Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9973 1298

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR CLASS F HOME CARE PROVIDERS

November 18, 2010

Ms. Raisa Kotula, Administrator
Wendigo Pines Assisted Living & Memory Care
20371 Wendigo Park Road
Grand Rapids, Minnesota 55744

Re: Project # HL21725016

Dear Ms. Kotula:

On August 3, 4, 5 and 13, 2010, survey staff of the Minnesota Department of Health, Home Care and Assisted Living Program completed a reinspection of the provider named above, to determine correction of orders found on the complaint investigation completed on June 7, 2010 with orders received by you on June 10, 2010.

State licensing orders issued pursuant to the complaint investigation completed on June 7, 2010 and found corrected at the time of the August 13, 2010 reinspection, are listed on the attached Informational Memorandum.

State licensing orders issued pursuant to the complaint investigation completed on June 7, 2010, found not corrected at the time of the August 13, 2010 revisit and subject to penalty assessment are as follows:

1. MN Rule 4668.0050 Subp. 1	**$350.00**
2. MN Rule 4668.0815 Subp. 2	**$250.00**
3. MN Rule 4668.0825 Subp. 2	**$250.00**
5. MN Rule 4668.0865 Subp. 8	**$300.00**
7. MN Statute 144A.44 Subd. 2	**$250.00**

Therefore, in accordance with Minnesota Statutes section 144.653 and 144A.45 Subdivision 2. (4) the total amount you are assessed is $1,400.00. This amount is to be paid by check made payable to the Commissioner of Finance, Treasury Department, State of Minnesota and sent to the Minnesota Department of Health, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900 within 15 days of the receipt of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Division of Compliance Monitoring, within 15 days of the receipt of this notice. Any request for a hearing as well as payment of the assessment shall be sent to the attention of Mary

Henderson at the Minnesota Department of Health, Division of Compliance Monitoring, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

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

Also, at the time of the reinspection completed on August 13, 2010, additional violations were cited and are documented on the enclosed Correction Order form. When all orders are corrected, the order form should be signed and returned to this office at the Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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.

Sincerely,

Mary Henderson, Program Assurance Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651)201-4115 Fax: (651)215-9697

Enclosures

cc: Licensing and Certification File
Mary Absolon, Licensing and Certification Program
Pat Nelson, Home Care and Assisted Living Program
Stella French, Office of Health Facility Complaints
Itasca County Social Services
Ron Drude, Provider Enrollment Unit, Department of Human Services
Sherilyn Moe, Office of Ombudsman
Jocelyn Olson, Office of the Attorney General
Minnesota Board of Nursing

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

INFORMATIONAL MEMORANDUM

PROVIDER: WENDIGO PINES ASSTED LIVING

DATE OF SURVEY: August 3, 4, 5 and 13, 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:
Raisa Kotula, Registered Nurse/Owner
Cherie Alsaker, Licensed Practical Nurse
Dawn Bachal, Personnel Care Attendant
Kayle Higgins, Personnel Care Attendant
Carrie Hersehbach, Personnel Care Attendant
Bonnie Weimers, Personnel Care Attendant
Cassie Thoennes, Personnel Care Attendant
Becky Wilcox, Personnel Care Attendant
Donna Meyers, Personnel Care Attendant
Debbie Gordon, Office Manager

SUBJECT: Licensing Survey X Licensing Order Follow Up: X

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to determine compliance with state licensure requirements. 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.

2) An unannounced visit was made to follow up on the status of state licensing orders issued as a result of complaint investigations completed on April 6, 2010 and June 7, 2010. The results of the status of the state licensing orders 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 state licensing orders issued as a result of a complaint investigation completed on April 6, 2010, is as follows:

1. MN Statute 144A.44 Home Care Bill of Rights. Subdivision 1. State of Rights (13), (14), (15) Corrected

The status of the state licensing orders issued as a result of a complaint investigation completed on June 7, 2010, is as follows:

1. MN Rule 4668.0050 Subp. 1 Not Corrected $350.00

Based on interview and record review, the facility failed to ensure that there was sufficient staff in numbers to adequately provide the services agreed to in the service plans for three of three client's (A6, A7 and A8) who lived in housing with services A on July 16, 2010. The findings include:

Documentation by employee BB (unlicensed personnel) in the agency communication book in housing with services B on July 16, 2010, on the 10:00 p.m. to 6:00 a.m. shift, indicated she was having problems with one of the clients and that employee AE (unlicensed personnel) went over to housing with services site B to assist employee BB with the client.

A review of the July 2010 schedule indicated on July 15 and 16, 2010, employee BB was the only staff person working in housing with services site B and employee AE was the only staff person working in housing with services site A from 10:00 p.m. on July 15, 2010 to 6:00 a.m. on July 16, 2010.

Client A6 had a diagnosis of Cerebral Palsy and Arthritis. The client's service plan, dated February 16, 2006, indicated the client was to receive services 24 hour care.

Client A7 had a diagnosis of Dementia. The client's service plan, dated March 16, 2009, indicated the client was to receive services 24 hours a day.

