Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6949

September 1, 2010

Michael Demmer, Administrator
Prairie Senior Cottages New Ulm
1304 Birchwood Drive
New Ulm, MN 56073

Re: Licensing Follow Up visit

Dear Mr. Demmer:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Home Care & Assisted Living Program, on July 29, 2010.

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
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) 201-5273.

Sincerely,

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosure(s)

cc: Brown County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: PRAIRIE SR COTTAGES NEW ULM

DATE OF SURVEY: July 21, 2010

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:
Sue Altmann, RN
Ashley Weiland, LPN
Linda Tauer, LPN/Housing Director
Ashley Geiger, Caregiver

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 February 4, 8, 9 and 10, 2010. 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 July 21, 2010, is as follows:

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

2. MN Rule 4668.0835 Subp. 3 **Corrected**

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

4. MN Statute §144A.441 **Corrected**

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

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7168

July 23, 2010

Michael Demmer, Administrator
Prairie Senior Cottages New Ulm
1304 Birchwood Drive
New Ulm, MN 56073

Re: Prairie Senior Cottages New Ulm
Correction Orders - February 10, 2010

Dear Mr. Demmer:

This is in response to your letter received on May 28, 2010, in regard to your request for review for the correction order **MN Statute §144A.44 Subd. 1(2),** issued pursuant to a survey completed on February 10, 2010 and sent to you on April 26, 2010. Information presented with your letter, the correction order, as well as survey documents and discussion with representatives of MDH staff have been carefully considered and the following determination has been made:

MN Statute §144A.44 Subd. 1(2): A person who receives home care services has these rights: …(2) 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.

This correction order has been modified. The correction order as modified is valid. The revised correction order is attached. Please sign the correction order form, make a copy for your file, and return the entire original form to this office when all orders are 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.

Please feel free to call our office with any questions at (651) 201-4309.

Sincerely,

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

cc: Brown County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Deb Peterson, Office of the Attorney General
MN Board of Nursing

Certified Mail # 7009 1410 0000 2303 7168

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900
Home Care and Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	MICHAEL J DEMMER	April 26, 2010
PROVIDER:	PRAIRIE SR COTTAGES NEW ULM	COUNTY: BROWN
ADDRESS:	1304 BIRCHWOOD DRIVE NEW ULM, MN 56073	HFID: 21584

REVISED CORRECTION ORDERS

On February 4, 8, 9 and 10, 2010, a surveyor of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed:_____ Date: _____

In accordance with Minnesota Statute §144A.45, this correction order has been issued pursuant to a survey. If, upon re-survey, it is found that the violation or violations cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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 may be considered lack of compliance and subject to a fine.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

1. MN Rule 4668.0815 Subp. 4

Based on record review and interview, the licensee failed to ensure that service plans were complete for one of one client's (1) record reviewed. The findings include:

Client #1's service plan, dated November 11, 2009, just noted "personal cares." There was not a description of what the personal cares were.

When interviewed February 8, 2010, a registered nurse stated the client received total care except for walking and that the service plans were generic for everyone and not individualized.

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 class F 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 class F 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 class F 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.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0835 Subp. 3

Based on record review and interview, the licensee failed to ensure that unlicensed personnel who performed assisted living home care services, received eight hours of in-service training for each twelve months of employment for one of one employee's (B) record reviewed. The findings include:

Employee B was hired April 16, 2007, as a unlicensed direct care staff. Documentation of in-service training for January through December 2009 did not identify how many minutes and/or hours of training were provided.

When interviewed February 10, 2010, employee A indicated training could be two hours sometimes, but couldn't find any documentation of the length of time for the training.

TO COMPLY: For each unlicensed person who performs assisted living home care services, a class F home care provider licensee must comply with items A to C.

A. For each 12 months of employment, a person who performs assisted living home care services must complete at least eight hours of in-service training in topics relevant to the provision of home care services, including training in infection control required under part 4668.0065, subpart 3, obtained from the licensee or another source.

B. If a person has not performed assisted living home care services for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence according to part 4668.0840, subpart 4, item C.

C. A licensee must retain documentation of satisfying this part and must provide documentation to a person who completes the in-service training.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Statute §144A.44 Subd. 1(2)

Based on record review and interview, the licensee failed to provide services according to acceptable medical and nursing standards for seven of seven clients' (#1, #2, #3, #4, #5, #6 and #7) reviewed. The findings include:

Clients #1, #2, #4, #5 and #7 lacked an assessment and interventions related to the prevention of falls. A review of facility documentation revealed client #1 had 27 falls between January 8, 2009 and February 6, 2010. A fall on November 6, 2009 and January 28, 2010, resulted in emergency room visits, one with a scalp hematoma. Client #2 had eight falls between January 3, 2009 and January 3, 2010 and client #4 had fifteen falls between February 5, 2009 and January 24, 2010. Client #5 and #7 had a fall July 26, 2009 and November 18, 2009, respectively which resulted in hip fractures.

When interviewed February 9, 2010, employee F, registered nurse (RN), indicated there had been no analysis of the clients' falls, because they did not have a form. Employee (F) also indicated the licensee felt client #1's falls were related to urinary tract infections.

