares prior to accepting clients for four of four clients' (#1, #2, #3 and #4) records reviewed. The findings include:

Clients #1, #2, #3 and #4 had complex care needs including tracheostomies requiring suctioning, tube feedings, insulin dependent diabetics, open wounds, colostomy, indwelling urinary catheters, nebulizer treatments, methicillin resistant staphylococcus aureus (MRSA), and seizures.

During an interview, August 29, 2007, the owner provided a schedule for August 29, 30 and 31, 2007, which stated staff members were scheduled as follows:

- Employee E, an unlicensed care giver was scheduled to work from 6:30 a.m. to 3:30 p.m. on August 29 and 30, 2007.
- Employee D, an unlicensed care giver was scheduled to work from 6:30 a.m. to 3:30 p.m. on August 31, 2007.
- Employee C, an unlicensed care giver was scheduled to work from 2:30 p.m. to 11:30 p.m. on August 29, 30 and 31, 2007.
- Employees C and D, both unlicensed care givers, and the licensed practical nurse were scheduled to work at 11 p.m. on August 29, 30 and 31, 2007.

When interviewed, August 29, 2007, employee C stated that he suctioned clients when they needed it and when asked about his training stated that he had worked for a medical supply company and knew how to suction from this previous employment. He noted that because of this, he had not been trained at the agency on how to suction clients.

During the survey, the licensee's staff members listed on the schedule provided were not consistently the same as the staff members who came to work. On the evening of August 30, 2007, employee C, an unlicensed person who had worked both the day shift and the evening shift on August 30, 2007 indicated to the reviewer that the night person had not shown up and he would stay for the night shift (note: employee C was on the schedule for 11 p.m. on August 30, 2007). When the reviewer arrived at the housing with services site at 7:30 a.m. on the morning of August 31, 2007, employee C was still there and appeared extremely fatigued. Employee D was at the establishment prior to 7 a.m. on August 31, 2007, and when interviewed that same day, stated she had been at the establishment all night (note: employee D was on the schedule for 11 p.m. on August 30, 2007). The LPN arrived at 7 a.m. on August 31, 2007 (note: the LPN was on the schedule for 11 p.m. on August 30, 2007).

When time sheets were requested for August 16, 2007, the manager stated that he would call and get the requested information from the company that provided the electronic time records. No information was provided.

At 11 p.m. on August 30, 2007, the licensed practical nurse (LPN) who had worked since approximately 8:30 a.m., was heard to state on the phone to the manager, "she's a no show no call." She then stated to the reviewer that her relief had not reported to work and had not called in. (note: the LPN was on the schedule for 11 p.m. on August 30, 2007.) The LPN then stated that the manager was sending a nurse and that when the nurse arrived, she would leave for her second job. The LPN was observed to return to work at 7:00 a.m. on August 31, 2007. Employee C stated, on the morning of August 31, 2007, that he had worked all night. No other LPN or RN was observed to be on site when reviewers arrived at 6:45 a.m. on the morning of August 31, 2007.

Client #2 began receiving services August 24, 2007. His cares included tube feedings, suctioning of his tracheostomy, and administration of oral, topical and inhalant medications. From August 24 through August 29, 2007, all of his medications and treatments including 1 a.m. and 5 a.m. Replete with fiber via G tube were signed out on the medication administration record as having been given by the same licensed practical nurse (LPN). During the survey, August 29, 30 and 31, 2007, this same LPN was observed to be on site during the morning, afternoon and evening.

6. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the agency failed to ensure that employees had tuberculosis screening prior to having direct contact with clients for three of three current unlicensed employees' (C, D and E) records reviewed. The findings include:

Employees C, D and E were hired and began providing direct care as personnel care attendants in October 2006, January 2007 and June 18, 2007, respectively. There was no evidence available of tuberculosis screening for these employees. When interviewed, August 30, 2007, the manager stated that if the tuberculosis screening was not in the employee's record, "it doesn't exist".

When interviewed August 30, 2007, employee E indicated she thought she had gotten a Mantoux test and would look for it. As of September 12, 2007, no evidence of tuberculosis screening was provided.

7. MN Rule 4668.0070 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to provide a job description for one of one management employee (B) record reviewed. The findings include:

Employee B began employment at an undetermined time. When interviewed, August 29, 2007, the owner identified employee B as "management." When interviewed at the agency office, August 29, 2007, employee B first identified himself as hired to do computer "stuff" and then at the housing with services site identified himself as "a visitor". Later that evening after staff identified him as an employee who worked in administration, he said he worked "doing all sorts of things" but mostly "maintenance." When asked what his official title or capacity with the agency was he stated "I'm not sure." On August 31, 2007, employee B identified himself as the agency manager. When asked if he had a job description he stated he did not know and if there was one, it would be in the computer and he could not access it.

8. MN Rule 4668.0805 Subp. 1

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that employees who provided direct care received orientation to home care for two of four current employees' (E and F) records reviewed who provided direct care. The findings include:

Employees E and F began providing direct services on June 18, 2007, and January 26, 2007, respectively. There was no evidence in their records that they had completed orientation to home care requirements. When interviewed regarding orientation to home care, August 30, 2007, employee E stated, "I saw some movies June 7th."

9. MN Rule 4668.0810 Subp. 1

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to establish records for six of six discharged clients' (#6, #7, #8, #9, #10, and #11) records reviewed. The findings include:

Clients #6, #7, #8, #9, #10, and #11 were no longer receiving services from the agency.

Client #6 did not have a record. Client #6 had medications remaining in central storage at the housing with services establishment including Bromocriptine 2.5 mg. patch dated May 4, 2007, a vial of Heparin sodium 50 MU dated April 30, 2007, regular insulin, one vial dated and Lantus insulin 100U one vial both dated May 4, 2007, and one vial dated April 9, 2007.

Client #7 did not have a record. Client #7 had medications remaining in central storage at the housing with services establishment including Tums dated October 3, 2006 and Seroquel 300 mg dated August 24, 2006.

Client #8 did not have a record. Client #8 had medications remaining in central storage at the housing with services establishment including Genebs 325 mg. dated December 15, 2007.

Client #9 did not have a record. Client #9 had medications remaining in central storage at the housing with services establishment including Liquibid 600 mg dated July 24, 2006.

Client #10 did not have a record. Client #10 had medications remaining in central storage at the housing with services establishment including oxybutynin 5 mg dated June 2, 2005.

Client #11 had a nurse's note dated January 31, 2007, which included his room number, date of birth, and listed his diagnoses and services. There was also a medication administration record dated December 2006 which included the name and phone number of the client's physician. No other contents of client #11's medical record were available for review.

When questioned, August 30, 2007, regarding other information for these clients, the manager stated "that's all there is."

10. MN Rule 4668.0810 Subp. 5

INDICATOR OF COMPLIANCE: # 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 four clients' (#1, #2 and #3) records reviewed. The findings include:

Client #1 had a personal care giver weekly charting form titled, "PCA Weekly Flowsheet Charting" for the week of August 27 to August 30, 2007. Employee C's initial's were documented as having provided personal care for client #1, although the document did not include the employee's name and title. When interviewed on August 30, 2007, the licensed practical nurse confirmed that the initials were employee C's initials. Client #1 had a form titled, "PCA Care Plan" which did not have a date, or the name and title of the person who made the entries pertaining to client #1's care.