Client A8 had a diagnosis of Dementia. The client's service plan, dated August 3, 2007, indicated the client was to receive services 24 hours a day.

When interviewed August 13, 2010, employee AA stated that all of clients needed 24 hour assistance because of their diagnoses and from time to time they are unsteady on their feet and need assistance to ambulate to the bathroom at night.

A review of in-service training documentation revealed that on June 17, 2010 an in-service was held regarding leaving the clients unattended in the houses. The in-service sign in sheet indicated that employee BB had attended the in-service training and employee AE had not signed the sheet as attending the in-service training.

When interviewed August 15, 2010, regarding the events that occurred in housing with service site B on July 16, 2010, employee BB stated that employee AE had come over to housing with service site B to assist her with a client who had become very agitated. Employee BB went on to state that employee AE was in the house assisting her for about 10 minutes. Employee BB did not recall what time it was that employee AE was assisting her.

When interviewed August 3, 2010, employee AA (registered nurse) stated that there was only

one person scheduled to work in each house on the 10:00 p.m. to 6:00 a.m. shift. She stated the clients in housing with services A should not have been left unattended and went on to state they probably left the clients in housing with services site A unattended while employee AE was helping out in housing with services site B. Employee AA also stated that she had trained staff on not leaving the houses unattended. When interviewed on August 13, 2010, employee AA stated at the in-service meeting she had told the staff that they were not to leave their house and leave the clients unattended. If they were the only one scheduled on their shift and they needed assistance they were to call housing with services site C or D, because there was always two staff scheduled shift.

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

Based on record review and interview, the agency failed to ensure that a registered nurse (RN) reviewed a client's service plan at least annually for two of two clients (C2 and D4) reviewed. The findings include:

Client C2 began receiving services on March 2, 2009. The client's record contained a service plan, dated March 1, 2009, that indicated the client received 24 hour care, meals and medications. When interviewed August 4, 2010, employee AA (RN) stated the client's service plan had not been reviewed since March 2009 (one year and five months). Employee AA also stated she was not aware that the service plan had to be reviewed annually.

Client D4 began receiving services on November 24, 2008. The client's record contained a service plan dated November 24, 2008. The service plan indicated the client received 24 hour care, medication administration and meals. The client's record lacked evidence that the service plan had been reviewed since November 24, 2008. When interviewed August 4, 2010, employee AA stated the client's service plan had not been reviewed since November 24, 2008.

3. MN Rule 4668.0825 Subp. 2 Not Corrected $250.00

Based on record review and interview, the licensee failed to develop a service plan that included the frequency of supervision of the tasks for seven of seven clients (A1, C1, C2, D1, D2, D3 and D4) reviewed. The findings include:

Client A1's record contained a service plan that was dated April 29, 2010. The service plan did not include the frequency of supervision of staff. The client's record indicated she required assistance with bathing, dressing, grooming and medication administration.

Client C1's record contained a service plan that was not dated. The service plan did not include the frequency of supervision of staff. The client's record indicated she needed assistance with bathing, dressing and hair care.

Client C2's record contained a service plan that was dated March 1, 2009. The service plan did not include the frequency of supervision of staff. The client's record indicated he required assistance with bathing, dressing, grooming, toileting and medication administration.

Client D1's record contained a service plan that was dated September 24, 2009. The service plan did not include the frequency of supervision of staff. The client's record indicated he required

assistance with dressing, toileting, bathing and medication administration.

Client D2's record contained a service plan that was dated June 29, 2010. The service plan did not include the frequency of supervision of staff. The client's record indicated he needed assistance with bathing, grooming, dressing and medication administration.

Client D3's record contained a service plan dated September 18, 2009. The service plan did not include the frequency of supervision of staff. The client's record indicated he needed assistance with bathing and was observed to receive medications from staff on August 4, 2010.

Client D4's record contained a service plan dated November 24, 2008. The service plan did not include the frequency of supervision of staff. The client's record indicated the client required assistance with bathing, grooming and medication administration.

When interviewed August 4, 2010, employee AA (registered nurse) confirmed the clients' service plans did not include the frequency of supervision of staff.

4. MN Rule 4668.0845 Subp. 2 A (2) Corrected

5. MN Rule 4668.0865 Subp. 8 Not Corrected $300.00

Based on observation and interview, the licensee failed to provide central storage of medication that assured that all drugs were stored in locked compartments. The findings include:

On August 3, 2010, at 8:15 a.m., employee AA (registered nurse) and the surveyor entered the office, which is a separate building from the four other housing with services sites. The door to the office was unlocked and no one was in the office. The following was observed: five blister pack cards of medications belonging to client A2 (who expired on July 25, 2010) were sitting on a chair in the office; on a open shelf there were two bottles of Aspirin 325 milligrams (mg.), a box of Budesonide 0.5 mg belonging to client A3 (who expired on June 10, 2010); six bottles of Acetaminophen 500 mg. and a blister pack of Senna belonging to client A4 (who expired on June 19, 2010); four sealed bottles of Milk of Magnesia, two bottles of antidiarrheal caplets, a bottle of Aspirin 81 mg., two bottles of Tussin Cough Syrup, a bottle of Zyprexa 5 mg., a bottle of Zyprexa 10 mg, a four week cycle of Namenda belonged to client A5 (who was discharged on August 2, 2010); and five four week cycle cards of Namenda that were not labeled with a client's name.