Client #1 lacked an assessment and interventions prior to the use of restraints. Client #1's record contained a fax to the physician, dated August 13, 2009, which noted the following: The client is so focused on standing that she forgets to eat. Her daughter indicated that this goes back in her life and stated "she was always standing at the counter to eat." The client is too unsteady to be able to do that now and "Once we apply a transfer belt around her lower abd. area," and around the chair, she is content to sit et eat. "Is this ok? Family is ok with doing this." The doctor responded on August 17, 2009, "If it gets her to eat and keeps her safe from falling - this is ok!" The current care plan in the caregiver's book, dated October 14, 2008, indicated the client is very restless at meal times and that a transfer belt may be used around the resident and the chair. This could be done only during meals and staff was to be present at all times to "promote nutrition." There was no documentation present to indicate when the restraint was used.

Client #1 was observed eating February 10, 2010, at 11:30 a.m. She was not restrained and was feeding herself. There was no staff in attendance and the transfer belt was hanging on the back of the chair.

When interviewed February 8, 2010, employees B and D, unlicensed caregivers, stated client #1 was usually restrained with the transfer belt for lunch and supper. When interviewed February 9, 2010, employee E, unlicensed caregiver, stated client #1 was sometimes restrained for supper.

Client #1, #3 and #6 lacked prescriber's orders prior to receiving medication dose changes by nursing. Client #1 was admitted and began receiving services October 14, 2008, in the locked memory unit. A facsimile (fax), dated September 8, 2009, sent by the facility to the physician stated "restarted Seroquel (antipsychotic medication) 25 mg qd at 8 pm & PRN was not sleeping at night. Is sleeping better now that Seroquel given." The physician responded "all ok!" to the fax on September 9, 2009.

The October 2009 MAR indicated client #1 was to receive Seroquel 25 mg., one tablet by mouth – at bedtime and as needed. The "at bedtime and as needed" was crossed out and written was "n.o. (nursing order) 10/20 (October 20, 2009) Seroquel 25 mg 8 am daily." Another notation read "10/27 (October 27, 2009)-start 25 mg daily at noon-use from prn (pro re nata, as needed) card, n.o."

A fax, dated October 20, 2009, sent by the facility to the physician stated "receives Seroquel 25 mg q (every) HS (bedtime) would like to increase to Seroquel 25 mg 8 a & 8 p et PRN." The physician approved the increase at 8 a.m. and 8 p.m. on October 25, 2009.

A fax, dated October 28, 2009, sent by the facility to the physician stated, "we have been managing Seroquel per nurse's discretion trying to increase to find adequate dosage using the PRN order." On October 29, 2009, the physician responded with an order which read "Increase Seroquel to 50 mg tid with 25 mg PRN outbursts. Decrease dose if too sedated."

The November 2009 MAR noted an order for Seroquel 25 mg. tablet, take one tablet by mouth twice daily in the a.m. and at bedtime as as needed. There was a notation by the order indicating a change on "11/2/09." The 25 mg. was crossed out and 50 mg. was written in. Also, crossed off was "twice daily in the a.m. and at bedtime and as needed."

Below the preceding order were other directions for the Seroquel on "11/18/09." The Seroquel 25 mg. was crossed off and 50 mg. was written in to give at 12 noon "per N.O." Further documentation noted "increased 11/30/09."

A fax, dated November 30, 2009, was sent by the facility to the physician stated "had been receiving Seroquel 50 mg tid as ordered on 10/28/09. We decreased to 50 mg at 8 A – 25 mg at noon- 50 mg at 5 p due to unsteadiness et increased falls. Due to increased behaviors of pushing et hitting et shoving

other residents (she pushed another resident down over the weekend) we are increasing it back to Seroquel 50 mg tid." There was no a physician acknowledgement of the fax.

The December 2009 MAR noted handwritten documentation of an order, dated December 4, 2009. The documentation read to give Seroquel 75 mg. at 8:00 a.m. and 12 Noon per "N.O."

A fax, dated December 4, 2009, sent by the facility to the physician stated "is on Seroquel 50 m 8a/12N/5 p. I have increased noon to 75 mg." There was no physician acknowledgement of the fax.

A fax, dated December 7, 2009, sent by the facility to the physician stated, stated "will now try 75 mg Seroquel 8am/12N with 50 mg @ 5pm." The physician responded to the fax December 9, 2009, "let me know how that works."

The December 2009 MAR included an order for Seroquel 50 mg. tablets, take one tablet by mouth by mouth three times a day. The order had been changed to read "1 ½ tablets" with a notation "increased to 75 mg 12/14/09 (with employee A's (licensed practical nurse) initials)."

A fax, dated December 14, 2009, sent by the facility to the physician stated "still trying to control behaviors- unprovoked hitting, hard to re-direct or give cares without much hitting/swearing. Ok to increase Seroquel to: Seroquel 75 mg tid and 25 mg PRN." The physician provided a written response on the fax December 16, 2009, which read "agree."