Client #2's medication administration record had the licensed practical nurse's initials in all slots for medications that had been given since admission. There were no names and titles on the back of the form which was designed to identify the initials of the individuals who had signed out medications.

Client #3's record had forms titled "Mayfair Home Health Care Progress Notes" dated June 25, July 25, 26, 27, August 3, 5, 29, and 30, 2007 which contained multiple timed entries regarding client #3 that were not signed by the person who made the entry.

11. MN Rule 4668.0810 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to have complete client records for two of four current clients' (#2 and#3) records reviewed and six of six discharged clients' (#6, #7, #8, #9, #10, and #11) who had limited records available for review. The findings include:

Client #2 had a diagnosis of quadriplegia. Client #2's record had a physician's name on the bottom of the nurse's notes and the medication administration record but there was no phone number in the chart for this physician and was noted to lack physician's orders for his medications and treatments. When interviewed, August 29, 2007, the licensed practical nurse indicated she had not gotten medication orders for client #2 as she was trying to reach the case manager to determine which physician she should call for orders. Client #2's record was reviewed and was noted to lack physician's orders for his medications and treatments.

Client #3 began receiving services on January 23, 2007. Client #3 had diagnoses of quadriplegia, diabetes mellitus, and had a indwelling urinary catheter, colostomy, tracheostomy, and open areas. The record lacked documentation of a service agreement that described the services being provided, lacked current physician's orders for his medications and treatments, names, addresses, and telephone numbers of the client's medical services providers and other home care providers, and notes summarizing each contact with the client. During an interview, August 30, 2007, the licensed practical nurse stated the record contained all information the agency had for client #3.

Clients' #6, #7, #8, #9, #10, and #11 all were no longer served by the agency but had medications with their names on them stored in a box that the licensed practical nurse referred to as the stock medications. There were no records available clients #6, #7, #8, #9, and #10.

Client #11 had a nurse's note dated January 31, 2007, which indicated his room number, date of birth, and listed his diagnoses as paranoid schizophrenia, diabetes, paraplegia, hypertension, and spinal stenosis requiring assistance with bathing, skin care, and transfers. There was also a medication administration record dated December 2006 which included the name and phone number of the client's physician. No other contents of a medical record were present for client #11.

When interviewed, on August 30, 2007, and asked if there was any other information for these clients, the manager stated "that's all there is."

12. MN Rule 4668.0815 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse conducted an individualized evaluation of the client's needs and established a written service plan for four of four current clients' (#1, #2, #3, and #4) records reviewed. The findings include:

There was no evidence of a registered nurse evaluation of the client's needs for client's #1, #2, #3 and #4. When interviewed, August 29, 2007, the owner stated that the registered nurse (RN) had been on leave for about two months and a new RN was starting soon.

Client #1 began receiving services from the licensee on October 28, 2005. The client's PCA (personal care attendant) care plan, which was not dated indicated that the PCA was to assist the client with occasional set-up with grooming, one assist with bathing, monitor and safety precautions for seizures, meal planning and preparation, laundry, light housekeeping and shopping for food and clothing. In addition the PCA weekly flow sheet charting indicated the PCA assisted the client with range of motion exercises on July 31, and August 6, 2007. There was no written service plan for this client that described the services provided. When interviewed on August 30, 2007, the licensed practical nurse (LPN) stated that there should be a service plan for client #1, but she was unable to locate the plan.

Client #2 began receiving services including medication administration and suctioning on August 24, 2007. There was no evidence of a service plan in his record. When asked about the service plan, August 29, 2007, the licensed practical nurse stated that she had not completed his chart and was working with the case manager to get the information that she needed.

Client #3 began receiving services on January 23, 2007. Client #3 had diagnoses of quadriplegia, diabetes mellitus, and had an indwelling urinary catheter, tracheostomy, colostomy, and open areas. The record lacked documentation of a service plan that described the services being provided. When interviewed, August 30, 2007, the licensed practical nurse stated the record contained all information the agency had for client #3.

Client #4 began receiving services June 29, 2005. Client #4 had a diagnosis of morbid obesity, diabetes and cellulitis with open areas. The record lacked documentation of a service plan that described the services being provided. When interviewed August 30, 2007, the licensed practical nurse could not find a service plan for client #4.

13. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on interview and record review, the agency failed to ensure that current unlicensed personnel satisfied the training requirements for performance of delegated medical or nursing procedures for three of three unlicensed employee's (C, D, and E) records reviewed who performed delegated procedures. The findings include:

Employees C, D, and E were hired in October 2006, January 2007 and June 18, 2007 provided delegated procedures including suctioning, indwelling urinary catheter care, colostomy care. Employees C, D, and E did not have evidence of having been trained by a registered nurse or demonstrated competency to a registered nurse for suctioning, colostomy care or "catheter flushing".

According to documentation in the establishment communication book, employee C flushed client #2's catheter on August 7, 2007.

According to documentation in the establishment communication book, employee D emptied client #3's colostomy bag on August 27, 2007. The facility "shift report" document dated August 24, 2007, noted employee D assisted the owner (who had been disqualified by the Department of Human Services from direct contact with clients effective August 24, 2007) with suctioning client #2 during the course of employee D's night shift.

A notation in the facility communication book dated August 26, 2007, noted that client #2 "trained" employee E how to do his suctioning.

When interviewed, August 29, 2007, employee C stated that he suctioned clients when they needed it and when asked about his training stated that he had worked for a medical supply company and knew how to suction from this previous employment. He noted that because of this, he had not been trained at the agency on how to suction clients.

14. MN Rule 4668.0825 Subp. 5

INDICATOR OF COMPLIANCE: # 5

Based on observation and interview, the licensee failed to ensure that there was a policy to communicate to the registered nurse regarding available nursing staff to determine the appropriateness of delegating tasks in individual situations. The findings include:

During the survey, August 29, 30, and 31, 2007, there was no registered nurse on site. When interviewed, August 29, 2007, the owner stated that the registered nurse (RN) had been on leave for about two months and a new RN was starting soon. When interviewed regarding who she would communicate client changes in condition to on August 30, 2007, the licensed practical nurse (LPN) indicated she would call the owner, who is not a registered nurse. When questioned further regarding the availability of an RN from the agency, the LPN stated she was sure there was one but didn't know where to find the number. She went on to say that if she needed to talk to an RN, she would call a friend who was an RN but not an employee of the agency.