Throughout the survey employee AF (office manager), family members and clients accompanied by staff members were observed to enter the office.

When interviewed on August 3, 2010, employee AA confirmed the office was unlocked when the office was entered on August 3, 2010, at 8:15 a.m. Employees AA also stated that the medications were stock supply medications or belonged to clients who were no longer living at the housing with services. Employee AA went on to state that employee AF was not authorized to administer medications.

When interviewed on August 3, 2010, employee AF (office manager) stated that she does not lock the office when she leaves the office to go to one of the other buildings on site.

6. MN Rule 4668.0865 Subp. 9 Corrected

7. MN Statue 144A.44 Subdivision (2) Not Corrected $250.00

Based record review and interview, the license failed to provide care and services according to acceptable medical and nursing standards by failing to ensure narcotic medication were counted every shift. The findings include:

The controlled medication records kept in the secured locked box in the medication room in housing with services C revealed the following:

The controlled medication record for client C1's Lorazepam 0.5 milligrams (mg.) was not documented as being counted at the end of the 10:00 p.m. to 6:00 a.m. shift on July 23, 24, 25 and August 1 and 2, 2010.

The controlled medication record for client C4's Lorazepam 1 mg. was not documented as being counted at the end of the 10:00 p.m. to 6:00 a.m. shift on July 23, 24, 26, 27 and August 1 and 2, 2010.

A review of the medication procedure that was signed by employee AA and dated May 10, 2010, indicated narcotic count sheets are to be done at the beginning and ending of each shift.

When interviewed on August 4, 2010, employee AA (registered nurse) stated the staff is to count the medications at the beginning and end of each shift and confirmed that the controlled medication records for client C1 and C4 indicated the medications were not being counted according to the policy.

On August 3, 2010, at 8:15 a.m., employee AA (registered nurse) and the surveyor entered the office, which is a separate building from the four other housing with services sites. The door to the office was unlocked and no one was in the office. The following was observed: five blister pack cards of medications belonging to client A2, who expired on July 25, 2010, were sitting on a chair in the office; on a open shelf there was two bottles of Aspirin 325 milligrams (mg.) and a box of Budesonide 0.5 mg. belonging to client A3, who expired on June 10, 2010; six bottles of Acetaminophen 500 mg., a blister pack of Senna belonging to client A4, who expired on June 19, 2010, four sealed bottles of Milk of Magnesia, two bottles of antidiarrheal caplets, a bottle of Aspirin 81 mg., two bottles of Tussin Cough Syrup, a bottle of Zyprexa 5 mg., a bottle of Zyprexa 10 mg, a four week cycle of Namenda belong to client A5, who was discharged on August 2, 2010, and five four week cycle cards of Namenda that were not labeled with a client's name.

Throughout the survey employee AF (office manager), family members and clients accompanied by staff members were observed to enter the office.

When interviewed on August 3, 2010, employee AA confirmed the office was unlocked when the office was entered on August 3, 2010, at 8:15 a.m. Employee AA also stated that these medications were stock supply medications or belonged to clients who were no longer living at the housing with services. Employee AA went on to state that employee AF was not authorized

to administer medications.

When interviewed on August 3, 2010, employee AF (office manager) stated that she does not lock the office when she leaves the office to go one of the other buildings on site.

8. MN Statue 144A.441 Subdivision (14) **Corrected**

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9973 1298

November 18, 2010

Raisa Kotula, Administrator
Wendigo Pines Assisted Living
20371 Wendigo Park Road
Grand Rapids, MN 55744

Dear Ms. Kotula:

1) RE: Results of State Licensing Survey

The above agency was surveyed on August 3, 4, 5, and 13, 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.

2) RE: Licensing Follow Up Visit

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 August 3, 4, 5, and 13, 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.

__X__ MDH Correction Order
Correction order(s) issued pursuant to visit of your facility.

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

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

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

Sincerely,

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

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

CERTIFIED MAIL #: 7003 2260 0000 9973 1298

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 & Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	RAISA KOTULA	DATE: November 18, 2010
PROVIDER:	WENDIGO PINES ASSTED LIVING	COUNTY: ITASCA
ADDRESS:	20371 WENDIGO PARK ROAD GRAND RAPIDS, MN 55744	HFID: 21725

On August 3, 4, 5 and 13, 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. 6

Based on record review and interview, the licensee failed to retain documentation in the client's record of receipt of the Home Care Bill of Rights for one of two clients (C1) reviewed in housing with services site C. The findings include:

Client C1's record contained a Home Care Bill of Rights Acknowledgement form that was not signed or dated to indicate the client received the bill of rights. When interviewed August 4, 2010, employee AA (registered nurse) stated the client did receive the bill of rights, but there was no documentation in the client's record indicating the client received the bill of rights.

