MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7236

July 16, 2010

Gayle Carney, Administrator
People Incorp Epilepsy Service
630 Cedar Avenue #201
Minneapolis, MN 55454

Re: Results of State Licensing Survey

Dear Ms. Carney:

The above agency was surveyed on June 1, 2, 3, 7 and 9, 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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

01/07 CMR3199

CERTIFIED MAIL #: 7009 14010 0000 2303 7236

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:	GAYLE CARNEY	DATE: July 16, 2010
PROVIDER:	PEOPLE INCORP EPILEPSY SERVIC	COUNTY: HENNEPIN
ADDRESS:	630 CEDAR AVENUE #201 MINNEAPOLIS, MN 55454	HFID: 21819

On June 1, 2, 3, 7 and 9, 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 current Minnesota Home Care Bill of Rights for two of two clients' (#1 and #2) records reviewed. The findings include:

Clients #1 and #2 began receiving services from the home care provider June 4, 2004, and April 20, 2010 respectively. Although client #1's and #2's records indicated the clients had received a copy of the bill of rights, it was not the Minnesota Home Care Bill of Rights, but rather the Minnesota Bill of Rights for hospitals, which covered MN Statute 144.651 instead of MN Statute 144A.44 as required. The hospital version of the bill of rights did not include information about discharge notices.

When interviewed June 2, 2010, employee A (director) confirmed they were using the incorrect version of the bill of rights, and was not aware of the Minnesota Home Care Bill of Rights.

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 4668.0030 Subp. 4

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

Clients #1 and #2 began receiving services from the home care provider June 4, 2004, and April 20, 2010, respectively. Documentation in the clients' record revealed the clients received a copy of the hospital version of rights. This version did not include a current telephone, mailing address of the Office of Health Facility Complaints and office of the ombudsman for older Minnesotans.

When interviewed June 2, 2010, employee A (director) stated she was not aware the information in the bill of rights did not include the required information.

TO COMPLY: In addition to the text of the bill of rights in Minnesota Statutes, section 144A.44, subdivision 1, the written notice to the client must include the following:

A. a statement, printed prominently in capital letters, that is substantially the same as the following:

IF YOU HAVE A COMPLAINT ABOUT THE AGENCY OR PERSON PROVIDING YOU HOME CARE SERVICES, YOU MAY CALL, WRITE, OR VISIT THE OFFICE OF HEALTH FACILITY COMPLAINTS, MINNESOTA DEPARTMENT OF HEALTH. YOU MAY ALSO CONTACT THE OMBUDSMAN FOR OLDER MINNESOTANS.

B. the telephone number, mailing address, and street address, of the Office of Health Facility Complaints;

C. the telephone number and address of the office of the ombudsman for older Minnesotans; and

D. the licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed.

The information required by items B and C shall be provided by the Commissioner to licensees upon issuance of licenses and whenever changes are made.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0800 Subp. 1

Based on observation and interview, the licensee failed to ensure that services were provided to clients in a building that was registered as a housing with services establishment for one of one (#1) client reviewed. The findings include:

Client #1 was observed on June 3, 2010, to receive services from the home care provider. The client resided in an apartment building at 1627 South 6th Street in Minneapolis, Minnesota. The building was not registered as a housing with services establishment.

When interviewed June 1, 2010, employee A (director) stated the home care provider had been providing services to client #1 at 1627 South 6th Street since the client started services in 2004. Employee A confirmed the building had not been registered as housing with services establishment, and that it was an "oversight."

TO COMPLY: Scope of license. A class F home care provider licensee may provide nursing services, delegated nursing services, other services performed by unlicensed personnel, or central storage of medications, solely for residents of one or more housing with services establishments registered under Minnesota Statutes, chapter 144D.

TIME PERIOD FOR CORRECTION: Thirty (30) days

4. MN Rule 4668.0805 Subp. 2

Based on interview and record review, the licensee failed to ensure that orientation to the home care requirements included all of the required topics for three of four employees' (D, E and F) records reviewed. The findings include:

Employees D, E and F were hired to provide direct care to clients August 31, 2009, August 10, 2009, and April 20, 2004, respectively. There was no evidence the employees received orientation that included an overview of the rules and statutes related to home care, handling client complaints and how to report a complaint to the Office of Health Facility Complaints, and the services of the ombudsman.

