MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7182

July 23, 2010

Linus Soppa, Administrator
St Charles Assisted Living Inc
402 West Fourth Street
St Charles, MN 55972

Re: Results of State Licensing Survey

Dear Mr. Soppa:

The above agency was surveyed on May 17, 18 and 19, 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 Correction Order 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) 201-4309.

Sincerely,

Patricia Nelson

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

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

01/07 CMR3199

CERTIFIED MAIL #: 7009 1410 0000 2303 7182

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:	LINUS SOPPA	DATE: July 23, 2010
PROVIDER:	ST CHARLES ASSISTED LIVING IN	COUNTY: WINONA
ADDRESS:	402 WEST FOURTH STREET ST CHARLES, MN 55972	HFID: 21667

On May 17, 18 and 19, 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 4668.0030 Subp. 2

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

Client #1 was admitted and began receiving home care services February 5, 2008. There was no evidence that the client had received a copy of the home care bill of rights.

When interviewed May 19, 2010, the manager/owner did not know what the home care bill of rights was or where documentation of the receipt of the home care bill of rights would have been.

TO COMPLY: The provider shall give a written copy of the home care bill of rights, as required by Minnesota Statutes, section 144A.44, to each client or each client's responsible person.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0040 Subp. 2

Based on record review and interview, the licensee failed to provide a written notice related to the procedure for making a complaint for one of one client's record (#1) reviewed. The findings include:

Client #1 was admitted and began receiving home care services February 5, 2008. There was no evidence that the client received a copy of the licensee's procedure for making a complaint. The licensee's Complaint Policy and Procedure indicated every assisted living resident would be informed as to how to file a complaint with the Offices of Health Facility Complaints and the Ombudsman for Older Adults.

When interviewed May 19, 2010, the manager/owner did not know what the complaint procedure was or where documentation of the receipt of the complaint procedure would have been.

TO COMPLY: The system required by subpart 1 must provide written notice to each client that includes:

A. the client's right to complain to the licensee about the services received;

B. the name or title of the person or persons to contact with complaints;

C. the method of submitting a complaint to the licensee;

D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and

E. a statement that the provider will in no way retaliate because of a complaint.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0065 Subp. 3

Based on record review and interview, the licensee failed to ensure yearly infection control training was done for three of four unlicensed direct care employee (B, C and D) records reviewed. The findings include:

Employee B was hired February 5, 2005, as an unlicensed direct care staff. Documentation indicated employee B last received infection control training on February 7, 2005.

Employee C and D and were hired September 25, 2008, and May 10, 2008, respectively as unlicensed direct care staff. There was no documentation of infection control training in their records.

The licensee's In-service Training policy and procedure indicated all unlicensed staff performing Assisted Living Home Care services would complete a minimum of 8 hours of in-service training for each 12 months of employment.

When interviewed May 19, 2010, the manager/owner stated the staff were not trained in infection control and everyone would have to be trained in infection control.

TO COMPLY: For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;

B. the need for and use of protective gloves, gowns, and masks;

C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;

D. disinfecting reusable equipment; and

E. disinfecting environmental surfaces.

TIME PERIOD FOR CORRECTION: Thirty (30) days

4. MN Rule 4668.0805 Subp. 1

Based on record review and interview, the licensee failed to ensure each employee received an orientation to home care requirements before providing home care services to clients for five of five employee records (A, B, C, D and E) reviewed who provided direct care. The findings include:

Employee A (registered nurse/RN) was hired April 25, 2008. Employees B, C, D and E were hired February 5, September 25, 2008, May 10, 2008, and January 25, 2010, respectively as unlicensed direct care employees. There was no documentation of orientation to home care requirements in their records. The licensee's Home Care Orientation policy and procedure indicated that all employees, including those who provide direct care, who provide supervision of direct care, or who provide management services, must complete their orientation to home care requirements before providing home care services to clients.

When interviewed May 18, 2010, neither employee A nor the manager/owner knew what orientation to home care was.