TO COMPLY: The licensee shall retain in the client's record documentation of compliance with this part.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0810 Subp. 6

Based on record review and interview, the licensee failed to maintain a complete record for three of three clients reviewed (A1, A2 and A3) in housing with services A, and one of one client reviewed (B1) in housing with services B. The findings include:

A review of the agency communication book in housing with services C indicated a client had left the building on July 16, 2010. During an interview with employee AA (registered nurse) on August 3, 2010, employee AA verified client A1 had left housing with services C on July 16, 2010. Employee AA went on to state that the local police were called and assisted in finding the client. There was no documentation in client A1's record pertaining to this incident.

Client B1 began receiving services on October 19, 2009. The client's record contained a physician's visit note, dated July 12, 2010, indicating the client had an incision and drainage of an abscess. The client was to have a sterile dressing change every day. The client's record lacked evidence that the dressing had been changed daily as ordered. When interviewed August 4, 2010, employee AA (registered nurse) stated the licensed practical nurse did the dressing changes daily. Employee AA also confirmed the dressing changes were not documented in the client's record and there was no documentation in the client's record pertaining to the abscess. When interviewed August 4, 2010, employee AB (licensed practical nurse) stated she had done the dressing change daily, but could not find were she had documented the treatment.

Client A2 began receiving services on January 5, 2010. The discharge client roster form given to the surveyor indicated the client expired on July 25, 2010, at the facility. The last documentation in the client's record, dated July 25, 2010, stated the client was unresponsive and refused liquid. The client's record did not contain any further documentation as to when the client expired. When interviewed August 5, 2010, employee AA (registered nurse) also stated there was no discharge summary completed.

Client A3 began receiving services on April 26, 2007. The discharge client roster form given to the surveyor indicated the client expired on June 19, 2010, at the facility. The last note in the client's record was dated June 18, 2010, 2:00 p.m. to 10:00 p.m. which indicated staff would continue to try and give fluids and check on her every one to two hours. The client's record did not contain any further documentation as to when the client expired. When interviewed August 5, 2010, employee AA stated the client had expired on June 19, 2010 and that there was no further documentation pertaining to the client's condition at the time of death.

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

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

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

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

(7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

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

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

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

D. medication and treatment orders, if any;

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

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

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

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

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

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

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

TIME PERIOD FOR CORRECTION: Seven (7) days

3. MN Rule 4668.0815 Subp. 1

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) established a service plan no later than two weeks after initiation of assisted living home care services for one of

two clients (C1) reviewed in housing with services C. The findings include:

Client C1 began receiving services on March 29, 2009. The service plan in the client's record was not dated or signed by the responsible person nor did it include a signature of the provider staff.

When interviewed August 4, 2010, employee AA (registered nurse) confirmed that the service plan was not dated or signed by the client or the person preparing the service plan.

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

4. MN Rule 4668.0815 Subp. 4

Based on observation, record review and interview, the licensee failed to ensure that service plans were complete for one of one client (A1) reviewed in housing with services A, one of one client (B1) reviewed in housing with services B, two of two clients (C1 and C2) reviewed in housing with service C and three of three clients (D1, D2 and D3) reviewed in housing with services D. The findings include:

Client A1 began receiving services on April 24, 2010. The client's monthly activities of daily living record for July 2010 indicated she received assistance with bathing once a week and assistance with grooming daily. Client A1's medications were observed stored in central storage on August 4, 2010. The client's service plan, dated April 29, 2010, did not include bathing, grooming, central storage of medication, the frequency for which the services were to be provided, or the person who was to provide the service. The client's service plan also did not include the name, address and phone number of the person to be notified in case of a condition change or emergency.

Client B1 began receiving services on October 19, 2009. The client's service plan, dated March 16, 2010, listed the following services: 24 hour care, meals, snacks and medication administration. On August 4, 2010, the client was observed to have a catheter. When interviewed August 4, 2010, employee BA (unlicensed personnel) indicated she assisted the client on emptying the catheter leg bag throughout the day and also performed catheter care. On August 4, 2010, the client's medications were also observed stored in the locked medication cupboard. The service plan did not include the catheter care, the frequency, the title of the person that was to provide the service, schedule for supervision, or the fees for service.

Client C1 began receiving services on March 29, 2009. The client's service plan, which was undated, stated the client received 24 hour care. The service plan did not include the frequency of services, the title of person to provide the care, schedule for supervisory visits or the fees. When interviewed August 4, 2010, employee CB (unlicensed personnel) stated staff assists the client with dressing, shower, ambulation to table, application of Ted stockings, oxygen and filling of the portable oxygen tanks and medication administration. The client's medications were observed on August 4, 2010, to be stored in the medication cupboard**.**

Client C2 was observed on August 4, 2010, to receive assistance with dressing, toileting, medication administration, blood sugar monitoring and insulin injection. The client's resident care plan, that was not dated, stated the client received assistance with a weekly shower, oral care and toileting. The client's service plan, dated March 1, 2009, stated the client received 24 hour care, meals and "med." The client's service plan did not include the frequency of the services to be provided, the title of the person providing the service and the schedule of supervisory visits.