When interviewed June 7, 2010, employee A (director) confirmed the staffs' orientation did not include an overview of the rules and statutes related to home care, handling client complaints and how to report a complaint to the Office of Health Facility Complaints, and the services of the ombudsman.

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

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

B. handling emergencies and using emergency services;

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

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

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

F. the services of the ombudsman for older Minnesotans.

TIME PERIOD FOR CORRECTION: Thirty (30) days

5. MN Rule 4668.0840 Subp. 3

Based on record review and interview, the licensee failed to ensure that unlicensed persons who performed assisted living home care services successfully completed training or demonstrated competency to a registered nurse (RN) in the required topics, for three of three unlicensed employees' (D, E and F) records reviewed. The findings include:

Employees D, E and F were hired to provide direct care to clients August 31, 2009, August 10, 2009, and April 20, 2004, respectively. Employee D's, E's and F's records lacked evidence that a RN conducted the training/competency in the areas of communication skills; observing, reporting, and documenting client status and care; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and physical, emotional and developmental needs of clients and ways to work with clients who have problems in these areas.

When interviewed June 7, 2010, employee A (director) confirmed that the required topics for the training/competency of unlicensed staff was not conducted by a RN, but rather herself or the program coordinator.

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

6. MN Rule 4668.0855 Subp. 3

Based on observation and interview, the licensee failed to ensure that medications were set up by a nurse, physician, or pharmacist for two of two clients' (#3 and #5) reviewed. The findings include:

Clients #3 and #5 began receiving services from the home care provider July 13, 1999, and June 12, 2008, respectively which included assistance with medication set-ups weekly.

Observations on June 7, 2010, at 11:00 a.m., revealed employee D (unlicensed staff person) assisted client #5 with setting up his medications in a medi-set container for one week. Observations on June 7, 2010, at 2:00 p.m., revealed employee E (an unlicensed staff person) assisted client #3 with setting up his medications in a medi-set container for one week.

The definition at MN Rule 4668.0003 Subp. 2a defined assistance with self-administration of medications as: "opening a container containing medications set up by a nurse physician or pharmacist."

When interviewed June 7, 2010, employee C (registered nurse), and employee A (director), stated that it was the practice of the home care provider to have a primary counselor, (an unlicensed staff) assist the clients with setting up their medications in a medi-set container if medication set-up was part of the client's service plan. Employee A confirmed that another unlicensed staff at a later date and time would assist the clients with administration of the medications that were previously setup in the medi-set container. Employee C and A stated they were not aware that unlicensed staff could not set up a client's medications for administration at a later date and time.

TO COMPLY: A registered nurse may delegate medication administration or assistance with self-administration of medication only to a person who satisfies the requirements of part 4668.0835, subpart 2, and possesses the knowledge and skills consistent with the complexity of medication administration or assistance with self-administration of medication, only in accordance with Minnesota Statutes, sections 148.171 to 148.285.

TIME PERIOD FOR CORRECTION: Seven (7) days

7. MN Rule 4668.0855 Subp. 4

INDICATOR OF COMPLIANCE: # 6

Based on observation, interview and record review, the licensee failed to ensure that the registered nurse (RN) instructed unlicensed staff in the proper method of medication administration for one of three unlicensed staffs' (D) records reviewed. The findings include:

The home care provider's Medication Administration Policy was reviewed and indicated that when a client came to the office to receive medication from his/her pre-set medi-set container, that staff would do three checks. The third check included counting the number of medications and verifying the accurate number of tablets or capsules to be given by using the client's medication administration record.

Employee D (unlicensed staff person) was observed on June 1, 2010, at 8:30 a.m. to assist client #7 with administration of a nasal spray. Employee D was observed to take the nasal spray out of the locked medication drawer and administer the nasal spray without checking the client's medication administration record.