TO COMPLY: An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation
may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

TIME PERIOD FOR CORRECTION: Thirty (30) days

5. MN Rule 4668.0810 Subp. 2

Based on observation and interview, the licensee failed to provide security of client records for 25 client records observed. The findings include:

The licensee provided service in a housing with services building which consisted of two wings with an entrance/living room on each wing. There were two metal filing cabinets in the front entrance/living room of each wing, behind a desk and under a counter top.

Observations conducted throughout the survey May 17 through May 19, 2010, noted the four metal filing cabinets, containing 25 client medical records unlocked and unattended. Throughout the survey visitors and clients were observed in the entrance/living room when the records were stored unattended.

The licensee's security of client records policy and procedure indicated all information in the client record is confidential and is accessible only to authorized personnel.

When interviewed May 17, 2010, the manager/owner indicated there was not a procedure for client medical record security and did not know the files had to be secure.

TO COMPLY: A class F home care provider licensee must establish and implement written procedures for security of client records, including:

A. the use of client records;

B. the removal of client records from the establishment; and

C. the criteria for release of client information.

TIME PERIOD FOR CORRECTION: Seven (7) days

6. MN Rule 4668.0815 Subp. 1

Based on record review and interview, the licensee failed to establish a service plan for five of six clients' records (#1, #2, #3, #4 and #6) reviewed. The findings include:

Client #1 was admitted and began receiving home care services February 5, 2008. The service plan in the client's medical record was blank except for the client's name and address.

Clients #2, #3, #4 and #6 were admitted and began receiving home care services July 15, 2007, September 2, 2008, June 3, 2008, and March 7, 2007, respectively. Client #2's, #3's, #4's and #6's records did not contain a service plan.

The licensee's service plan policy and procedure indicated all assisted living home care services will be provided in accordance with a suitable and up-to-date service plan and the service plan would be completed by the registered nurse as soon as possible and no later than two weeks after the initiation of assisted living home care services.

When interviewed May 17, 2010, the manager/owner verified that most of the service plans were probably not done.

TO COMPLY: No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

TIME PERIOD FOR CORRECTION: Thirty (30) days

7. MN Rule 4668.0815 Subp. 2

Based on record review and interview, the licensee failed to have a registered nurse (RN) reevaluate a client's evaluation and service plan at least annually or more frequently when there is a change in client's condition for two of two clients' (#1 and #5) records reviewed. The findings include:

Client #1 was admitted and began receiving home care services February 5, 2008. Client #1's record contained an RN evaluation dated February 11, 2008. There was no reevaluation by the RN in the client's record.

Client #5 was admitted and began receiving home care services August 15, 2003. Client #5's service plan was dated August 18, 2003. There was no documentation that the client's service plan had been reviewed since that time. The licensee's service plan policy and procedure indicated the RN must review and revise the client's baseline assessment/evaluation and service plan at least annually.

When interviewed May 17, 2010, the manager/owner verified that most of the service plans were probably not done.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

8. MN Rule 4668.0825 Subp. 4

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) instructed employees in delegated nursing procedures, documented specific written instructions, and competency tested employees in procedures for four of four employee records (B, C, D and E) reviewed. The findings include:

Client #4 had a prescriber's order, dated February 22, 2010, for Lotrimen (anti infective) cream under the breast. The client's May 2010 medication administration record (MAR) included a type written note which indicated that twice a day the area under her breasts was to be cleaned with a warm cloth, patted dry, air dried and then the Lotrimin cream was to be applied to the areas. There was no documentation on the MAR who wrote the note or that the treatment was being done.

When queried on May 19, 2010, regarding the order the manager/owner stated that she had written/typed the note on the MAR. She also said that employees B, C, D and E (unlicensed personnel) had performed the delegated nursing procedure of cleaning and drying client #4's skin before being trained, competency tested and having received written instructions by the RN.