15. MN Rule 4668.0835 Subp. 2

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed staff were qualified for three of three current unlicensed employees' (C, D, and E) records reviewed who performed delegated nursing services. The findings include:

Employees C, D, and E began providing direct care in October 2006, January 2007 and June 18, 2007, respectively. The files for employees C and D included a form stating that each had successfully completed home health aide/PCA competency testing. The name of the registered nurse (RN) who had signed these forms was not legible and there was no information available regarding what competencies had been completed. There was an orientation outline and check off that was signed by each of the employees that did not include the required content for home health aide training.
There was no documentation of any training or competency testing for employee E. When interviewed August 30, 2007, employee E indicated she had given baths, changed a colostomy bag, suctioned and was trained by the licensed practical nurse. She also indicated that "as of today" (August 30, 2007) she no longer passed medications. When questioned further, employee E stated, "you'll have to talk to (the nurse) about that**."**

16. MN Rule 4668.0835 Subp. 5

INDICATOR OF COMPLIANCE: # 5

Based on observation and interview, the licensee failed to provide orientation by a registered nurse for each person who is to perform home health aide tasks to each client and to the tasks to be performed for one of three current unlicensed employees' (C) records reviewed. The findings include:

On August 30, 2007, employee C was observed providing care to client #2 with the licensed practical nurse (LPN). The LPN was instructing employee C on the use of the mechanical lift, and the procedure for peri care and application of ointment to the skin. When interviewed, August 30, 2007, employee C

stated he had been trained by an LPN who was no longer employed at the agency to do client #2's cares and that he had received additional training from the current LPN. He confirmed a registered nurse had not oriented him to the client's care.

17. MN Rule 4668.0845 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for three of three clients' (#1, #3 and #4) records reviewed who had received services long enough to require supervisory visits. The findings include:

Client #1 began receiving services from the licensee on October 28, 2005. Documentation included one supervisory visit of the personal care attendant since the client began services in 2005. The RN visit note was dated July 1, 2007, and included that observations were made of "TPR/BP (temperature, pulse, respiration, blood pressure) and ROM/Positioning (range of motion). There was no indication in the client's record that his vital signs were taken, nor that range of motion exercises was conducted other on July 31 and August 6, 2007, both after the RN visit date. When interviewed on August 30, 2007, client #1 indicated that he did his own physical therapy, and required no assistance with exercises from staff. When interviewed on August 30, 2007, employee B confirmed the July 1, 2007, visit note was the only supervisory visit he was able to find for client #1.

Client #3 began receiving services on January 23, 2007. Client #3 had diagnoses of quadriplegia, diabetes mellitus, and had an indwelling urinary catheter, tracheostomy, colostomy, and open areas. His record indicated cares were completed by unlicensed staff and a licensed practical nurse. The record lacked evidence of supervisory visits by a registered nurse or monitoring visits by a licensed practical nurse. During an interview, August 30, 2007, the licensed practical nurse stated the record contained all information the agency had for client #3.

Client #4 began receiving services June 29, 2005. Client #4 had a diagnosis of morbid obesity, diabetes, and cellulitis with open areas. The record indicated services were provided by unlicensed personnel. One undated supervisory note was signed by the registered nurse (RN) and included a list of services. There was one additional supervisory note which was signed and dated by the RN on January 31, 2007.

When interviewed, August 29, 2007, the owner stated that the registered nurse that does supervisory visits had left two months ago, so none had been completed since that time.

18. MN Rule 4668.0855 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review the licensee failed to ensure that a registered nurse conducted a nursing assessment of the client's functional status and need for medication administration for three of three clients' (#2, #3 and #4) records reviewed who received medication administration. The findings include:

Client's #2, #3 and #4 all received medication administration. There was no evidence in their records that an assessment for the need for medication administration had been conducted by a registered nurse (RN). When interviewed, August 29, 2007, the owner stated that the RN had been on leave for about two months and a new RN was starting soon.

19. MN Rule 4668.0855 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review, the licensee failed to ensure that a registered nurse (RN) delegated medication administration only to unlicensed persons who were qualified to provide delegated nursing services and had completed training for medication administration for three of three current unlicensed employees' (C, D, and E) records reviewed. The findings include:

Employees C, D, and E all worked as unlicensed staff members who provided direct care to clients including medication administration. There was no evidence available that they had been trained for providing medication administration.

When interviewed, August 29, 2007, the owner stated that the RN had been on leave for about two months and a new RN was starting soon. When interviewed regarding training for medication administration, August 30, 2007, employee E stated she had received training for medication administration from the licensed practical nurse and that as of August 30, 2007, she no longer administered medications.

20. MN Rule 4668.0855 Subp. 4

INDICATOR OF COMPLIANCE: # 6

Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) instructed unlicensed persons in the correct procedure for medication administration for three of three current unlicensed employees' (C,D, and E) records reviewed. The findings include:

Employees C, D, and E were hired in October 2006, January 2007 and June 18, 2007 and passed medications including the controlled drug, Vicodin according to documentation in the shift reports in communication book of July 27 and 31, 2007, and August 1, 7, 9, 17, 24, 27, 29, 2007.
Employees C, D, and E did not have evidence of having been trained by a registered nurse or demonstrated competency to a registered nurse for medication administration.

When interviewed, August 29, 2007, the owner stated that the RN had been on leave for about two months and a new RN was starting soon.

21. MN Rule 4668.0855 Subp. 5

INDICATOR OF COMPLIANCE: # 6

Based on record review, the agency failed to ensure that unlicensed personnel reported the administration of a pro re nata (PRN as needed) medication to a registered nurse for one of one unlicensed employee (E) record reviewed who administered a PRN medication. The findings include:

Shift report of August 1, 2007 stated under employee E's name: "pass out meds with "Vicdon"" (Vicodin). There was no evidence that a registered nurse had been notified that this pro re nata (prn as needed) medication had been given.

22. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review, the agency failed maintain complete medication records for three of three clients' (#2, #3 and #4) records reviewed who received medication administration. The findings include:

During a visit on August 29, 2007 to the housing with services building at which the licensee was providing home care services, it was observed that clients #2, #3, and #4, had their medications in a medi-set container for a week. When interviewed, the licensed practical nurse, verified that clients' #2, #3 and #4 had their medications set-up in a medi set by an agency employee. The LPN stated that the clients' medications were administered either by her or by unlicensed staff on a daily basis. There was no documentation of who had performed the weekly set-up of medications.. When interviewed, August 29, 2007, the licensed practical nurse stated that she thought she documented the medication set-up in the clients' record, but was unable to find the documentation.

Clients #2, #3, and #4 received medication administration or assistance with administration of medication. Staff initialed the medication administration records (MAR) when assisting or administering medications to these clients. The signature legend on the back of the MARs of clients #2, #3 and #4 did not have a current, up to date list of the signatures, titles and initials of all staff administering medications.

Client #3's April 2007 MAR indicated the client received eleven oral medications daily. There were no signatures for any medications on April 1, 2007. The MAR indicated client #3 received a Combivent inhaler two puffs four times daily. The MAR had a horizontal line drawn through all medication documentation areas for April 24, 25, 26, 27, and 28, 2007. The MAR had a blank area for April 22, 2007, at 8 p.m. where the Combivent inhaler would have been documented as given. There were no signatures for the aforementioned April dates.