The physician was sent another fax on January 4, 2010, indicating that the Seroquel was increased to 100 mg. at noon. The order on the fax read Seroquel 75 mg. at 8:00 a.m. and 5:00 p.m., 100 mg. at noon and 25 mg. prn. The physician provided a written response on the fax on January 7, 2010, which read "Agree w/all above."

A fax to the physician with an electronic sent date of January 29, 2010, included information that the client had fallen on January "21st, 23rd, 25th, 28th, 29th." The fax included an undated note by the physician, which read, "maybe falling because sedated with Seroquel."

Client #3 was admitted July 9, 2009, to the locked memory care facility. The facility communication log included documentation on January 26, 2010, which read "I started him on his PRN Zyprexa 2xday. Give at 8 A – 5 P. I'm not sure this is the right med for anxiety/paranoia but that is what is ordered and we need to try it B/4 we can tell the Dr. its not working, could we try something different." Another entry in the communication log on February 4, 2010 read, "we are trying to get his Zyprexa chgd to Seroquel but his Dr. is out of office till Weds and no other Dr. wants to address it. Hopefully, next wk. we'll get it done. In the mean time, use his PRN Zyprexa if needed." Both notes were signed by employee A.

Client #6 was admitted December 6, 2006, to the locked memory care facility. A note in the communication log, dated January 20, 2010, read "I started her back on her PM Seroquel." Another note on January 21, 2010, read "I put her Seroquel back on hold- zonked her out way too much. Give

Seroquel 25 mg PRN only- call nurse 1st." Both entries were signed by employee A (licensed practical nurse).

When interviewed February 9, 2010, employee A confirmed that she should not be adjusting the doses of medications for clients #1, #3 and #6, but indicated that she thought it was part of nursing responsibility to see if the medication worked. When interviewed February 9, 2010, employee (F) indicated she had informed employee A that she (employee A) would not be adjusting the doses on medications again.

TO COMPLY: A person who receives home care services has these rights:
(2) 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;

TIME PERIOD FOR CORRECTION: Thirty (30) days

4. MN Statute §144A.441

Based on record review and interview, the licensee failed to provide the current Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted and began receiving services October 14, 2008. The Minnesota Home Care Bill of Rights (dated, September 4, 2004,) and a Resident Bill of Rights (dated, August 20, 1999,) were documented as received on October 11, 2008, but did not include the current language for assisted living clients in clause 16, which included the right to at least a 30 day advance notice of termination of service by a provider.

When interviewed February 8, 2010, the director indicated the documents covered the required information because she had compared it to the current bill of rights.

TO COMPLY: Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):
"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:
(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;
(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

TIME PERIOD FOR CORRECTION: Thirty (30) days

5. MN Statute §626.557 Subd. 14(b)

Based on record review and interview, the licensee failed to develop an individualized abuse prevention plan for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted to the locked memory care housing with services on October 14, 2008. The vulnerability assessment, dated September 30, 2008, indicated the client was not oriented to person, place, and time and had no speech barriers. She was unable to understand, communicate or follow directions. She was "at risk for abuse or abusing" and the intervention was to follow the "Alzheimer's/Dementia Lessons." The care plan upon admission indicated the client "lacks mental/physical self preservation skills."

The client's record indicated that she had several adjustments by nursing of her Seroquel (antipsychotic medication). The medication was increased on September 8, 2009, due to not sleeping, on October 28, 2009, due to outbursts, and on November 30, 2009, due to pushing, hitting and shoving other residents, on December 14, 2009, to try and control her behaviors. The Seroquel was again increased on January 4, 2010. The client had 27 falls between January 8, 2009 and February 6, 2010.

Client #1 had an incident report, dated December 13, 2009, which indicated that while doing morning cares employee C was holding the client in a hug style when she became combative. The report further indicated that when the client was being laid down "she twisted" and her right foot, big toe, was accidently stepped on.

The assessment had not been updated and the plan lacked specific measures to be taken to assist in minimizing the risk of abuse to the client and other vulnerable adults.

When interviewed February 8, 2010, a registered nurse stated she had not understood the form.

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: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

TIME PERIOD FOR CORRECTION: Thirty (30) days

cc: Brown County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Deb Peterson, Office of the Attorney General
MN Board of Nursing

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7380

May 5, 2010

Michael Demmer, Administrator
Prairie Senior Cottages New Ulm
1304 Birchwood Drive
New Ulm, MN 56073

Dear Mr. Demmer:

On April 26, 2010, you were sent a letter with State Licensing deficiencies delineated on a correction order form in relation to a survey that was conducted on February 4, 8, 9, and 10, 2010. In error we may have neglected to send you a copy of the Licensing Survey form with this information.

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

Sorry for any inconvenience this may have caused. Please feel free to call our office with any questions at (651) 201-4309.

Sincerely,

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 2810 0001 2257 4193

April 26, 2010

Michael Demmer, Administrator
Prairie Sr Cottages New Ulm
1304 Birchwood Drive
New Ulm, MN 56073

Re: Results of State Licensing Survey

Dear Mr. Demmer:

The above agency was surveyed on February 4, 8, 9, and 10, 2010, for the purpose of assessing compliance with state licensing regulations. State licensing orders 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. If further clarification is necessary, an informal conference can be arranged.