Employee D was observed on June 2, 2010, at 9:10 a.m. to administer Lorazepam to client #6. Employee D was observed to take a bottle of Lorazepam that was locked in a black box in the locked medication drawer and administer the medication to the client. It was not until after employee D had administered the medication that employee D used the client's medication administration record and documented the administration.

Employee D was hired August 31, 2009, to provide assistance with medication administration to clients. Employee D's record was reviewed and there was no evidence of medication administration training/competency by the RN.

When interviewed June 7, 2010, employee D stated she had medication training at another program she worked at prior to her hire with this program. Employee D stated she "thought" the RN had reviewed some medication information with her upon hire, but she could not recall what it was.

When interviewed June 9, 2010, employee C (RN) stated she had not completed medication training/competency with employee D. Employee C stated employee D should have utilized the client's medication administration record to check the medications prior to administration.

When interviewed June 9, 2010, employee A (director) confirmed employee D did not have documentation of medication training/competency by the RN in her record. Employee A stated employee D's lack of training was an oversight.

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

8. MN Rule 4668.0855 Subp. 9

Based on observation, interview and record review, the licensee failed to ensure that medications were administered as prescribed for one of one client's (4) record reviewed who had medication orders. The findings include:

Client #4 began receiving services from the home care provider April 20, 2010, which included weekly medication set-ups and assistance with self administration of medications. Client #4 had a prescriber's order dated April 10, 2010 for a Multivitamin to be administered daily and Dilantin 290 milligrams to be given every bedtime. A review of the client's June 2010 medication administration record (MAR) did not include the administration of the multivitamin and the Dilantin that was being administered was 300 milligrams every bedtime. The record did include why the multivitamin and Dilantin were not administered as ordered.

When interviewed June 7, 2010, employee C (registered nurse) confirmed client #4 was not receiving his multivitamin as ordered. Employee C stated the client's family member thought a multivitamin was the same as calcium, and she knew he was already receiving calcium. Employee C stated she was not aware of the dosage discrepancy in the Dilantin from what was ordered to what was being administered. Employee C stated she would clarify the order with the prescriber.

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

9. MN Rule 4668.0860 Subp. 2

Based on observation, interview and record review, the licensee failed to ensure that medications that were administered had written prescriber's orders for two of two clients' (#1 and #3) records reviewed. The findings include:

Client #1 began receiving assistance with medication administration by unlicensed staff on February 26, 2010. Employee F (unlicensed staff person) was observed on June 3, 2010, to assist client #1 with medication administration. Employee F was observed to take the client's medications that were pre-set up in a medication administration dispensing machine, and compare what was in the client's medication cup to what was listed on the client's medication administration record. Employee F was observed to administer twelve pills to the client which included aspirin, hydrochlorothiazide, Januvia, Lisinopril, Plavix, potassium, bupropion, Detrol and Toprol. Client #1's record did not contain any prescriber's orders for the client's medications that were being administered. When interviewed June 2, 2010, employee C (registered nurse) confirmed client #1 did not have any prescriber's orders in her record. Employee C stated that originally the home care provider was not assisting the client with her medications, but in February of 2010, client #1 began declining, and they began assisting the client with medication administration. Employee C stated they should have obtained prescriber's orders at that time.

Client #3 began receiving services from the home care provider July 13, 1999, which included assistance with medication administration. The client's June 2010 medication administration record indicated the client received Certagen 1 tablet every morning, Ferrous Sulfate 325 milligrams twice a day, Tegretol 500 milligrams in the morning, and 750 milligrams every evening. The client's record did not contain prescriber's orders for these medications. When interviewed June 7, 2010 employee C confirmed there were no written prescriber's orders for the aforementioned medications that were being administered to client #3. Employee C stated she thought the pharmacy label on the bottles of medications was sufficient for a prescriber's order.

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

10. MN Rule 4668.0860 Subp. 6

Based on interview and record review, the licensee failed to ensure that verbal orders were recorded, signed, and forwarded to the prescriber for signature for one of one client's (#4) record reviewed who received Coumadin. The findings include:

Client #4 began receiving services from the home care provider October 10, 2008, which included assistance with medication administration on a daily basis. Client #4's record indicated that he received Warfarin Sodium (a blood thinner) on a daily basis with frequent dosage changes. The only prescriber's order for Warfarin Sodium in the client's record was obtained on April 10, 2010. Notation in the client's progress notes and medication administration records indicated that the Warfarin dose was changed on a weekly basis after having an INR (lab test to determine how thin the blood was) drawn.