The MAR indicated client #3 received vitamin C 500 mg orally four times daily. The MAR had not been initialed April 1 through 7, April 9 through 13 and April 17 through 30 where the Baclofen 20 mg at 9 p.m. would have been documented as given. It was also not initialed for vitamin C doses at 9 a.m. on April 14 and April 20 through 30, 2007, and the 1 p.m. doses were not initialed on April 14, 20, and 22 through 30, 2007, and the 5 p.m. doses were not initialed on April 2, 18 through 21, and 23 through 30, 2007.

The MAR indicated client #3 received Senna 8.6 mg orally every bedtime. The MAR had areas that had not been initialed for April 1 through 7, April 9 through 13, April 15, and April 17 through 22, with the lined out dates as described previously and was not signed April 30, 2007.

When interviewed, August 31, 2007, the licensed practical nurse stated she was not sure why the MAR's were blank.

23. MN Rule 4668.0860 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that there were signed orders by the prescriber for medications and treatments for three of four current clients' (#1, #2, and #3) records reviewed. The findings include:

Client #1 began receiving services from the licensee on October 28, 2005. The client had a medication administration record in his chart for the month of August, 2007, and had medication set-up in a medi set box, although he frequently refused his medication. Client #1 was interviewed on August 29, 2007, and indicated that he was taking vitamin E and a multivitamin on a daily basis. There was no evidence in the client's record of a prescriber's order for the vitamin E.

Client #2 began receiving cares including medication administration August 24, 2007. There were no signed prescriber's orders for the twenty-six medications and treatments he received which included baclofen (a muscle relaxant used for severe spasticity); Tegretol (an anticonvulsant); Neurontin (an anticonvulsant); scopolamine patch (used for spasticity and prevention of nausea); lorazepam intramuscular injection (for seizure that persists), acetylcysteine Mucomyst inhaler nebulizer (respiratory drug that reduces the viscosity of pulmonary secretions), nystatin topical to skin folds, hip, lower ribs and groin (an antifungal agent); and replete with fiber (a very high protein liquid nutrition) via gastrostomy tube. When interviewed, August 29, 2007, the licensed practical nurse indicated she believed the list of medications from the previous home care agency was adequate but she was working with the case manager to complete the chart including the prescriber's orders.

Client #3's medication administration record dated April 2007 indicated the client received medication administration from the agency staff. A nurse's note dated August 30, 2007, read Tylenol given as ordered per physician order, although there was no physician's order for Tylenol in the record. When interviewed August 30, 2007 the licensed practical nurse stated client #3 got Tylenol for pain.

24. MN Rule 4668.0860 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that orders received by telephone were communicated to the registered nurse (RN) within one hour of receipt, and were immediately recorded or placed in the client's record for one of four clients' (#4) records reviewed. The findings include:

Client #4 began receiving services from the licensee on or about June 28, 2005. On August 29, 2007, the LPN was observed to administer 7.5 milligrams of Coumadin to the client at 8:20 p.m. A review of client #4's medication administration record indicated that he had also received 5 milligrams of Coumadin at 8:00 p.m. that same evening. When questioned on August 30, 2007, as to where the prescriber's orders for the 5 milligrams and 7.5 milligrams of Coumadin were, the licensed practical nurse (LPN) stated she received the orders by telephone, and that she had written them on "sticky" notes because she had not had time to document the orders in the client's record. The LPN was unable to locate the "sticky" notes. In addition, the LPN stated that since she had returned from her leave of absence, there had not been any telephone order forms to document orders received by phone.

Orders received by telephone were not communicated to the registered nurse within one hour of receipt. When the LPN was questioned on August 29, 2007, regarding to whom she reported client changes in condition, physician's order changes and other client issues, she stated she is the supervisor, and she reports to the owner. The LPN stated she did not usually call a registered nurse, but if she did need one, she would call a friend of hers, who does not work for the licensee. The LPN stated that she thought the licensee had a registered nurse she could call if she needed to, but stated that she hadn't needed to.

25. MN Rule 4668.0860 Subp. 8

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the facility failed to implement an order for one of two current clients' (#2) records reviewed with physicians' orders. The findings include:

Client #3 had a physician's order, dated February 20, 2007, for a "Podiatry eval for heal." There was no evidence of scheduling the evaluation, an evaluation, or of the client declining the referral for evaluation. When interviewed August 30, 2007, client #3 stated he never was seen and that the agency had not made an appointment for him to be seen for his heal. On August 30, 2007 client # 3 was observed to have bilateral open areas on his heals and also a spongy area on his left heal.

26. MN Rule 4668.0865 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review the agency failed to ensure that a registered nurse assessed the clients' functional status, need for medication storage, and developed a service plan for providing that service according to the clients needs for four of four current clients' (#1, #2, #3 and #4) records reviewed. The findings include:

Client #1 began receiving services including central storage of medications on October 28, 2005. Observations on August 30, 2007, revealed that client #1 had medications including but not limited to Depakote, Vitamin C, Albuterol Inhaler, Flovent, and Albuterol Sulfate, and Azmacort Inhaler centrally stored in a locked medication closet. On August 30, 2007, it was observed that client #1 had bottles of Vitamin E, and Centrum Multi-Vitamin stored in a bag in the back of his wheelchair. There was no assessment of the client #1's need for central storage of medications.

Client #2 began receiving services including central storage of medications on August 24, 2007. There was no evidence of a registered nurse assessment of the client's functional status and need for central storage of medications in the client record.
Client #3 began receiving services including central storage of medications January 23, 2007. There was no evidence of a registered nurse assessment of the client's functional status and need for central storage of medications in the client record.

Client #4 began receiving services including central storage of medications June 29, 2005. There was no evidence of a registered nurse assessment of the client's functional status and need for central storage of medications in the client record.

When interviewed, August 29, 2007, about the agency's registered nurse (RN), the owner stated that the RN has been traveling and that a new RN was starting soon.

27. MN Rule 4668.0865 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review the agency failed to establish and maintain a medication control system. The findings include:

While two reviewers reconciled the medications for three of four current clients' (#2, #3, and #4) records reviewed who had central storage of medications at the housing with services, on Thursday, August 30, 2007, it was noted that medications were set up incorrectly in the weekly medi set.

Client #2 received medications including Keppra 1000 mg. three times daily, Baclofen 20 mg. four times daily and Prevacid SoluTab 30 mg daily according to the medication administration records but was missing Keppra from his medi set for mid day and evening on Thursday and Friday and Baclofen in the 9 p.m. slot for Sunday. It was also noted that the Prevacid SoluTab was not in the medi set. When interviewed, August 30, 2007, the licensed practical nurse(LPN) indicated she had not set up the medications for these days and made adjustments to the medication set up for the Keppra and Baclofen and noted that the Prevacid was "sticky" and could not be put in with other medications so wasn't put in the medi set. When asked how staff would know to give the Prevacid, the LPN noted that she gave the medications and she would check the medication administration record and would know that she needed to give it. There was no note on the medication administration record that the Prevacid was not in the medi set.