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) 201-5273.

Sincerely,

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

cc: Brown County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Deb Peterson, Office of the Attorney General
MN Board of Nursing

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: PRAIRIE SR COTTAGES NEW ULM

HFID #: 21584

Date(s) of Survey: February 4, 8, 9 and 10, 2010

Project #: QL21584007

Indicators of Compliance	Outcomes Observed	Comments
1. The provider only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. **Focus Survey** • MN Rule 4668.0815 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0825 Subp. 2 • MN Rule 4668.0845	• Each client has an assessment and service plan developed by a registered nurse within 2 weeks and prior to initiation of delegated nursing services, reviewed at least annually, and as needed. • The service plan accurately describes the client's needs. • Care is provided as stated in the service plan. • The client and/or representative understand what care will be provided and what it costs.	**Focus Survey** ____Met _X_Correction Order(s) issued _X_Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes the clients' rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170 • MN Statute §144D.04 • MN Rule 4668.0870	• Clients are aware of and have their rights honored. • Clients are informed of and afforded the right to file a complaint. • Continuity of Care is promoted for clients who are discharged from the agency.	**Focus Survey** ____Met _X_Correction Order(s) issued X 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 _X_Correction Order(s) issued X Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. • Nurse licenses are current. • The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. • The process of delegation and supervision is clear to all staff and reflected in their job descriptions. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** ____ Met _X_ Correction Order(s) issued X 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** _X_ Met ___ Correction Order(s) issued _X_ Education Provided **Expanded Survey** _X_ Survey not Expanded ___ Met ___ Correction Order(s) issued ___ Education Provided **Follow-up Survey** #___ ___ New Correction Order issued ___ Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• The CLASS F license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. • The agency operates within its license(s) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** _X_ Met ___ Correction Order(s) issued ___ Education Provided **Expanded Survey** _X_ Survey not Expanded ___ Met ___ Correction Order(s) issued ___ Education Provided **Follow-up Survey** #___ ___ New Correction Order issued ___ Education Provided

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

<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 4668.0815 Subp. 4

<u>INDICATOR OF COMPLIANCE</u>: # 1

Based on record review and interview, the licensee failed to ensure that service plans were complete for one of one client's (1) record reviewed. The findings include:

Client #1's service plan, dated November 11, 2009, just noted "personal cares." There was not a description of what the personal cares were.

When interviewed February 8, 2010, a registered nurse stated the client received total care except for walking and that the service plans were generic for everyone and not individualized.

2. MN Rule 4668.0835 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed personnel who performed assisted living home care services, received eight hours of in-service training for each twelve months of employment for one of one employee's (B) record reviewed. The findings include:

Employee B was hired April 16, 2007, as a unlicensed direct care staff. Documentation of in-service training for January through December 2009 did not identify how many minutes and/or hours of training were provided.

When interviewed February 10, 2010, employee A indicated training could be two hours sometimes, but couldn't find any documentation of the length of time for the training.

3. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide services according to acceptable medical and nursing standards for seven of seven clients' (#1, #2, #3, #4, #5, #6 and #7) reviewed. The findings include:

Clients #1, #2, #4, #5 and #7 lacked an assessment and interventions related to the prevention of falls. A review of facility documentation revealed client #1 had 27 falls between January 8, 2009 and February 6, 2010. A fall on November 6, 2009 and January 28, 2010, resulted in emergency room visits, one with a scalp hematoma. Client #2 had eight falls between January 3, 2009 and January 3, 2010 and client #4 had fifteen falls between February 5, 2009 and January 24, 2010. Client #5 and #7 had a fall July 26, 2009 and November 18, 2009, respectively which resulted in hip fractures.

When interviewed February 9, 2010, employee F, registered nurse (RN), indicated there had been no analysis of the clients' falls, because they did not have a form. Employee (F) also indicated the licensee felt client #1's falls were related to urinary tract infections.

Client #1 lacked an assessment and interventions prior to the use of restraints. Client #1's record contained a fax to the physician, dated August 13, 2009, which noted the following: The client is so focused on standing that she forgets to eat. Her daughter indicated that this goes back in her life and stated "she was always standing at the counter to eat." The client is too unsteady to be able to do that now and "Once we apply a transfer belt around her lower abd. area," and around the chair, she is content to sit et eat. "Is this ok? Family is ok with doing this." The doctor responded on August 17, 2009, "If it gets her to eat and keeps her safe from falling - this is ok!" The current care plan in the caregiver's book, dated October 14, 2008, indicated the client is very restless at meal times and that a transfer belt may be used around the resident and the chair. This could be done only during meals and staff was to be present at all times to "promote nutrition." There was no documentation present to indicate when the restraint was used.

Client #1 was observed eating February 10, 2010, at 11:30 a.m. She was not restrained and was feeding herself. There was no staff in attendance and the transfer belt was hanging on the back of the chair.