When interviewed June 7, 2010, employee C (registered nurse) stated that client #4's Warfarin dosage changed almost weekly. Employee C stated she would obtain a verbal order from the prescriber with the dosage change. Employee C confirmed that she had not recorded and signed the verbal order and forwarded the order to the prescriber for signature.

TO COMPLY: Upon receiving an order verbally from a prescriber, a nurse must:

A. record and sign the order; and

B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

TIME PERIOD FOR CORRECTION: Seven (7) days

11. MN Rule 4668.0860 Subp. 9

Based on interview and record review, the licensee failed to ensure that medications and treatments were renewed by the prescriber at least every 12 months for one of one client's (#3) record reviewed who was receiving services greater than a year. The findings include:

Client #3 began receiving assistance with medication administration July 13, 1999. The client's record did not contain evidence that his medications had been renewed at least every twelve months.

When interviewed June 9, 2010, employee C (registered nurse) confirmed client #3's medications had not been renewed by the prescriber every twelve months as required. Employee C stated there was not a system in place to renew client's medications at least every twelve months.

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 Statute §144A.44 Subd. 1(2)

Based on observation, interview and record review, the licensee failed to ensure that care and services were provided in accordance with accepted medical and nursing standards for one of one client's (#1) record reviewed. The findings include:

Client #1 began receiving assistance with medication administration by the licensee on February 26, 2010. Client #1's medications were set-up by a nurse employed by another home care provider. The nurse from the other home care provider would set-up the client's medications into a MD2 machine on a weekly basis. The MD2 machine dispensed the client's medications out at specific pre-set times, and the unlicensed staff from the licensee administered the medications. Problems were noted in the client's record with the medications not being set-up correctly by the nurse at the other home care provider, and were being corrected by the unlicensed staff employed by the licensee prior to administration. The corrections were made based on information provided to the licensee by the other home care provider, and put on a medication administration record. The licensee did not have any prescriber's orders for

these medications to verify that what the other home care provider had given them was an accurate reflection of the medications the prescriber wanted the client to receive.

Client #1 was observed on June 3, 2010, at 7:00 a.m. to receive assistance with medication administration by employee F (an unlicensed staff). Employee F was observed to check the client's pills that came out of the MD2 machine against the client's medication administration record. Employee F then administered the medications to the client.

A progress note dated May 4, 2010, indicated employee C (registered nurse) went to the client's apartment, at 8:15 a.m. due to a report that the client's MD2 machine did not dose the client's morning medications. Employee C checked the client's MD2 machine and noted that it was empty. Employee C contacted the other home care provider who sets up the client's medications and the home care provider stated they were unsure how that happened, but would have someone come out around 11:30 a.m. Employee C set up the client's medication for eight days in the MD2 machine and ordered refills from the pharmacy for the client's medications. The client was administered her medication by employee C at 9:00 a.m. The client's medication administration record indicated the client took two blood pressure medications; HCTZ and Lisinopril, Januvia to control her type II diabetes, Plavix, Potassium, Bupropion, ASA and Detrol every morning.

A progress note in client #1's record dated May 11, 2010, at 7:00 p.m. by an unlicensed staff indicated that there was a note in the pill container in client #1's MD2 machine from the other home care provider that stated one Simvastatin needed to be added to the medication container. The unlicensed staff from the licensee placed a Simvastatin into the client's medication container.

An incident report dated May 15, 2010, at 7:10 a.m. indicated that when the unlicensed staff person of the licensee went to administer client #1's a.m. medications, the staff person noted that only a half of a tablet of potassium was in the medication cup. The staff person verified on the client's medication administration record that the client was to receive a whole tablet of potassium, so the unlicensed staff person of the licensee made the correction before administering the medications.