Client #3 received medications including Baclofen 20 mg four times daily, Simvastatin 40 mg in the evening and Neurontin 300 mg four times per day according to the medication administration record but there appeared to be one extra tablet of Neurontin in two slots and Baclofen appeared to be missing in the Sunday a.m. slot. There was also an unlabeled bottle in client #3's box of meds that contained pink tablets similar to the appearance of the tablets in the labeled Simvastatin 40 mg. When interviewed, August 30, 2007, the LPN looked at the unlabeled bottle and said, "I don't know what this is all about. I will take it out and destroy it." She examined the areas of the medi set with apparent discrepancies and adjusted the medication set up for Baclofen and Neurontin by removing tablets from the medi set.

Client #4 had three extra medications in his pill box which included one gold oval pill with a 32 on one side, one light pink oval tablet with 93 on one side, and one rust capsule with "Pziffer PGN 200 written on one side. Employee E was not able to identify the three pills. Two different kinds of medications were found in a bottle labeled: "Coumadin" (an anticoagulant), (two pills that were small lighter orange and fourteen and ½ pills that were a rusty orange color and not scored). Client #7's Polyethylene Glycol (a laxative) bottle (approximately ¾ full of medications), was found in Client #4's medication box. An expired Epi Pen (a bronchodilator) 3 mg injection was out dated from June 8, 2007. A physician transfer note on July 25, 2007 indicated client #4 was severely allergic to codeine and Penicillin.

Client #4 had a physician's order dated August 15, 2007, for Lasix 80 milligrams, one tab daily. Prior to August 14, 2007, the client had been receiving Lasix 20 milligrams, three tablets daily. When the client's medi set container was reviewed on August 30, 2007, there were two tablets of Lasix in the Saturday slot and the label on the bottle stated to give three tablets.

Client #4's box of medications contained a bottle of Polyethylene glycol 3359. The name on the label was that of a discharged client. Also, the client had a bottle of labeled Coumadin which contained pills that were two different sizes and appearances.

When interviewed August 30, 2007, the licensed practical nurse (LPN) did not know why two different pills were in a Coumadin bottle. The LPN later stated she thought the extra pills were aspirin. When interviewed, August 30, 2007, the LPN indicated that the extra pill bottle was in the wrong box "he was a resident before," the pill boxes "were a mess," and she would never give anything she hadn't set up herself. Some one else had set up Thursday through Saturday, but she didn't know who.

28. MN Rule 4668.0865 Subp. 5

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review the agency failed to ensure that legend drugs were kept in their original container bearing the original prescription label for two of four client's (#2 and #3) records reviewed. The findings include:

On August 30, 2007, the establishment refrigerator was observed. It contained a 10 ml bottle of Acetylcysteine solution USP 20%. There were only 1 to 2 drops remaining in the bottle. The bottle did not have a pharmacy label.

Client #3's medications were centrally stored. While reconciling client #3's medication set up with the medication administration record, August 30, 2007, an unlabeled bottle was found in client #3's box of meds that contained pink tablets similar to the appearance of the tablets in the labeled bottle of Simvastatin 40 mg. When interviewed, August 30, 2007, the licensed practical nurse looked at the unlabeled bottle and said, "I don't know what this is all about. I will take it out and destroy it."

29. MN Rule 4668.0865 Subp. 8

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure all drugs were stored in locked compartments. The findings include:

On August 30, 2007, the refrigerator in the kitchen that was observed to be used by clients and staff and was noted to contain discharged client #6's medications including one vial of Heparin, and three vials of insulin. They were kept in the upper right covered door storage area of the refrigerator. The manager was interviewed on August 30, 2007, and stated he was unaware the medications needed to be locked. On August 31, 2007 the refrigerated drugs remained in the refrigerator, unlocked.

30. MN Rule 4668.0865 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that schedule II medications were stored in a separately locked compartment. The findings include:

The main central storage area for medications schedule II drugs was observed on August 29, 2007 with the licensed practical nurse (LPN) in attendance. There was a locked metal box inside the medication closet on top of the medication cart. The box was not permanently affixed to the physical plant. The box contained Vicodin and OxyContin, both schedule II drugs. The manager was interviewed on August 30, 2007 and stated they were unaware schedule II drugs had to be stored in a separately locked compartment permanently affixed to the physical plant. He brought in a box and permanently affixed it to the physical plant that day.

31. MN Rule 4668.0870 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation and interview, the licensee failed to ensure that unused portions of legend drugs were disposed after clients were discharged for six of six clients' (#6, #7, #8, #9, #10 and #11) who no longer received services from the licensee but had medications in central storage at the housing with services establishment. The findings include:

Clients #6, #7, #8, #9, #10 and #11 had medications including, but not limited to, bromocriptine, heparin, Oxybutynin and Seroquel that were stored in a box in the medication closet. When interviewed, August 29, 2007, the licensed practical nurse referred to this box as "stock meds." Clients #6, #7, #8, #9, #10 and #11 were not at the housing with services establishment and were not included in the list of clients who currently received services provided by the owner on August 29, 2007.

32. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on observation, record review and interview, the licensee failed to ensure that care and services were provided according to accepted medical or nursing standards for four of four clients' (#1, #2, #3 and #4) records reviewed. The findings include:

LACK OF CARE AND SERVICES
On August 30, 2007, the licensed practical (LPN) got supplies for client #3 to do his blood sugar check and gave the supplies to him. The LPN did not offer or attempt to check client #3's blood sugar for him. The LPN was watching TV while client #3 did his blood sugar check. He did it partially with his teeth holding the equipment due to his lack of extremity use (diagnosis quadriplegia). When asked what his blood sugar was, the LPN did not initially respond as she was watching TV. "What? Oh!" Then the LPN asked client #3 "What was it?" Client #3 voiced concern regarding the LPN stating, "see, she doesn't do anything." The LPN said to client #3 in a loud voice "I wasn't talking to you. I was talking to her (the reviewer)."

On the evening of August 30, 2007, employee C was observed to ask the client "Have you taken your vitamin C yet?" Client#3 shook his head no. The vitamin C was observed to be stored in the client's room along with his insulin. Employee C moved the vitamin C bottle to the client's over bed table. No attempt was made to open or assist client further with Vitamin C. The client opened the bottle with his mouth and wrists and took a vitamin C with his tongue.

On August 30, 2007, at 10:05 p.m.**,** client #3 was observed drawing up his insulin and injecting it. He used his teeth and the heels of his hands to hold the equipment. The client lifted a bag of syringes with the pad of the heels of his hands and used his teeth to pull out syringes, one at a time. He spat the plastic syringes out of his mouth onto the bedside table and took the top off the syringes using the same technique. Client #3 then held a syringe in his teeth, plunger side in his mouth and needle pointing out, lifted an insulin vial with the pads of his hands and drew back the plunger with his teeth and tongue to draw up the insulin. He looked very closely several times to ensure the correct dose and adjusted the dose with his teeth and tongue. He gave himself 6 units of regular and 22 units of Lantus insulin. He stated he knew 'In head' what to give him self. Client #3 stated he had started doing his own insulin because no one checked on him and the timing of his insulin injections was off, and he subsequently had felt bad and had been very shaky with tremors. When his blood sugar was checked during this time it was high "sometimes 500," but when he administered his own insulin consistently, his blood sugars went down and he felt better. He concluded by stating regarding his insulin, "I'll do it, they don't."