When interviewed February 8, 2010, employees B and D, unlicensed caregivers, stated client #1 was usually restrained with the transfer belt for lunch and supper. When interviewed February 9, 2010, employee E, unlicensed caregiver, stated client #1 was sometimes restrained for supper.

Client #1 had an incident report, dated December 13, 2009, which indicated that while doing morning cares employee C was holding the client in a hug style when she became combative. The report further indicated that when the client was being laid down "she twisted" and her right foot, big toe, was accidently stepped on.

When interviewed February 9, 2010, employee (F) stated client #1 was restrained three shifts out of five days a week for meals. She stated the belt was used for convenience to feed the client, and a "hug style" was considered a restraint.

Client #1, #3 and #6 lacked prescriber's orders prior to receiving medication dose changes by nursing. Client #1 was admitted and began receiving services October 14, 2008, in the locked memory unit. A facsimile (fax), dated September 8, 2009, sent by the facility to the physician stated "restarted Seroquel (antipsychotic medication) 25 mg qd at 8 pm & PRN was not sleeping at night. Is sleeping better now that Seroquel given." The physician responded "all ok!" to the fax on September 9, 2009.

The October 2009 MAR indicated client #1 was to receive Seroquel 25 mg., one tablet by mouth – at bedtime and as needed. The "at bedtime and as needed" was crossed out and written was "n.o. (nursing order) 10/20 (October 20, 2009) Seroquel 25 mg 8 am daily." Another notation read "10/27 (October 27, 2009)-start 25 mg daily at noon-use from prn (pro re nata, as needed) card, n.o."

A fax, dated October 20, 2009, sent by the facility to the physician stated "receives Seroquel 25 mg q (every) HS (bedtime) would like to increase to Seroquel 25 mg 8 a & 8 p et PRN." The physician approved the increase at 8 a.m. and 8 p.m. on October 25, 2009.

A fax, dated October 28, 2009, sent by the facility to the physician stated, "we have been managing Seroquel per nurse's discretion trying to increase to find adequate dosage using the PRN order." On October 29, 2009, the physician responded with an order which read "Increase Seroquel to 50 mg tid with 25 mg PRN outbursts. Decrease dose if too sedated."

The November 2009 MAR noted an order for Seroquel 25 mg. tablet, take one tablet by mouth twice daily in the a.m. and at bedtime as as needed. There was a notation by the order indicating a change on "11/2/09." The 25 mg. was crossed out and 50 mg. was written in. Also, crossed off was "twice daily in the a.m. and at bedtime and as needed."

Below the preceding order were other directions for the Seroquel on "11/18/09." The Seroquel 25 mg. was crossed off and 50 mg. was written in to give at 12 noon "per N.O." Further documentation noted "increased 11/30/09."

A fax, dated November 30, 2009, was sent by the facility to the physician stated "had been receiving Seroquel 50 mg tid as ordered on 10/28/09. We decreased to 50 mg at 8 A – 25 mg at noon- 50 mg at 5 p due to unsteadiness et increased falls. Due to increased behaviors of pushing et hitting et shoving other residents (she pushed another resident down over the weekend) we are increasing it back to Seroquel 50 mg tid." There was no a physician acknowledgement of the fax.

The December 2009 MAR noted handwritten documentation of an order, dated December 4, 2009. The documentation read to give Seroquel 75 mg. at 8:00 a.m. and 12 Noon per "N.O."

A fax, dated December 4, 2009, sent by the facility to the physician stated "is on Seroquel 50 m 8a/12N/5 p. I have increased noon to 75 mg." There was no physician acknowledgement of the fax.

A fax, dated December 7, 2009, sent by the facility to the physician stated, stated "will now try 75 mg Seroquel 8am/12N with 50 mg @ 5pm." The physician responded to the fax December 9, 2009, "let me know how that works."

The December 2009 MAR included an order for Seroquel 50 mg. tablets, take one tablet by mouth by mouth three times a day. The order had been changed to read "1 ½ tablets" with a notation "increased to 75 mg 12/14/09 (with employee A's (licensed practical nurse) initials)."

A fax, dated December 14, 2009, sent by the facility to the physician stated "still trying to control behaviors- unprovoked hitting, hard to re-direct or give cares without much hitting/swearing. Ok to increase Seroquel to: Seroquel 75 mg tid and 25 mg PRN." The physician provided a written response on the fax December 16, 2009, which read "agree."

The physician was sent another fax on January 4, 2010, indicating that the Seroquel was increased to 100 mg. at noon. The order on the fax read Seroquel 75 mg. at 8:00 a.m. and 5:00 p.m., 100 mg. at noon and 25 mg. prn. The physician provided a written response on the fax on January 7, 2010, which read "Agree w/all above."

A fax to the physician with an electronic sent date of January 29, 2010, included information that the client had fallen on January "21st, 23rd, 25th, 28th, 29th." The fax included an undated note by the physician, which read, "maybe falling because sedated with Seroquel."