Client D1 began receiving services on September 23, 2009. The client's registered nurse assessment, dated September 23, 2009, indicated the client required assistance with dressing, toileting, bathing, hair care and oral hygiene. The client's service plan that was dated and signed on September 24, 2009, did not include a description of services, frequency of services, title of person to provide the service, a schedule of supervision or the fees.

Client D2 began receiving service on June 29, 2010. The client's service plan, dated June 29, 2010, did not include the frequency of services, the title of the staff person to provide the services, a schedule for supervisory visits or the fees.

Client D3 began receiving services on September 18, 2009. The client's service plan, dated September 18, 2009, only listed the fees for services. The client's record indicated he received assistance with bathing, dressing, medication administration and toileting.

When interviewed August 4, 2010, employee AA (registered nurse) confirmed the clients' service plans were not complete.

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

5. MN Rule 4668.0825 Subp. 4

Based on observation, record review and interview, the licensee failed to ensure that unlicensed staff was instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure, that the RN specified in writing specific instructions for performing the procedure and demonstrated to the RN that he\she was competent to perform the procedure for two of two clients (B1 and C1) who were observed receiving delegated nursing procedures. The findings include:

Client B1 was observed on August 4, 2010, to have a catheter connected to a leg bag by employee BA (unlicensed personnel). The client's record lacked evidence that the RN had specified in writing specific instructions for caring for the client's catheter. Employee BA's record lacked evidence that she had been trained by a RN in catheter care.

When interviewed August 4, 2010, regarding client B1's catheter care employee BA stated she assisted the client with his catheter. Employee BA was unable to find any written instruction pertaining to the catheter care. Employee BA also stated that another unlicensed personnel had showed her how to do the catheter care.

When interviewed August 4, 2010, employee AA (RN) stated there should have been written instructions pertaining to the catheter care in the medication administration book, but they were not here when she looked for them. Employee AA also verified employee BA's record lacked documentation that she had been trained by a RN in catheter care.

Client C1 was observed on August 4, 2010, at 8:00 a.m. during medication administration observation to be receiving oxygen per nasal cannula at two liters. The client's record did not contain written instructions for how the oxygen was to be administered. When interviewed August 4, 2010, client C1 stated the staff assisted her with the oxygen.

When interviewed regarding client C1's oxygen on August 4, 2010, employee CB (unlicensed personnel) stated she did not know if there were written instructions for the oxygen. Employee CB went on to state the client usually used two liters of oxygen unless she was having breathing problems and then the client received three liters of oxygen. Employee CB also stated that unlicensed personnel showed her how to administer the oxygen and how to fill the portable oxygen tank. Employee CB's record lacked documentation that she had been trained by a RN.

When interviewed August 4, 2010, employees AA (RN) stated that a respiratory therapist from the oxygen company had been there and trained all the staff. Employee AA went on to state she could not find documentation as to who attended the training or written instructions on how to perform the oxygen procedures. When interviewed August 4, 2010, employee CB stated that she was not trained by the respiratory therapist.

Employee CA (unlicensed personnel) was observed on August 4, 2010, at 11:25 a.m. to do a blood sugar check on client C2. The client's record did not contain written instructions on how to perform the procedure.

When interviewed regarding client C2's blood sugar checks on August 4, 2010, employee CA stated there were no written instructions for the blood sugar checks. Employee CA went on to state that she had been shown by another unlicensed staff on how to do the blood sugar checks. Employee CA's record lacked evidence that she had been trained by the RN prior to performing the procedure.

When interviewed August 5, 2010, employee AA(RN) confirmed that employee CA's record lacked evidence that she had been trained by a RN on to how to perform blood sugar checks and that the client's record did not contain written instructions.

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

6. MN Rule 4668.0855 Subp. 2

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) conducted a nursing assessment of the client's functional status and need for assistance with medication administration for six of six clients (A1, C1, C2, D1, D2 and D3) reviewed. The findings include:

Client A1 began receiving services on April 24, 2010. The client's RN evaluation lacked evidence that a RN conducted a nursing assessment of the client's functional status and need for assistance with medication administration.

Clients C1 and C2 began receiving services on March 29, 2009, and March 2, 2009, respectively. Client C1's and C2's registered nurse evaluation dated March 30, 2009, and March 2, 2009, respectively lacked evidence that a RN conducted a nursing assessment of the client's functional status and need for assistance with medication administration.