On August 31, 2007, client #4 stated he had his legs débrided this a.m. at the hospital and was in "exquisite pain." He stated he had asked the LPN immediately upon his return at 11:30 a.m. for pain medication. The LPN was in the office. She told client #4 he'd have to wait because she needed to get another client up. At 1:35 p.m. the LPN approached client #4 in the back yard stating his name three times and then asked, "What do you want?" He again requested a medication for pain. At 1:45 p.m. he still had not received a pain pill.

Client #3's cares were observed on August 30, 2007, at 9:40 p.m. The LPN was asked if the client's dressing change (to his feet) had been done. The LPN stated, "No, he always refuses, didn't you read my charting? He has a behavior problem; it's explosive. He called me the 'N' word and I don't have to take that. When he's verbally abusive I walk out." When asked if she had offered to change client #3's dressing tonight she said "No." The LPN changed the client's dressing stating "if he's abusive I'm walking out."

Client #3 received wound care. When observed, August 30, 2007, the LPN placed wound gel on an adhesive dressing and then applied the dressing to the heel. She did not place the adhesive dressing to be positioned over the open area and the mushy looking area. The dressing was approximately four inches by three inches. The mushy area was half covered with the soft dressing area. The dressing adhesive area was also on the mushy looking area. The LPN did not touch the mushy appearing area nor did she ask the client anything about it. As she went to put Kerlix on, client #3 asked her to "put gauze on top there (arch of his left foot). He had two purple areas approximately one inch by one-half inch crossway on the anterior of his left foot between the arch and the ankle. The LPN complied and did not ask the client anything about the areas, why they were purple-a bruise, how long they had been there, etc. She then applied Kerlix which immediately became loose at the top.

Client #4's record contained a nursing note dated August 21, 2007, indicating, "client's wound clinic called the licensee today inquiring as to when client's wound care and dressing changes were getting completed." When interviewed, September 11, 2007, person I, a wound care specialist from the client's wound care clinic, stated there were times the agency failed to provide the client with the ordered wound care, so she would increase the client's visits to the wound clinic so the wound care would be done consistently. She stated the client would inform her when a new nurse would be hired at the agency and the client would want to decrease his visits to the wound clinic, so the agency nurse could do the wound treatments. She stated the wounds would start to regress when the agency was doing the wound treatments and she would have to increase his appointments again at the wound clinic.

Client #4 was dependent on agency staff for his foot care due to physical limitation with a recorded body mass of greater than 450 pounds According to a PCA weekly flow sheet contained in the client's record, documentation indicated the client had been receiving skin care and assistance with dressing and undressing at least six days per week for the three weeks prior to his hospitalization July 19, 2007, with foot maggots. A history and physical exam from Methodist Hospital dated August 7, 2007, indicated the client had been hospitalized from July 19 until July 25, 2007, for "chronic wounds/cellulitis and new athlete's foot with secondary maggots."

When observed, August 30, 2007, the LPN gathered supplies from shelves in the client #3's room to do his dressing change. The LPN did not wash her hands before gloving with two pair of gloves. She cut off Kerlix type gauze from the client's left foot first, then his right foot using bandage scissors correctly, then she inserted the scissors upside down into the bandage with the sharp pointy side next to the client's skin and began to cut away at the dressing. The Kerlix appeared thin and worn and there was no date on the dressing. When asked when the bandage had last been changed, the LPN stated, "I don't know." After the Kerlix dressings were removed, the LPN asked employee C "Can you get me a towel?' He handed her a white towel from inside the room that was folded as a fresh towel. The towel had multiple shreds and one side was almost all strings. The LPN placed the towel below client #3's feet but not under them. She then removed the adhesive bandage from the clients' right foot, lifted the foot approximately 6-8 inches off the bed and sprayed wound cleaner, without looking at the wound, and blotted the wound area with the shredded towel. Client #3 was observed to have an open area slightly larger than an eraser on the back of his right foot just above the heel by the tendon. The LPN placed his foot on the edge of the towel but some of the bloody wash got on his bed. She removed the adhesive bandage from his left foot. He had an open area the size of a quarter on the back of his left heel, and a quarter sized, red edged, white area that looked spongy on the heel base. She sprayed the open area with wound cleaner and it bled. She was about to put client #3's left heel down when the reviewer asked about the spongy appearing spot. The LPN responded "I didn't see that." The LPN then asked employee C if he'd seen it. He responded "Yes, it used to be real purple." The LPN did not inquire further. She applied wound gel and adhesive dressing to the right heel and then Kerlix and placed the foot on the towel between two blood stained areas. When this reviewer questioned the placement and potential for contamination with blood from the towel she lifted up the foot and said 'See it's between, I didn't touch it (the blood)." She then set foot back down between blood spots on the towel and began to dress the left foot. The licensed practical nurse (LPN) was observed to take the bloody treatment towel, ball it up, set it on the foot end of the bed atop the sheets and then place it in a bag on other side of the room. She removed her gloves to reveal a 2nd pair on underneath. When asked who last changed his foot dressings prior to this observed change client #3 indicated the owner had changed the dressings about two weeks ago.

Latex was listed as an allergy on client #3's history and physical of December 2, 2006. When the dressing change was observed on client #3 on August 31, 2007, employee D held up the client's leg with latex gloves on her hands and verified she had on latex gloves, stating "that's all we have."

INFECTION CONTROL

Client #3 began receiving services on January 23, 2007. Client #3 had diagnoses of quadriplegia, diabetes mellitus, Methicillin resistant staphylococcus aureus,(MRSA) and had an indwelling urinary catheter, colostomy, tracheostomy, and open areas. Client #3's cares were observed on August 30, 2007, at 6:45 p.m. Employee C was observed emptying the client's catheter bag. He did not wash his hands prior to putting on gloves. He emptied urine into a graduate container and then emptied the contents of

the container into the toilet. Employee C asked the client where the alcohol wipes were kept and client #3 told him. Employee C did not wash his hands afterward and was observed to go directly to assisting another client.

When morning care was observed on client #3 on August 31, 2007, employee D picked up a container that had previously been used as a urine container, which she then put water in. Client #3 told her to get a clean container, which employee D did. Employee D then poured the water from the clean container into the colostomy bag and onto the colostomy stoma to clean it. Employee D touched Bacitracin (ointment) from a tube with her gloved hand that had already touched the insulin supplies, supply drawers in room, the wound dressing, and suprapubic catheter tube. Then with the same gloves on, employee D took the pump out of the lotion bottle and ran her gloved hand the length of the pump to get lotion out to rub on client's skin, thus contaminating the lotion. A suction machine was observed on August 29, and 30, 2007 in client #3's room. The collection canister was completely full of water with whitish sediment that had sunk to the bottom and particulate matter in the liquid. Based on client #3's discharge summary of December 8, 2007, client #3 had Methicillin-resistant Staphylococcus aureus, (MRSA) in his sputum. This was also noted in his agency chart. When interviewed August 31, 2007, client #3 indicated it had been days since he had been suctioned.