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

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

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

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

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

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

9. MN Rule 4668.0835 Subp. 3

Based on record review and interview, the licensee failed to ensure eight hours of in-service training was completed for each 12 months of employment for three of four unlicensed direct care employee records (B, C and D) reviewed. The findings include:

Employees B, C and D were hired and began providing delegated nursing services February 5, 2005, September 25, 2008, and May 10, 2008, respectively. Employees B, C, D and E did not have documentation of eight hours of inservice training for each 12 months of employment.

When interviewed May 15, 2010, the owner/manager indicated that the licensee had each employee take tests in various subjects every other year, but training was not done.

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

10. MN Rule 4668.0840 Subp. 3

Based on record review and interview, the licensee failed to ensure core training of unlicensed direct care staff was completed for four of four employees (B, C, D and E) records reviewed. The findings include:

Employees B, C, D and E were hired and began providing delegated nursing services February 5, 2005, September 25, 2008, May 10, 2008, and January 25, 2010, respectively.

Employee C's and D's records lacked documentation that the core training had been completed. Employee E's record just included a test.

Employee B was trained February 7, 2005, in Creating a Clean Environment, Infection Control: Standard and Additional Precautions, Fire and Safety Disaster Response, Basic Nutrition: Guidelines for Balance Meals and Special Diets, and Food Safety.

When interviewed May 19, 2010, the manager/owner stated that they did not train the unlicensed staff and that they only do a test.

TO COMPLY: A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

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

(2) recognizing and handling emergencies and using emergency services;

(3) reporting maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

(4) the home care bill of rights, Minnesota Statutes, section 144A.44;

(5) handling clients' complaints and reporting complaints to the Office of Health Facility Complaints;

(6) the services of the ombudsman for older Minnesotans;

(7) communication skills;

(8) observing, reporting, and documenting client status and the care or services provided;

(9) basic infection control;

(10) maintaining a clean, safe, and healthy environment;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

TIME PERIOD FOR CORRECTION: Thirty (30) days

11. MN Rule 4668.0855 Subp. 4

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) instructed unlicensed direct care employees in medication administration for four of four unlicensed employee records (B, C, D and E) reviewed. The findings include:

Employees B, C, D and E were hired and began providing delegated nursing services, which included medication administration, February 5, 2005, September 25, 2008, May 10, 2008, and January 25, 2010, respectively.

Employee B's record contained a medication pass observation worksheet, dated August 26, 2008, which was signed by the RN. Employee C's record contained a medication assistance matching test which was not dated. Employee D's record contained a medication pass observation worksheet, dated August 3, 2008, which was signed by the RN and employee E's record contained a medication assistance matching test which was not signed or dated.

When interviewed May 19, 2010, the manager/owner stated that employees B, C, D and E had all administered medications without training, but the RN had started training each individual unlicensed employee in medication administration two days ago.

TO COMPLY: Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

(1) the complete procedure for checking a client's medication record;

(2) preparation of the medication for administration;

(3) administration of the medication to the client;

(4) assistance with self-administration of medication;

(5) documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

(6) the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

12. MN Rule 4668.0860 Subp. 2

Based on record review and interview, the licensee failed to obtain a prescriber's order for medication for one of two clients' (#2) records reviewed. The findings include:

Client #2 was admitted and began receiving home care services July 15, 2007. The unlicensed direct care staff communication log notes, dated May 17, 2010, at 11:30 a.m. indicated the client had a tooth pulled and that she was to take three Ibuprofen (pain) at 11:30 a.m. and then Ibuprofen PRN (as needed) after that. Another note at 7:15 p.m. indicated the client received three Ibuprofen. The client's post operative dental instruction sheet (which was found in the waste basket after the surveyor requested to see it) and the current prescriber's orders of May 9, 2010, did not include an order for the Ibuprofen. On May 18, 2010, a facsimile order was obtained by the licensee for Ibuprofen 600 milligrams take 1 tablet every 6 hours as needed for pain.