Clients D1, D2 and D3 began receiving services on September 23, 2009, June 29, 2010, and September 18, 2009, respectively. Client D1's, D2's, and D3's registered nurse evaluation dated September 24, 2009, June 29, 2010, and September 18, 2009, respectively lacked evidence that a RN conducted a nursing assessment of the client's functional status and need for assistance with medication administration.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

7. MN Rule 4668.0855 Subp. 5

Based on record review and interview, the licensee failed to ensure that the registered nurse (RN) was notified, either within twenty-four hours after it's administration, or within a time period that was specified by a RN prior to the administration, when an unlicensed person administered a pro re nata (PRN, as needed) medication to a client for one of one client (A1) reviewed in housing with services A who received PRN medications. The findings include:

Client A1's PRN medication record indicated the client received Tylenol #3 one tablet on August 1, 2010, at 10:15 p.m., Tylenol #3 one tablet on August 2, 2010, at 9:00 a.m., Ativan 0.5 milligrams (mg.) one tablet on August 2, 2010, at 3:00 p.m., Tylenol #3 one tablet on August 2, 2010, at 7:30 p.m., and Tylenol 500 mg. two tablets on August 3, 2010, at 3:00 a.m. The client's record lacked evidence the RN was notified that the PRN medications were administered to the client.

The client's monthly activities of daily living record for July 2010 contained a statement which stated, all PRN medications given must be documented on the medication administration record (MAR) and in the nurses notes and if the nurse was called.

When interviewed August 4, 2010, employee AA (RN) stated that the unlicensed personnel are to call the RN before giving PRN medications or the licensed practical nurse if she is there at the time. Employee AA stated she could not remember if she was called or not regarding administration of the client's PRN medication on August 1, 2 and 3, 2010.

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

A. the medications are regularly scheduled; and

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

(1) within 24 hours after its administration; or

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

TIME PERIOD FOR CORRECTION: Seven (7) days

8. MN Rule 4668.0855 Subp. 7

Based on observation, interview and record review, the licensee failed to ensure that the registered nurse (RN) documented in the client's record, the specific instructions for performing the procedures for each client and the unlicensed staff person demonstrated to an RN their ability to assist with or administer the medications. The findings include:

Client B2 had a prescriber's orders, dated October 7, 2009, for Albuterol MDI two puffs four times a day, June 3, 2010, for Advair 250/50 micrograms one puff twice a day and January 19, 2010 and for Albuterol Sulfate 2.5 milligrams/3 milliliters one vial four times a day.

Employee BA was observed on August 4, 2010, at 3:40 p.m. to administer two inhalers and a nebulizer treatment to client B2. Client B2's record did not contain written instructions for how the inhalers or nebulizer treatment were to be administered. A review of employee BA's record lacked evidence the RN had trained employee BA on inhalers or nebulizer treatments.

When interviewed August 4, 2010, employee BA stated the RN had trained her in medication administration. When interviewed August 5, 2010, employee AA (RN) stated she had trained the staff in medication administration, but there were no written instructions in the client's record to address how to administer inhalers or nebulizers. Employee AA also stated there was no documentation in employee BA's record pertaining to the training.

Client C2's record contained prescriber's orders, dated February 3, 2010, for Lantus Insulin 23 units every hours of sleep and an order, dated January 5, 2010, for NovoLog insulin 11 units twice a day. The client was observed to be given NovoLog insulin 11 units on August 4, 2010, at 12:00 noon by employee BA (unlicensed personnel). The client's record did not contain written instructions for how to administer the insulin injection. When interviewed August 4, 2010, employee BA stated the RN had showed her how to give insulin injections. A review of employee BA's record lacked evidence that the RN had trained employee BA on insulin injections.

When interviewed August 5, 2010, employee AA (RN) confirmed there were no written instructions in the client's record on how to administer the insulin injection. Employee AA went on to state that she had trained employee BA on insulin injections, but there was no documentation of the training in employee BA's record.

TO COMPLY: A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration 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 records; 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: Seven (7) days

9. MN Rule 4668.0855 Subp. 8

Based on observation, record review and interview, the licensee failed to ensure the registered nurse (RN) retained documentation of medication administration training for three of three unlicensed personnel (C, CB and BA) observed administering medications to clients. The findings include:

Employees CA, CB and BA (unlicensed personnel) were observed to administer medications to clients on August 4, 2010. Employee CA's, CB's and BA's personnel records lacked documentation that they had been trained by a RN in medication administration.

When interviewed on August 4, 2010, employees CA, CB and BA all stated that they had been trained in medication administration by the registered nurse. When interviewed August 5, 2010, employee AA (RN) stated she had trained the unlicensed personnel in medication administration and went on to state the employees' records lacked documentation of the training.

TO COMPLY: A class F home care provider licensee must retain documentation in the personnel records of the unlicensed personnel who have satisfied the training requirements of this part.