When suctioning was observed on client #2, August 31, 2007, the licensed practical nurse indicated she had washed her hands before coming into the room and said she was going to wash her hands after doing the cares. She had opened the door to come into the room (before cares) thus contaminating the gloves and opened the door to leave the room after providing cares with the gloves on thus contaminating the door knob. The suction container for client #2 was full of water and phlegm.

MEDS:
On August 29, 2007, at 8:15 p.m. the licensed practical nurse (LPN) was observed passing medications. The LPN was observed to take pills out of a medi-set container that had previously been set-up and gave the pills to the clients. The LPN did not have the medication administration record available to use when administering the medications, until she dropped one of the pills out of the medi-set onto the floor. The LPN checked the medication administration record to identify what pill had been dropped. The LPN was observed to not sign out the medications as being administered until she had administered all the clients' medications. In addition, the LPN was observed at 8:30 p.m., to sign out that she administered the client's 4:00 p.m. medications as well as the clients' 8:00 p.m. medications. The licensee's policy related to medication administration indicated that the five rights for safely giving medication were to be reviewed; right client, right medication, right time, right route, and right dose. The medication policy also indicated that after administering the medication, the person administering the medication was to document the administration in the clinical record.

On August 31, 2007, client #3 indicated he had asked for his morning medications at 8:03 a.m., but the licensed practical nurse (LPN) did not bring them until 8:48 a.m. There was a digital clock observed to be directly visible to client #3 in his room. When interviewed regarding this delay the LPN stated "I still have a window." At 1:00 p.m. client #3 stated to the reviewer, "I haven't got my noon pills yet." At 2:25 p.m. client #3 indicated that the nurse had brought the pills in at 1:30 p.m. but had taken them back right away. At 4:00 p.m. the client had not had his medication yet and was asking for a pain pill.

Client #4 Coumadin
It could not be determined if client # 4 had received the appropriate dosage of Coumadin as the dosage as stated on the medication record did not match the physician's order of August 16, 2007.

Client #4 had a physician's order dated, August 16, 2007, for Coumadin 10 mg. (milligrams) "Adjust Dose per INR (International Normalized Ratio – a test to determine the clotting time of the blood) Value;" Coumadin 5 mg. "Adjust Dose per INR Value;" and Coumadin 7.5 mg. "Adjust Dose per INR Value." There were no physician's orders to indicate when to administer a particular dose of Coumadin, when to hold the Coumadin and when to draw an INR

The August 2007 medication record noted that Coumadin 10 milligram one tab orally was to be administered at bedtime, with an additional 2.5 mg. to be given on Tuesday, Thursday and Saturday. The record indicated by staff initials that client #4 received Coumadin on August 16, 17, 18, 19, 20, 21 and 22, 2007. It could not be determined which dose was given and whether the August 16, 2007, physician's order had been implemented. The record indicated that employee C, an unlicensed staff member, administered the Coumadin on August 16, 17, 20, 21 and 22, 2007. It could not be determined under what direction employee C had administered the Coumadin.

There was documentation of only one INR result. The medication record indicated an INRs were "done" on August 17 and 29, 2007. On August 29, 2007, the medication record indicated the INR was 1.6

The Coumadin was held on August 23, 24, 25, 26 and 27, 2007. It could not be determined which employee held the Coumadin between August 23-27, 2007 as the medication record just indicated "held." When interviewed, August 30, 2007, the licensed practical nurse stated, "I held the Coumadin."

Staff documented that the client received Coumadin 5 mg. on August 28, 2007, and 7.5 mg. on August 29 and 30, 2007. It could not be determined who administered the Coumadin as staff documented only the dosage and not their initials.

LACK OF ASSISTANCE WITH BATHING:
During a tour on August 30, 2007, of the bathroom/shower area, the shower appeared to have dust in it. The bathtub was observed to have equipment stored in it. Documentation on the back of the bathroom/shower door titled "Bath List" listed two clients that were not current clients of the licensee.

Documentation on client #1's personal care attendant's (PCA) care plan indicated that he required assist of one to bathe. The "Bath List" indicated client #2 was to get a bath two times a week, one being Thursday a.m. When interviewed on August 30, 2007, (Thursday) in the afternoon, employee E stated that client #1 had not had a bath that morning. The "PCA Weekly Flowsheet Charting" form from July 9 through August 30, 2007 lacked evidence that client #1 was assisted with a bath/shower during that time period.

Client #2 began receiving services on August 24, 2007, and was not listed on the bath list. During the survey, client #2 was observed to have a strong urine odor on himself and in his room. There was no evidence in the nurse's notes that he had received a bath since he began receiving services.

On August 30, 2007, client #3's toenails were very long and the right great toe nail was black and purple down the entire nail bed and was curling under the toe. All client #3's toenails were very long beyond the ends of his toes and some were curling back under the toe. The left baby toe nail was black as well. And the left great toe nail was very thick as well as long. When interviewed during the dressing change on August 30, 2007, the LPN stated "the nurse" cut his nails. When asked when it was last done? She

responded "I'll have to see when he's due." There was no documentation client #3's toenails had been cut since prior to April 2007.The client was observed to look greasy with shiny skin on his face and oily clumped hair. During this dressing change and cares, client #3 stated his last bath was two weeks ago. Employee C said he thought it was supposed to be done on Tuesday and he'd make sure client #3 got a bath the next day. The agency bath list indicated that client #3 was to be bathed "Friday AM" in a shower chair with the assist of one staff and had every a.m. added as an undated entry. There was no documentation of client #3 having been bathed since before April 2007. On August 31, 2007, at 4:00 p.m. client #3 had still not been bathed.

Client #4 weighed in excess of 450 pounds, and was wheelchair bound. When observed, August 31, 2007, client #4 had a stomach apron of skin that filled his lap and hung over his knees to mid way between his knees and his ankles. His lower extremities were partially covered with a blanket leaving the lower portion of the stomach apron exposed. The skin on the stomach apron was blackened with crustations approximately the size of a nickel covering the entire area that was exposed. When interviewed, August 31, 2007, client #3 stated he was not bathed or showered at the establishment because it was difficult for him to fit into the shower and he had open areas on both lower extremities. He said "I basically have no skin on the backs of my legs," pointing to his posterior lower leg area. He further stated that his physician did not want the open areas to get wet. I asked if he got a bed bath at the establishment. He stated that the agency staff members were to "wash me up when I'm getting ready but that just doesn't happen." He was unable to recall when staff had last assisted him to bathe and stated the last time he had a complete "wash up" was when he had been hospitalized. The agency bath list indicated that client #4 was to be bathed "Friday AM" in a shower chair with the assist of one staff and had every AM added as an undated entry. When interviewed, August 31, 2007, employees C and D both confirmed that client #4 was not bathed at the establishment. Employee C stated there was a "doctor's order" not to bathe client #4 so his wounds would not get wet. Employee D stated client #4 was washed while at the wound clinic so it was not done by the agency staff.