When interviewed May 19, 2010, the manager/owner did not know client #2 had a dental extraction instruction sheet nor did the licensee have any orders from the dentist for the Ibuprofen for pain. The manager/owner stated that the dentist must have told client #2 to take three Ibuprofen, if needed and so the unlicensed staff administered them.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

13. MN Rule 4668.0860 Subp. 5

Based on record review and interview, the facility failed to obtain medication orders with directions for use for four of four clients' records (#1, #2, #4 and #6) reviewed. The findings include:

Client #1 was admitted February 4, 2008, and began receiving medication administration on approximately October 22, 2008. The current prescriber's orders, dated February 25, 2010, included twenty two medications without the route of administration indicated.

Client #2 was admitted July 15, 2007, and received medication administration. The current prescriber's orders, dated May 10, 2010, included eighteen medications without the route of administration indicated.

Client #4 was admitted June 3, 2008, and began receiving medication administration. The current prescriber's orders, dated February 22, 2010, included four medications without the route of administration indicated.

Client #6 was admitted March 7, 2007, and received medication administration. The current prescriber's orders dated, April 23, 2010, included thirteen medications without the route of administration indicated. The client had a Coumadin (anticoagulant) order that did not include a dose or route of administration.

When interviewed May 18, 2010, employee A (registered nurse) verified that the prescriber's orders did not include the directions for use of the medications.

TO COMPLY: An order for medication must contain the name of the drug, dosage indication, and directions for use.

TIME PERIOD FOR CORRECTION: Seven (7) days

14. MN Rule 4668.0860 Subp. 7

Based on record review and interview, the facility failed to notify a registered nurse (RN) within one hour of receipt of orders received by facsimile (fax) for one of one client's record (#2) reviewed. The findings include:

Client #2 was admitted and began receiving home care services July 15, 2007. Client #2 had a tooth extraction May 17, 2010. On May 18, 2010, the manager/owner called the dentist requesting an order be sent for the pain medication she was taking per his verbal instructions. A facsimile order for Ibuprofen was received May 18, 2010, at 2:27 p.m.

During the entrance interview on May 17, 2010, the manager/owner indicated the RN is not notified of fax orders. On May 19, 2010, at 10:35 a.m. the manager/owner had not yet notified the RN of the fax order for Ibuprofen which was received on May 18, 2010, at 2:27 p.m.

TO COMPLY: A. An order received by telephone, facsimile machine, or other electronic means must be kept confidential according to Minnesota Statutes, sections 144.335 and 144A.44.

B. An order received by telephone, facsimile machine, or other electronic means must be communicated to the supervising registered nurse within one hour of receipt.

C. An order received by electronic means, not including facsimile machine, must be immediately recorded or placed in the client's record by a nurse and must be countersigned by the prescriber within 62 days.

D. An order received by facsimile machine must have been signed by the prescriber and must be immediately recorded or a durable copy placed in the client's record by a person authorized by the class F home care provider licensee.

TIME PERIOD FOR CORRECTION: Seven (7) days

15. MN Statute §144A.44 Subd. 1 (2)

Based on observation, record review and interview, the licensee failed to provide nursing services according to accepted professional medical and nursing standards related to notification of the registered nurse (RN) and administration of medications for four of four clients' (#1, #3 #4 and #9) records reviewed. The findings include:

Client #1 was admitted and began receiving home care services February 5, 2008. A review of incident reports indicated the client had six falls between January 20, 2009, and April 2, 2010. The fall on January 20, 2009, and April 2, 2010, resulted in a pelvic fracture and a fractured ankle, respectively. There was no documentation that the RN was notified of the falls.

Client #1's May 2010 medication administration record (MAR) included an undated and unsigned note that indicated the client was prone to panic attacks which could also have been heart attacks. The note instructed unlicensed personnel, along with the daughter to decide if the client was having a heart attack or a panic attack and then call the ambulance if the event was a heart attack. Unlicensed direct care employee progress notes, dated April 13, 2008, and June 4, 2009, indicated the client had hospitalizations for angina. The unlicensed direct care employee progress notes dated April 23, July 29, August 19 and November 11, 2008; all indicated the daughter and ambulance were called for chest pain. There was no evidence the RN was notified of the client's change of condition.