A progress note and incident report dated May 17, 2010, at 7:10 a.m. indicated unlicensed staff of the licensee went to the client's apartment to assist with medication administration and noted there was one tablet too many in the medication cup that came out of the client's MD2 machine. The unlicensed staff verified the contents of the medication cup and noted that an Amlodipine Besylate 5 milligram tablet was in the medication cup in error. Client #1 was to receive this medication in the evening. The unlicensed staff person of the licensee removed the Amlodipine Besylate from the medication cup and placed it back into the medication bottle. An additional medication was unable to be identified in the medication cup, so the unlicensed staff had the nurse identify the medication. Staff removed the pill and replaced it with an aspirin 81 milligram tablet. The client's medications were then administered.

A progress note and incident report dated May 17, 2010, at 7:05 p.m. indicated that the client's medications in her bedtime pill container were dispensed from her medication machine and were incorrect. The unlicensed staff from the licensee verified the pills with the medication administration record and noted the medication Amlodipine Besylate 5 milligrams was missing from the pill container. The unlicensed staff made the corrections and administered the client's medications.

When interviewed June 2, 2010, employee C (registered nurse) confirmed that another home care provider nurse set-up the client's medications and that the unlicensed staff of the licensee administered

the medications. Employee C acknowledged that there have been problems with the accuracy of the medications set-up by the other home care provider nurse, and the unlicensed staff of the licensee had been correcting the errors. Employee C confirmed the licensee did not have any signed prescriber's orders for the medications client #1 was receiving and that the situation was unsafe medication administration.

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: Seven (7) days

13. MN Statute §626.557 Subd. 3

Based on record review and interview, the licensee failed to ensure that an incident of possible abuse was immediately reported to the common entry point for one of one client's (#2) record reviewed who had an alleged incident of abuse. The findings include:

Client #2 began receiving services from the home care provider March 10, 2006. An incident report dated May 12, 2010, indicated that on May 11, 2010, at approximately 6:30 p.m., the client got on the elevator on her way to her apartment and unknown male got onto the elevator with her and began grabbing his genitals and proceeded to touch the client in her private area through her clothing. Client #2 reported the incident to the home care provider staff at 3:00 a.m. on May 12, 2010. The home care provider followed up with the client on May 12, 2010, at 11:00 a.m. with further questions about the incident, and spoke with building management to review video tapes of the elevator. A notation in client #2's record dated May 12, 2010, indicated that the client had been "sexually violated" in the elevator on May 11, 2010, and that due to the incident the client was "quite frightened" and was afraid to ride the elevator alone.

Employee A (director) was questioned June 2, 2010, regarding whether this incident had been reported to the common entry point. Employee A stated the incident had not been reported to the common entry point because the client had stated she had not wanted the police notified. The licensee reported the incident during the survey.

TO COMPLY: Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c.

TIME PERIOD FOR CORRECTION: Thirty (30) days

cc: Hennepin 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 # 7005 0390 0006 1222 1637

May 11, 2006

Anne Barnwell, Administrator
People Incorp Epilepsy Service
630 Cedar Avenue #203
Minneapolis, MN 55454

Re: Licensing Follow Up visit

Dear Ms. Barnwell:

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 April 19, 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

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

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

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Ron Drude, Minnesota Department of Human Services
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: PEOPLE INCORP EPILEPSY SERVIC

DATE OF SURVEY: April 19, 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:
Heidi J. Hennen, Administrative Assistant
Ben Nusman, Registered Nurse
Janine Jordon, Client

SUBJECT: Licensing Survey _____ Licensing Order Follow Up ___#3_____

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to followup on the status of state licensing orders issued as a result of a visit made on December 27, 28, 29 and 30, 2004, and follow-up visits made on April 27, 2005 and November 10, 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 issued on December 27, 28, 29 and 30, 2004, is as follows:

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 9298

November 23, 2005

Anne Barnwell
People Incorp Epilepsy Services
630 Cedar Avenue #203
Minneapolis, MN 55454

Re: Amended Licensing Follow Up Revisit

Dear Ms. Barnwell:

On November 22, 2005 you were sent an Informational Memorandum and Notice Of Assessment For Noncompliance With Correction Orders the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. **Please disregard the information that was mailed to you.** Subsequent to that mailing, an error was noted in the information that was mailed to you.