Client #3 was admitted July 9, 2009, to the locked memory care facility. The facility communication log included documentation on January 26, 2010, which read "I started him on his PRN Zyprexa 2xday. Give at 8 A – 5 P. I'm not sure this is the right med for anxiety/paranoia but that is what is ordered and we need to try it B/4 we can tell the Dr. its not working, could we try something different." Another entry in the communication log on February 4, 2010 read, "we are trying to get his Zyprexa chgd to Seroquel but his Dr. is out of office till Weds and no other Dr. wants to address it. Hopefully, next wk. we'll get it done. In the mean time, use his PRN Zyprexa if needed." Both notes were signed by employee A.

Client #6 was admitted December 6, 2006, to the locked memory care facility. A note in the communication log, dated January 20, 2010, read "I started her back on her PM Seroquel." Another note on January 21, 2010, read "I put her Seroquel back on hold- zonked her out way too much. Give

Seroquel 25 mg PRN only- call nurse 1st." Both entries were signed by employee A (licensed practical nurse).

When interviewed February 9, 2010, employee A confirmed that she should not be adjusting the doses of medications for clients #1, #3 and #6, but indicated that she thought it was part of nursing responsibility to see if the medication worked. When interviewed February 9, 2010, employee (F) indicated she had informed employee A that she (employee A) would not be adjusting the doses on medications again.

4. MN Statute §144A.441

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide the current Minnesota Home Care Bill of Rights for Assisted Living Clients of Licensed Only Home Care Providers for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted and began receiving services October 14, 2008. The Minnesota Home Care Bill of Rights (dated, September 4, 2004,) and a Resident Bill of Rights (dated, August 20, 1999,) were documented as received on October 11, 2008, but did not include the current language for assisted living clients in clause 16, which included the right to at least a 30 day advance notice of termination of service by a provider.

When interviewed February 8, 2010, the director indicated the documents covered the required information because she had compared it to the current bill of rights.

5. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to develop an individualized abuse prevention plan for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted to the locked memory care housing with services on October 14, 2008. The vulnerability assessment, dated September 30, 2008, indicated the client was not oriented to person, place, and time and had no speech barriers. She was unable to understand, communicate or follow directions. She was "at risk for abuse or abusing" and the intervention was to follow the "Alzheimer's/Dementia Lessons." The care plan upon admission indicated the client "lacks mental/physical self preservation skills."

The client's record indicated that she had several adjustments by nursing of her Seroquel (antipsychotic medication). The medication was increased on September 8, 2009, due to not sleeping, on October 28, 2009, due to outbursts, and on November 30, 2009, due to pushing, hitting and shoving other residents, on December 14, 2009, to try and control her behaviors. The Seroquel was again increased on January 4, 2010. The client had 27 falls between January 8, 2009 and February 6, 2010.

Client #1 had an incident report, dated December 13, 2009, which indicated that while doing morning cares employee C was holding the client in a hug style when she became combative. The report further indicated that when the client was being laid down "she twisted" and her right foot, big toe, was accidently stepped on.

The assessment had not been updated and the plan lacked specific measures to be taken to assist in minimizing the risk of abuse to the client and other vulnerable adults.

When interviewed February 8, 2010, a registered nurse stated she had not understood the form.

A draft copy of this completed form was left with Linda Tauer, LPN, Housing Director, at a phone exit conference on February 12, 2010. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. Class F Home Care Provider general information is available by going to the following web address and clicking on the Class F Home Care Provider link:

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

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 8222

August 18, 2005

Michael Demmer, Administrator
Prairie Senior Cottages New Ulm
1304 Birchwood Drive
New Ulm, MN 56073

Re: Licensing Follow Up Revisit

Dear Mr. Demmer:

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 8, 2005.

The documents checked below are enclosed.

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

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

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

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

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Michael Demmer, President Governing Board
Kelly Crawford, Minnesota Department of Human Services
Brown County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Case Mix Review File

10/04 FPC1000CMR

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

INFORMATIONAL MEMORANDUM

PROVIDER: PRAIRIE SR COTTAGES NEW ULM

DATE OF SURVEY: 07/08/2005

BEDS LICENSED:

HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

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

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

NAME (S) AND TITLE(S) OF PERSONS INTERVIEWED: Jane Nuytten, LPN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up ___X_____

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to followup on the status of state licensing orders issued as a result of a visit made on December 28, 29, 30, 2004 and January 4, 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 4668.0815 Subp. 4 **Corrected.**

2. MN Rule 4668.0855 Subp. 9 **Corrected**

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 2876

March 24, 2005

Michael Demmer, Administrator
Prairie SR Cottages New Ulm
1304 Birchwood
New Ulm, MN 56073

Re: Results of State Licensing Survey

Dear Mr. Demmer:

The above agency was surveyed on December 28, 29, 30, 2004 and January 4, 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: Michael Demmer, President Governing Board
Case Mix Review File