When interviewed May 18, 2010, the manager/owner indicated the RN was notified of the fall which occurred on April 2, 2010, but she was not sure when. When interviewed May 17, 2010, the manager/owner (who is not a nurse) indicated she had written the directions in the MAR for staff to follow when the client was experiencing a panic attack or a heart attack. When interviewed May 18, 2010, the RN indicated she was not aware of the falls and did not know about the procedure regarding the client's heart attack/panic attack. She also added that she was unaware that unlicensed staff was directing client care.

The licensee's communication log contained the following entries:
On April 14, 2010, documentation indicated client #3 choked on Jello at dinnertime. A Heimlich Maneuver was performed, but the Jello didn't dislodge. The client was eventually able to get air and recovered.

On May 14 and 15, 2010, documentation indicated client #4's right eye was crusted shut. Her eye was red and puffiness was noted below the eye. A warm washcloth was placed on the eye. On May 16, 2010, the client's right eye was still red and crusty.

On May 16, 2010, documentation noted client #9's "head is still bleeding I have rebandaged it 2x (times) now. He is on a blood thinner too so I will talk to daughter when she comes to get him for church." There was no evidence that the RN had been notified regarding the preceding information related to clients #3, #4 and #9.

When interviewed May 18, 2010, at 3:15 p.m. employee B (unlicensed direct care staff) indicated unlicensed staff were to supposed to call the manager/owner first, then the nurse and then the family. When interviewed May 18, 2010, the manager/owner indicated she was being notified of the client's medical issues instead of the RN. When interviewed May 18, 2010, the RN indicated she was unaware of the information related to clients #3, #4 and #9. She also added that she was unaware that unlicensed staff was directing client care.

Client #1's medication administration was observed at 9:20 a.m. on May 19, 2010. Employee E (unlicensed direct care staff) checked the client's medications against the medication profile. The medication profile listed Norvasc 10 mg. (milligrams) and the prescription label listed amlodipine 10 mg.

When queried by the surveyor employee E said she was almost sure that Norvasc and amlodipine were the same medications, even though Norvasc was listed on the medication profile and amlodipine was noted on the prescription label. The medication profile also listed K-Dur (potassium) in mg. (milligrams) and on the prescription bottle it was noted as meq. (milliequivalents). The surveyor intervened because employee E was not sure of the name and dose of the medications that she was going to administer to the client. The nurse was notified and the medication was subsequently administered.

The licensee's medication administration employee skills test form, dated October 2002, stated the employee should know the five rights: right resident, right medication, right time and day, right dosage, and right route. On May 19, 2010, employee E was queried regarding the procedure to follow to ensure medications were administered correctly. Employee E stated she (employee E) would call another full time aide, or talk to the manager/owner, or call the pharmacy. When employee E was asked if she had been trained in medication administration and who had trained her, she indicated the RN had trained her two days ago.

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

16. MN Statute §144A.46 Subd. 5(b)

Based on record review and interview, the licensee failed to ensure a background study was done before employees began to provide home care services for two of four unlicensed direct care employees' records (C and D) reviewed. The findings include:

Employees C and D were hired and began providing delegated nursing services September 25, 2008, and May 10, 2008, respectively. Their records did not contain a background study. No background studies for employees C and D were provided during the survey of May 17 through May 19, 2010.

When interviewed May 19, 2010, the manager/owner indicated she still had employee C's background study worksheet because employee C had done it in pencil and employee C had to redo it. Later in the

day on May 19, 2010, the manager/owner informed the surveyor the background study had been sent in for employee C. She had not done a study for employee D.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

17. MN Statute §626.557 Subd. 14(b)

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

Client #1 was admitted and began receiving home care services February 5, 2008. The vulnerable adult assessment, dated February 11, 2008, stated "not vulnerable." The client experienced anxiety attacks and had sustained five falls between January and April 2010.