33. MN Statute §144A.44 Subd. 1(5)

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the agency failed to allow the resident to refuse treatment for one of one client (#1) record reviewed who chose not to take his medications. The findings include:

Client #1 began receiving services, October 28, 2005. On March 14, 2000, the client received a letter from his physician saying he understood he had been refusing his Dilantin (anti seizure) mediations. On a bubble pack of Depakote (anti seizure medication) dated March 20, 2007, the instructions included: "sprinkle on food w/ (with) each meal." No order was found to substantiate the instruction. When interviewed, August 30, 2007, the client repetitively brought up that the staff had tried to put medication on his food and he hadn't taken it because it made him feel bad.

34. MN Statute §144A.44 Subd. 1(11)

INDICATOR OF COMPLIANCE: # 2

Based on observation and interview, the licensee failed to provide the right to have personal and medical information kept private for one of three current clients' (#3) records reviewed. The findings include:

During client visits August 30, 2007, and August 31, 2007, two clients (#2 and #4) mentioned to the reviewers that client #3 was an illegal alien, charity case, accident victim, and wondered why client #3 should think that he should be first all the time for cares.

During an interview August 31, 2007, client #4 stated regarding client #3 "I think he's an illegal alien." He further stated client #3 "had his accident in the States." He stated that the owner "is carrying him as a charity case. She's not getting paid for him." He indicated he thought client #3 should be deported or should "go away without anything." When asked how he knew client #3's history he stated he used to live in another facility with client #3 but did not know these things until he heard it from the owner of this agency.

35. MN Statute §144A.44 Subd. 1(14)

INDICATOR OF COMPLIANCE: # 2

Based on record review, observation and interview, the licensee failed to treat clients with courtesy and respect for two of four current clients' (#3 and #4) records reviewed. The findings include:

Client #3 had diagnoses of quadriplegia, diabetes mellitus, and had an indwelling urinary catheter, tracheostomy, colostomy, and open areas. On August 30, 2007, during a home visit**,** client #3 stated "That nurse", "the… one here tonight she don't like me." He stated, "I ask for help she says 'No.' She's always smoking, smoking." He stated that the licensed practical nurse would not help him when he asked and would pull staff away to do other things so they could not help him either. He added, "But, she always has time for a cigarette." Nurse's notes dated August 30, 2007, stated "Writer left et not attempt to provide treatment for the remainder of the shift." A nurse's notes dated August 30, 2007, at 2:20 p.m. stated "Res informed NAR that he wanted pain meds and writer informed NAR that res needs to request pain meds from the nurse."

On August 31, 2007, the licensed practical nurse (LPN) changed client#3's decubitus dressings. When client #3 asked that the dressing be moved down, the LPN disregarded the client's two requests stating to the reviewer, "see what I have to put up with?" in front of the client and employee D. The LPN then told client #3, "you need to respect me," "I don't have to put up with this!" When the client responded with "you should do what I want," the LPN stated "I'm not putting up with it" and she dropped the client's leg down onto the pillow and bed and left the room for 45 minutes. During this time, employee D could not complete the morning cares so client #3 could get up for the day. When the LPN returned to the room, she did not speak to the client or look at him, stating, "I heard him, I just don't answer right away".

Client #3 stated he had asked for his morning medications at 8:03 am, but the LPN had not brought them until 8:48 a.m.., and the LPN stated "I still have a window." There was a digital clock clearly visible to the client in his room. The LPN's charting in the nurses notes on August 31, 2007 stated "writer went in to do res Tx, et applied allevyn to L heel with wound cream et remove it at resident request et reapplied it and he said you don't listen stupid lady, writer refused to be verbally abused, stop the treatment and left the room, state dept. observer, et a.m. aid was in room assisting the nurse, 0800 meds et res does not have nursing, only PCA care et services"

On August 31, 2007, 10:05 a.m. the LPN was observed in the agency central hallway yelling that she was refusing to do treatment on client #3. She was yelling about client #3 as client #1 was in the kitchen

and right outside client #2's door which was open. The reviewer was in the dining room and could easily hear the LPN. Employee B walked by the dining room and stated "It's not Mother Teresa around here" as he walked toward the kitchen.

36. MN Statute §144A.44 Subd. 1(15)

INDICATOR OF COMPLIANCE: # 2

Based on observation and interview, the licensee failed to ensure the right to be free from physical abuse for one of four current clients' (#3) records reviewed. The findings include:

During an interview August 31, 2007, client #3 who is cognitively intact and is his own legal guardian, indicated that the licensed practical nurse (LPN) had tried to choke him about 3-4 months ago. When the reviewer clarified by stating, "choke you?", he put his hands up to his throat in a choking motion. The reviewer then put her hands around her neck in a choking motion, and client #3 indicated that the LPN had done that to him, asking, "Why is she back here?" (When interviewed, August 29, 2007, the LPN noted that she had been on a leave of absence and had only recently returned.) The next time the reviewer saw the LPN she stated, "Wait 'til you guys leave, he won't be so nice anymore." On the afternoon of August 31, 2007, , the LPN was observed walking down the hall, saying in a loud voice, "what ever he said was a lie, if he told you I hurt him, he's lying".

37. MN Statute §144A.46 Subd. 5(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that background studies were conducted for one of one management employee (B). The findings include:

Employee B was observed to be working at the Housing with Services where the licensee's clients resided on all days of the survey. When interviewed on August 29, 2007, the owner stated that employee B was hired to take over the management of the home care agency. When interviewed on August 29, 2007, employee B stated that he "just got on payroll last week." There was no evidence that a background study had been submitted for employee B. The Department of Human Services, Background study unit verified on September 5, 2007, that they had not received a background study for employee B.

38. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the agency failed to ensure that clients were assessed for their susceptibility to abuse and potential to abuse other vulnerable adults for four of four current clients' (#1, #2, #3 and #4) records reviewed. The findings include:

Client #1 began receiving services from the licensee on October 28, 2005. Client #1 was deaf, had difficulty communicating, and had a history of seizures that required monitoring for his safety. There was no individual abuse prevention plan developed for this client. When interviewed on August 30, 2007, the licensed practical nurse (LPN) stated there should have been, but was unable to locate one.

Client #2 began receiving services August 24, 2007. There was no evidence of a vulnerability assessment in client #2's record.

Client #3 began receiving services on January 23, 2007. Client #3 had diagnoses of quadriplegia, diabetes mellitus, and had an indwelling urinary catheter, tracheostomy, and open areas. There was no assessment or plan for vulnerability.

Client #4 began receiving services June 29, 2005. Client #4 had a diagnosis of morbid obesity, diabetes and cellulitis with open areas. There was no evidence of a vulnerability assessment and plan. Client #4 indicated on August 31, 2007, that he could not stand for more than 30 seconds at a time, and had frequent falls.

An exit conference was not conducted. 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).