TIME PERIOD FOR CORRECTION: Thirty (30) days

10. MN Rule 4668.0855 Subp. 9

Based on record review and interview, the licensee failed to ensure medications were administered as prescribed for one of one client (A1) reviewed in housing with services site A. The findings include:

Client A1's record contained a prescriber's order, dated July 3, 2010, for Tylenol #3 one tablet every four hours as needed for pain. The client's "PRN" medication record indicated on July 30, 2010, at 7:15 p.m. the client received Tylenol #3 two tablets for mouth pain instead of the one tablet that was ordered. The client's record also had a prescriber's order, dated April 24, 2010, for Ativan 0.5 milligrams (mg.) one tablet three times daily as needed for anxiety. The client's "PRN" medication record indicated that on July 31, 2010, at 4:30 p.m. the client received two tablets of Ativan 0.5 mg. on August 1, 2010, at 9: 35 a.m. the client received two tablets of Ativan 0.5 mg. and on August 1, 2010, at 10:15 p.m. the client received two tablets of Ativan 0.5 mg. instead of the one tablet of Ativan that was ordered.

When interviewed August 4, 2010, employee AA (registered nurse) confirmed the Tylenol #3 and the Ativan were not given as ordered.

The medication room in housing with services site C was toured with employee AA (registered nurse) on August 4, 2010, at 10:00 a.m. In the bottom cupboard, there was a red box that contained a zip lock bag with client C2's name and Lantus 23 units written on the bag. The zip lock bag contained 21 filled insulin syringes. Upon review of the syringes it was noted that they had air bubbles in them. After employee AA removed the air bubble from one of the insulin syringes there was only 22 units of Lantus insulin in the syringe. Employee AA confirmed there was only 22 units of insulin in the syringe. In another zip lock bag in the red box there were 15 syringes with NovoLog insulin 11 units. There were also one or more small bubbles in all 15 syringes. This was also confirmed by employee AA at the time.

Client C2's record contained prescriber's orders, dated February 3, 2010, for Lantus Insulin 23 units every hours of sleep and January 5, 2010, for NovoLog insulin 11 units twice a day.

When interviewed August 4, 2010, employee AA stated employee BA (licensed practice nurse) drew up the insulin for the clients and the unlicensed personnel administered the insulin to the clients. Employee AA went on to state she would ask the LPN to re-draw the insulin for client C2.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

11. MN Rule 4668.0860 Subp. 9

Based on record review and interview, the licensee failed to ensure medication or treatment orders were renewed at least every 12 months two of two clients (C1 and C2) who had received services for longer than a year in housing with services C. The findings include:

Client C1 and C2 began receiving services on March 29, 2009, and March 2, 2009, respectively. The clients' records lacked evidence that their medication and treatment orders were reviewed at least annually. Client C1's and C2's orders had not been reviewed by the physician since March 29, 2009, and March 2, 2010, respectively.

When interviewed August 4, 2010, employee AA (registered nurse) stated she was unaware that the medication and treatment orders needed to be renewed annually.

TO COMPLY: A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

TIME PERIOD FOR CORRECTION: Seven (7) days

12. MN Rule 4668.0865 Subp. 2

Based on record review and interview, the licensee failed to have a registered nurse (RN) conduct an assessment of the client's functional status and need for central medication storage and develop a service plan for the provision of central storage of medications for one of one client (A1) reviewed in housing with services A, two of two clients (C1 and C2) reviewed in housing with services C and three of three clients (D1 and D2 and D3) reviewed in housing with service D. The findings include:

Client A1 began receiving services on April 24, 2010. The client's RN evaluation lacked evidence that a RN conducted a nursing assessment of the client's functional status and need for central storage of medications.

Clients C1 and C2 began receiving services March 29, 2009, and March 2, 2009, respectively. Client C1's and C2's RN evaluation dated March 30, 2009, and March 2, 2009, respectively lacked evidence that a RN conducted a nursing assessment of the client's functional status and need for central storage of medications.

Clients D1, D2 and D3 began receiving services on September 23, 2009, June 29, 2010, and September 18, 2009, respectively. Client D1's, D2's and D3's RN evaluation dated September 24, 2009, June 29, 2010, and September 18, 2009, respectively lacked evidence that a RN conducted a nursing assessment of the client's functional status and need for central storage of medications.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

13. MN Rule 4668.0865 Subp. 3

Based on observation and interview, the facility failed to establish and maintain a system to ensure medications were not used after their expiration date in three of four housing with services (B, C and D). The findings include:

On August 4, 2010, at 10:00 a.m. in the medication cupboard in housing with services C the following expired medications were noted: a jar of Vaporizing colds rub with a expiration date of May 2007, a bottle of anti diarrheal pills with an expiration date of January 2010, a bottle of liquid antacid with an expiration date of January 2010, a tube of Aspercreme with an expiration date of July 2009 and two tubes of Vitamin A&D ointment with expiration dates of April 2010 and July 2010.

On August 4, 2010, at 2:00 p.m. one bottle of stool softener with an expiration date of July 2009 was found in the medication cupboard in housing with services site D.

On August 4, 2010, at 3:00 p.m., a bottle of Aspirin 325 milligrams with an expiration date of August 8, 2010, and a bottle of anti diarrheal tablets with an expiration date of June 2010 were found in the medication cupboard in housing with services B.

When interviewed August 4, 2010, employee AA (registered nurse) confirmed that the medications had expired. Employee AA also stated that the house managers were to check periodically to see if medications had expired.