When interviewed May 18, 2010, employee A (registered nurse) and the manager/owner were informed that client #1 is a vulnerable adult. Employee A and the manager/owner indicated that the vulnerable adult assessments would be redone and include specific measures to be taken to minimize the risk of abuse for all clients.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 9984

January 31, 2006

Linus Sopa, Administrator
St. Charles Assisted Living
402 West Fourth Street
St. Charles, MN 55972

Re: Licensing Follow Up Revisit

Dear Mr. Sopa:

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 January 24, 2006.

The documents checked below are enclosed.

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

_____ 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: Linus Sopa, President Governing Board
Winona County Social Services
Gloria Lehnertz, Minnesota Department of Human Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Case Mix Review File

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

INFORMATIONAL MEMORANDUM

PROVIDER: ST CHARLES ASSISTED LIVING IN

DATE OF SURVEY: January 24, 2006

BEDS LICENSED:

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

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

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

NAME S) AND TITLE (S) OF PERSONS INTERVIEWED:

Dawn Wobschall, Assistant Manager
Melissa Wohlferd, RN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up ____X_____

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to followup on the status of state licensing orders issued as a result of a visit made on April 14, 15, and 19, 2005. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference. The status of the Correction orders is as follows:

1. MN Rule 4668.0065 Subp. 1	**Corrected**
2. MN Rule 4668.0805 Subp. 1	**Corrected**
3. MN Rule 4668.0815 Subp. 1	**Corrected**
4. MN Rule 4668.0815 Subp. 2	**Corrected**
5. MN Rule 4668.0815 Subp. 4	**Corrected**
6. MN Rule 4668.0835 Subp. 3	**Corrected**
7. MN Rule 4668.0845 Subp. 2	**Corrected**
8. MN Statute §626.557 Subd. 14 (b)	**Corrected**

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8715 0406

November 2, 2005

Terry Soppa, Administrator
St. Charles Assisted Living
402 West Fourth Street
St. Charles, MN 55972

Re: Results of State Licensing Survey

Dear Mr. Soppa:

The above agency was surveyed on April 14, 15, and 19, 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: Linus Soppa, President Governing Body
Gloria Lehnertz, Minnesota Department of Human Services
Winona County Social Services
Sherilyn Moe, Office of the Ombudsman
CMR File

Assisted Living Home Care Provider

LICENSING SURVEY FORM

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

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

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

Name of ALHCP: ST CHARLES ASSISTED LIVING IN

HFID # (MDH internal use): 21667

Date(s) of Survey: April 14, 15, and 19, 2005

Project # (MDH internal use): QL21667001

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

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

Indicators of Compliance	Outcomes Observed	Comments
7. The agency employs (or contracts with) qualified staff. (MN Statutes 144D.065; 144A.45, Subd. 5; MN Rules 4668.0070, 4668.0820, 4668.0825, 4668.0030, 4668.0835, 4668.0840)	Staff has received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff who are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	___ Met _X_ Correction Order(s) issued _X_ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	_X_ Met ___ Correction Order(s) issued ___ Education provided ___ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ___ Correction Order(s) issued ___ Education provided ___ N/A
10. The agency has a current license. (MN Statutes 144D.02, 144D.04, 144D.05, 144A.46; MN Rule 4668.0012 Subp.17) Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	The ALHCP license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. The agency operates within its license(s).	_X_ Met ___ Correction Order(s) issued ___ Education provided