CMR 3199 6/04

Assisted Living Home Care Provider

LICENSING SURVEY FORM

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

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

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

Name of ALHCP: PRAIRIE SR COTTAGES NEW ULM

HFID # (MDH internal use): 21584

Date(s) of Survey: December 28, 29, 30, 2004 and January 4, 2005

Project # (MDH internal use): QL21584001

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

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promotes the clients' rights as stated in the Minnesota Home Care Bill of Rights. (MN Statute 144A.44; MN Rule 4668.0030)	No violations of the MN Home Care Bill of Rights (BOR) are noted during observations, interviews, or review of the agency's documentation. Clients and/or their representatives receive a copy of the BOR when (or before) services are initiated. There is written acknowledgement in the client's clinical record to show that the BOR was received (or why acknowledgement could not be obtained).	_X_ Met ___ Correction Order(s) issued ___ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff observes infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	_X_ Met ___ Correction Order(s) issued ___ Education provided
4. The agency has a system to receive, investigate, and resolve complaints from its clients and/or their representatives. (MN Rule 4668.0040)	There is a formal system for complaints. Clients and/or their representatives are aware of the complaint system. Complaints are investigated and resolved by agency staff.	_X_ Met ___ Correction Order(s) issued ___ Education provided
5. The clients' confidentiality is maintained. (MN Statute 144A.44; MN Rule 4668.0810)	Client personal information and records are secure. Any information about clients is released only to appropriate parties. Permission to release information is obtained, as required, from clients and/or their representatives.	_X_ Met ___ Correction Order(s) issued ___ Education provided
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	_X_ Met ___ Correction Order(s) issued ___ Education provided

Indicators of Compliance	Outcomes Observed	Comments
7. The agency employs (or contracts with) qualified staff. (MN Statutes 144D.065; 144A.45, Subd. 5; MN Rules 4668.0070, 4668.0820, 4668.0825, 4668.0030, 4668.0835, 4668.0840)	Staff has received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff 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.	_X_ Met ___ Correction Order(s) issued ___ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff is trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	___ Met _X_ Correction Order(s) issued _X_ Education provided ___ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follows any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ___ Correction Order(s) issued _X_ Education provided ___ N/A
10. The agency has a current license. (MN Statutes 144D.02, 144D.04, 144D.05, 144A.46; MN Rule 4668.0012 Subp.17) Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	The ALHCP license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. The agency operates within its license(s).	_X_ Met ___ Correction Order(s) issued ___ 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. 3 Modifications of Service Plan.		X	**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 have a complete contingency plan for one of two current clients (#1) reviewed. The findings include: Client #1's current service plan was dated August 26, 2002. Client #1's record had an advance directive for the client for "DNR" that was signed April 9, 2004 by the client's responsible person. When reviewed September 24, 2004, Client #1's current service plan dated August 26, 2002 indicated the advanced directive for the client was "full code." When interviewed December 29, 2004 the director stated that she did not know that the advance directive needed to be modified on the service plan. **Education:** Provided.
8	MN Rule 4668.0855 Subp. 9 Medication Records	X	X	Based on record review and interview the licensee failed to document the reason a medication was not given as ordered, for one of two (#1) current clients reviewed. The findings include: Client #1 had medication administration provided as a service from the licensee. Client #1 had a physician order September 12, 2004 for oyster shell calcium 500mg. three times daily. The September 15, 2004 medication administration record indicated that the oyster shell calcium was to be held beginning with the 4 pm

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				dose onward. Client #1s' record did not contain a physician's order to hold the calcium nor was there documentation as to why the medication was not given as prescribed. When interviewed December 30, 2004, the licensee stated that they had a nursing communication notebook that went back and forth to the dialysis unit for the client and the notation to hold the calcium was in the notebook on December 15, 2004. **Education:** Provided.
8	MN Rule 4668.0865 Subp. 3 Control of medications	X	X	Based on client record review and interview, the licensee failed to establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records and disposition of medications for seven of eight clients (#1, #4, #5, #6, #7, #8, and # 10) reviewed with central storage of medication. The findings include: Client #1's physician order sheet, October 19, 2004, included an order for Lorazepam 0.5mg- take ½ tablet (0.25mg.) three times daily. On November 29, 2004, during a weekly medication audit the registered nurse discovered that the 12 noon dose of Lorazepam for November 21, 2004 had not been punched out of the bubble pack but was initialed as given. A medication error sheet was completed by the registered nurse and signed by the unlicensed staff that initialed the medication administration record. No further entry was made as to why the medication had not been administered as ordered or any follow up procedures. On December 3, 2004, client #1's physician ordered Oscal 500mg. at bedtime, as client had been receiving and Oscal 500mg.-one tablet with each meal. When interviewed, December 30, 2004, the registered nurse stated that when the facility received the