Attached are the corrected Informational Memorandum and Notice Of Assessment For Noncompliance With Correction Orders. The amended information that has been corrected is underscored and the stricken [~~stricken~~] information has been removed.

The documents checked below are enclosed.

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

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

__X__ Notice Of Assessment For Noncompliance With Correction Orders 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: Scott Sponheim, President Governing Board
Gloria Lehnertz, Minnesota Department of Human Services
Hennepin County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 9298
~~7004 1160 0004 8711 8963~~

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

November 23, 2005

RE: QL21819001:
~~QL21919001~~

Dear Ms. Barnwell:

On November 10, 2005 a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on December 27, 28, 29, and 30, 2004 with correction orders received by you on February 28, 2005.

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

1. MN Rule 4668.0815, Subp.4 **$100.00**
~~**$50.00**~~

Based on interview and record review, the licensee failed to provide a complete service plan on 3 out of
3 clients, #1, #2 #3 reviewed. The contents did not include an individualized description of services, persons providing services, fees for services and a plan for contingency action.
The current service plans contained documented statements of "rates per unit" for services that were documented with abbreviated letter codes that were not defined as to what services they provided.
On interview with the program director on 12/27, 12/28, and 12/30/04 at the exit conference, she stated she would review all of service plans in the facility and update as needed.

TO COMPLY: The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:
(1) the action to be taken by the assisted living home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the assisted living home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the assisted living home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 100.00
~~$50.00~~.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: $ 100.00 ~~$50.00~~. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to this Department within 15 days of this notice.

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

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

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

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Scott Sponheim, President Governing Board
Gloria Lehnertz, Minnesota Department of Human Services
Hennepin County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

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

INFORMATIONAL MEMORANDUM

PROVIDER: PEOPLE INCORP EPILEPSY SERVIC

DATE OF SURVEY: November 10, 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:

Ann Barnwell, Program Director
Terri Keacher, Program Assistant
Heidi Hennen, Administrative Assistant

SUBJECT: Licensing Survey _____ Licensing Order Follow Up X (#2)

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to followup on the status of a state licensing order issued as a result of a visit made on December 27, 28, 29, and 30, 2004, and a follow-up visit on April 27, 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 issued on December 27, 28, 29, and 30, 2004, is as follows:

   1. MN Rule 4668.0815 Subp. 4 **Not Corrected** **$ 100.00** ~~**$50.00**~~

   Based on record review and interview, the licensee failed to ensure that service plans were complete for three of three clients' (#1, #2, and #3) records reviewed. The findings include:

Client #1 began receiving services on September 7, 2005. Progress notes for September and October of 2005 indicated that the client received assistance with medication administration and meal preparation. There was no evidence of a service plan in client #1's record. Employee A, an administrative assistant, and the program director confirmed that client #1 did not have a service plan in her record. The program director stated that client #1 had just had her care conference last week, and the service plan had not been completed yet.

Client #2 began receiving services September 16, 2005. The client's service plan dated September 22, 2005, indicated that the client received assistance with housekeeping and medication box refill on a weekly basis. The caregiver to provide the services was noted as "Staff." Client #2's service plan did not include the fee for the services, frequency of supervision of the services, nor did it include a contingency action plan.

Client #3 began receiving services on July 8, 2003. The client's service plan dated July 28, 2005, indicated that the client received assistance with medication box set-up weekly, and assistance with cooking and meal prep every evening. The caregiver to provide the services was noted as "Staff." Client #3's service plan did not include the fee for the services, frequency of supervision of the services, nor did it include a contingency action plan.

Client #4 began receiving services on September 19, 2005. The client's service plan dated September 19, 2005, indicated that the client received assistance with budgeting and balancing his checkbook. The identification of the caregiver to provide the services indicated "Staff." Client #3's service plan did not include the frequency of the service, the fee for the service, the frequency of supervision of the service, nor did it include a contingency action plan.