TO COMPLY: A. A registered nurse or pharmacist must establish and maintain a system that addresses the control of medications, handling of medications, medication containers, medication records, and disposition of medications.

B. The system must contain at least the following provisions:

(1) a statement of whether the staff will provide medication reminders, assistance with self-administration of medication, medication administration, or a combination of those services;

(2) a description of how the distribution and storage of medications will be handled, including a description of suitable storage facilities;

(3) the procedures for recording medications that clients are taking;

(4) the procedures for storage of legend and over-the-counter drugs;

(5) a method of refrigeration of biological medications; and

(6) the procedures for notifying a registered nurse when a problem with administration, record keeping, or storage of medications is discovered.

TIME PERIOD FOR CORRECTION: Seven (7) days

14. MN Rule 4668.0870 Subp. 2

Based on observation, record review and interview, the licensee failed to ensure medications belonging to the client were given to the client or responsible person when the client was discharged and document in the client's record to whom the medications were given for two of two clients (A2 and A4) reviewed who were discharged. The findings include:

On August 3, 2010, at 8:15 a.m. on a chair in the main office there was a blister pack of Levothyroxine belonging to client A2 who was discharged on July 25, 2010. When interviewed August 3, 2010, employee AA (registered nurse) confirmed the client was discharged and went on to state the client's other medications were given to the family. Client A2's record lacked documentation to whom the medications were given to at the time of discharge.

On August 3, 2010, at 8:15 a.m. on an open shelf in the main office there was a bottle of Senna belonging to client A4 who was discharged on June 16, 2010. When interviewed August 3, 2010, employee AA confirmed the client was discharged and they were waiting for the family to pick up the medication as they forgot to give the Senna with the other medication that were given to the family. When interviewed August 5, 2010, employee AA confirmed the client's record did not indicate to whom the medications were given to at the time of discharge.

TO COMPLY: Current medications belonging to a client must be given to the client, or the client's responsible person, when the client is discharged or moves from the housing with services establishment. A class F home care provider licensee must document in the client's record to whom the medications were given.

TIME PERIOD FOR CORRECTION: Thirty (30) days

15. 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 (A1) reviewed in housing with services A and two of two clients (C1 and C2) reviewed in housing with services C. The findings include:

Client A1's vulnerable adult assessment, dated April 24, 2010, identified that the client was vulnerable in the following areas: ability to manage finances, ability to report abuse and neglect and social support system.

Client C1's vulnerable adult assessment, dated March 28, 2009, identified that the client was vulnerable in the following areas; ability to manage finances, ability to follow directions consistently, ability to report abuse or neglect and social support.

Client C2's vulnerable adult assessment, dated March 2, 2009, identified the client was vulnerable in the area of being able to report abuse or neglect.

A review of the Assessment for Resident Vulnerability and Safety form that is used by the licensee noted that areas of vulnerability should be addressed in the resident's care plan.

A review of client A1's, C1's and C2's records lacked evidence that the client assessment vulnerabilities were addressed on their care plans.

When interviewed August 4, 2010, employee AA (registered nurse) stated the client's care plans did not address all of the clients' vulnerabilities.

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8715 0208

July 14, 2005

Sandra Francisco, Administrator
Country Haven Alzheimer's Home
20371 Wendigo Park Road
Grand Rapids, MN 55744

Re: Licensing Follow Up Revisit

Dear Ms. Francisco:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Licensing and Certification Program, on March 24, 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 Assisted Living 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: Sandra Francisco, President Governing Board
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: COUNTRY HAVEN ALZHEIMERS HOME

DATE OF SURVEY: March 24, 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:
Sheila Phelps, office manager

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 March 24, 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) The exit conference was not tape -recorded.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 2517

January 28, 2005

Sandra Francisco, Administrator
Country Haven Alzheimer's Home
20371 Wendigo Park Road
Grand Rapids, MN 55744

Re: Results of State Licensing Survey

Dear Ms. Francisco:

The above agency was surveyed on January 11, 12, and 18, 2004 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: Sandra Francisco, 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: COUNTRY HAVEN ALZHEIMERS HOME

HFID # (MDH internal use): 21725

Date(s) of Survey: 01/11/2005, 01/12/2005 and 01/18/2005

Project # (MDH internal use): QL21725001

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 _X_ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff 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 who are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	_X_ Met ____ Correction Order(s) issued ____ Education provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff 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.	_X_ Met ____ Correction Order(s) issued _X_ Education provided _X_ 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 ____ 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.	MNRule 4668.0815 Subp.5	X	X	Based on record review and interview, the agency failed to provide contingency plans for four (#1, #2, #3 & #4) reviewed. The service plans did not include a plan for contingency. Findings include: Client #1 and #4 began receiving services in 2004. Client #2 and #3 began receiving services in 2003. On January 14, 2005, the director confirmed that the service plans did not include a plan for contingency

A draft copy of this completed form was left with Roberta Jo Jerry R.N at an exit conference on January 18,2005. 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)