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				medication order change, on December 3, 2004, the unlicensed staff notified the nurse by phone. The nurse, over the phone, directed the unlicensed staff to add the three new times to the medication administration record for Oscal, as the client was already receiving the bedtime dose. The administration times were documented as 8 AM, noon, 5PM, and 8PM (the dose that the client was receiving at the time of the order change). An arrow was drawn from December 1 through December 2, 2004 for the 5PM dose only. For December 4, 2004, December 5, 2004, and December 6, 2004, the client only received the 5PM and 8PM doses. On December 6, 2004, at 11:30AM, the registered nurse noted the order change on the order sheet and reentered on the medication administration record the medication Oscal and the four times of administration as per physician order, with arrows for the 8am and Noon dose from December 1, 2004 through December 6, 2004 and arrows from December 1, 2004 through December 5, 2004 for the 5pm and 8pm doses. No medication error record was noted nor was they're any further documentation as to why the Oscal had not been administered as ordered or any follow up procedures. Client #4 had a physician order, October 21, 2004, for Seroquel 25mg., ½ tablet at bedtime. On October 29, 2004 during a weekly medication exchange, it was noted that the 8PM doses of Seroquel for October 23, 2004 and October 24, 2004 were not punched out of the bubble pack nor initialed as given. Medication error reports were completed for these medications and it was documented on the back of the medication administration record that these medications were not punched out

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				and not initialed as given. No further entries were made as to why the medications had not been administered as ordered or any follow up procedures. On November 2, 2004, client #4 had an order change for Seroquel 25mg at bedtime. On December 6, 2004, during a random medication audit, the registered nurse noted that the 8PM dose of Seroquel for December 5, 2004 was initialed as given but medication was not punched out of bubble pack card. Notation was made on the back of the medication administration record on December 6, 2004, that Seroquel for December 5, 2004 was " not punched out and thus not given". No further entry was made as to why the medication had not been administered as ordered or any follow up procedures. Client #5 had physician orders signed October 19, 2004, which are effective October 1, 2004 through March 31, 2005 for Dyazide- one capsule daily, Aricept 10mg.- once daily, Lisinopril 10mg.- every morning, Norvasc 10mg.- daily, Seroquel 25mg. -twice daily, and Oyster Shell with Vitamin D-one tablet twice daily. On October 18, 2004, the caregiver noted that she had not given all of the 8AM medications on October 16, 2004. The medications listed as not given were Dyazide, Aricept, Lisinopril, Norvasc, Seroquel, and Oyster Shell with Vitamin. D. All of the 8AM medications for October 16, 2004 were circled as not given with notation on the back of the medication administration record "all meds not given". No further entry was made as to why the medication had not been administered as ordered or any follow up procedures. Client #6 had physician orders, for Seroquel 25mg.- two tablets (50mg.) three times daily. On October 23,

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				2004, at 12 Noon, the client received Risperdal. 25mg., which was another client's medication. The unlicensed personnel discovered the error immediately and notified the registered nurse, who gave instructions to hold the 12- noon Seroquel until the physician was notified and informed otherwise. The physician subsequently ordered the 12-noon Seroquel dose held for that day. " No further entry was made as to why the medication had not been administered as ordered or any follow up procedures. Upon interview December 29, 2004, the unlicensed personnel stated she had become distracted while administering the medications and that the client had made a comment to her that he was only getting one pill instead of two, but by that time he had already taken the medication. Client #6 's family was notified of the medication error October 23, 2004. Client # 7 had physician orders signed October 19, 2004 which were effective October 1, 2004 through March 31, 2005 for Lasix 20mg.- daily; Effexor XR 150mg.-daily; Effexor XR 37.5 mg.-one capsule daily; Klor 10 meq.-2 tablets twice a day; Reminyl 4 mg.- one tablet twice a day; and Ranitidine 150mg.-twice a day. On October 21, 2004, during a medication exchange, it was noted that the 8AM medications for October 19, 2004 were not punched out and not initialed as given. The medications listed as not given were: Lasix, Effexor XR; Klor; Reminyl and Ranitidine. It was noted on the back of the medication administration record that the caregiver did not give medications above listed on October 19, 2004. No further entry was made as to why the medications were not administered as ordered or any follow up procedures.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				Client #8 had physician orders signed October 27, 2004 effective October 1, 2004 through March 30, 2005 which included Risperal 0.25 mg.- three times daily. On November 29, 2004 during a medication audit it was noted that the 12 noon Risperdal for November 26, 2004 was initialed as given but not punched out of the bubble pack card. On the back of the medication administration record it was noted that the medication was not punched out on November 26, 2004. No further entry was made as to why the medication had not been administered as ordered or any follow up procedures. Client #10 had physician orders November 2, 2004 for Seroquel 25mg.- daily and Metoprolol 100mg-twice a day. On December 6, 2004 during a medication audit it was noted that the 12 noon dose of Seroquel 25mg. for December 3, 2004 was not punched out and not initialed as given; and the 5PM dose of Metoprolol 100mg.-for December 5, 2004 was not punched out and not initialed. On the back of the medication administration record for December 25, 2004, there was a notation that the 5PM dose of Seroquel was "forgot" and "not given". No further entry was made as to why the medications had not been administered as ordered or any follow up procedures. **Education:** Provided.
8	MN. Rule 4668.0003 Subp.2 Assistance with self-administration of medications.		X	**Education:** Provided.
9	MN. Rule 4668.0870 Subp. 2 Disposition of Medications		X	**Education:** Provided.

A draft copy of this completed form was left with Heather Hancock, Lynn Schaefer at an exit conference on January 4, 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 statute) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

(Form Revision 7/04)