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
#1	MN Rule 4668.0815 Subp. 1 Service plan	X	X	Based on record review and interview, the licensee failed to complete an individualized service plan for one of two current clients' (#1) records reviewed. The findings include: Client # 1 was admitted February of 2005. The client had signed the service plan. The only information on the service plan was that the client did not have a living will and was a full resuscitation. The rest of the form was blank. **EDUCATION:** Provided
#1	MN Rule 4668.0815 Subp. 2 Reevaluation of service plan	X	X	Based upon record review and interview, the licensee failed to have a registered nurse reevaluate the client's service plan at least annually for one of two current clients' (#2) reviewed. The findings include: Client #2 was admitted September of 2003. The service plan had not been reevaluated since admission. On interview April 15, 2005, the manager indicated she was not sure why the reevaluation had not been done. **EDUCATION:** Provided
#1	MN Rule 4668.0845 Subp. 2 Supervisory visits	X	X	Based on record review and interview, the licensee failed to ensure that the registered nurse (RN) supervised unlicensed personnel who preformed services that required supervision for two of two current clients' (#1 and #2) records reviewed. The findings include: Client #1 was admitted February of 2005. The client's record did not include a supervisory visit within 14 days after initiation of services. Client #2 was admitted September of 2003. The client's record did not include a 14-day supervisory

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				visit after initiation of services or supervisory visits every 62 days thereafter. On interview April 15, 2005, the registered nurse stated she had not been aware that supervisory visits needed to be done on the clients. **EDUCATION:** Provided
#3	MN Rule 4668.0065 Subp. 1 Tuberculosis screening	X	X	Based on record review and interview, the licensee failed to retain documentation of tuberculosis screening on one of three employees (#3) reviewed. The findings include: Employee #3 began employment February of 2005 as a direct care staff. Her record did not include documentation of tuberculosis screening for this employee. Upon interview April 15, 2005, the registered nurse confirmed there was no documentation on tuberculosis screening in the personnel record and stated she did not know why as it had been previously in the record. **EDUCATION**: Provided
#3	MN Rule 4668.0805 Subp. 1 Orientation to home care	X	X	Based record review and interview, the licensee failed to ensure that employees completed an orientation to home care requirements for one of three employees' (#3) records reviewed. The findings include: Employee #3 began employment February of 2005. Her record did not contain documentation of orientation to home care requirements. On interview April 15, 2005, employee #3 stated that she had never had any orientation or experience in home care. **EDUCATION**: Provided
#3	MN Statute 626.557 Subd. 14 (b) Abuse Prevention	X	X	Based upon record review and interview, the licensee failed to assess the susceptibility to abuse for one of two current clients' (#2) records reviewed. The findings include: Client #2 was admitted September 8, 2003.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				The form "Assessment for client vulnerability and safety" was completely blank except for the client's name. On interview April 14, 2005, the manager was unaware of the reason the form had not been completed. **EDUCATION:** Provided
#6	MN Rule 4668.0815 Subp. 4 Contents of service plan	X	X	Based on record review and interview, the licensee failed to ensure that the fees for each service were included on the service plan for two of two current clients' (#1 and #2) records reviewed. The findings include: Client #1 was admitted February of 2005. The service plan did not include the fees for home care services. The only information on the service plan was that the client did not have a living will and was a full resuscitation. The rest of the form was blank. Client #2 was admitted September of 2003. The service plan did not include fees for home care services. The service plan stated "rate per hour/visit per service plan" but did not include the level of care the client was assessed to be at. **EDUCATION:** Provided
#7	MN Rule 4668.0835 Subp. 3 Inservice	X	X	Based on record review and interview, the licensee failed to ensure eight hours of annual in-service training for one of two employees (#2) records reviewed. The findings include: Employee #2 had been employed since September of 2002. The in-service record for 2004 for employee #2 was documented as only being 3 hours for the year. On interview April 15, 2005, the assistant manager stated in-service hours were calculated on a yearly basis. She indicated she did not know why there was no more in-service recorded for employee #2. **EDUCATION:** Provided

A draft copy of this completed form was left with Terry Soppa, Owner, Manager at an exit conference on April 14, 15, and 19, 2005. Any correction orders issued as a result of the on-site visit and the final Licensing Survey Form will arrive by certified mail to the licensee within 3 weeks of this exit conference (see Correction Order form HE-01239-03). If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 215-8703. After supervisory review, this form will be posted on the MDH website. General information about ALHCP is also available on the website:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurvey.htm

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

(Form Revision 7/04)