When interviewed, November 10, 2005, employees A and the program director confirmed clients #1, #2, #3, and #4s' service plans were not complete, stating it just didn't get done and when asked about "staff" as the identified caregiver from the service plan they confirmed there were several categories of "staff" working at the assisted living.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8715 0239

June 20, 2005

Anne Barnwell, Administrator
People Inc. Epilepsy Services
630 Cedar Avenue #203
Minneapolis, MN 55454

Re: Licensing Follow Up Revisit

Dear Ms. Barnwell:

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 April 27, 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.

X 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: Scott Sponheim, President Governing Board
Case Mix Review File

10/04 FPC1000CMR

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #7004 1160 0004 8715 0239

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

June 20, 2005

Ms. Anne Barnwell, Administrator
People Inc. Epilepsy Services
630 Cedar Avenue #203
Minneapolis, MN 55454

RE: QL21819001

Dear Ms. Barnwell;

On April 27, 2005 a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders found during an inspection completed on December 27,28,29,and 30, 2004 with correction orders received by you on February 28, 2005

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

1. MN Rule 4668.0815, Subp.4

Based on interview and record review, the licensee failed to provide a complete service plan on 3 out of
3 clients, #1, #2 #3 reviewed. The contents did not include an individualized description of services, persons providing services, fees for services and a plan for contingency action.
The current service plans contained documented statements of "rates per unit" for services that were documented with abbreviated letter codes that were not defined as to what services they provided.
On interview with the program director on 12/27, 12/28, and 12/30/04 at the exit conference, she stated she would review all of service plans in the facility and update as needed.

TO COMPLY: The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:
(1) the action to be taken by the assisted living home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the assisted living home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the assisted living home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

TIME PERIOD FOR CORRECTION: Thirty (30) days

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the total amount you are assessed is**: **$ 50.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and sent to this Department within 15 days of this notice.

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

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

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

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Jocelyn Olson, Assistant Attorney General
Scott Sponheim, President Governing Board
Kelly Crawford, Minnesota Department of Human Services
Hennepin County Social Services
Mary Henderson, Program Assurance Unit
Licensing and Certification File
Case Mix Review File

12/04 FPCCMR 2697

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

INFORMATIONAL MEMORANDUM

PROVIDER: PEOPLE INCORP EPILEPSY SERVIC

DATE OF SURVEY: 04/27/05

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:
Heidi J. Hennen, Administrative Assistant

SUBJECT: Licensing Survey _____ Licensing Order Follow Up ___X_____

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to on the status of state licensing orders issued as a result of a visit made on 04/27/05. 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 **Not Corrected**

Based on record review and interview the licensee failed to provide a complete service plan on 3 out
0f 3 clients,(#1, #2, #3) reviewed. There were no service plans available in the records.
On interview 04/27/05 with the administrative assistant it was stated that the agency was in the process
of developing a system to address the individual assessment for the service plan.

2. MN Rule 4668. 0835 Subp. 3 **Corrected**

3. MN Rule 4668. 0855 Subp. 2 **Corrected**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 2807

February 25, 2005

Anne Barnwell, Administrator
People Inc. Epilepsy Service
630 Cedar Avenue #203
Minneapolis, MN 55454

Re: Results of State Licensing Survey

Dear Ms. Barnwell:

The above agency was surveyed on December 27, 28, 29, and 30, 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: Scott Sponheim, 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: PEOPLE INCORP EPILEPSY SERVIC

HFID # (MDH internal use): 21819

Date(s) of Survey: 12/27,28,29,30,2004

Project # (MDH internal use): QL21819001

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

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promotes the clients' rights as stated in the Minnesota Home Care Bill of Rights. (MN Statute 144A.44; MN Rule 4668.0030)	No violations of the MN Home Care Bill of Rights (BOR) are noted during observations, interviews, or review of the agency's documentation. Clients and/or their representatives receive a copy of the BOR when (or before) services are initiated. There is written acknowledgement in the client's clinical record to show that the BOR was received (or why acknowledgement could not be obtained).	X Met ___ Correction Order(s) issued ___ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff observes infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	X Met ___ Correction Order(s) issued 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.	X Met ___ Correction Order(s) issued ___ Education provided

Indicators of Compliance	Outcomes Observed	Comments
7. The agency employs (or contracts with) qualified staff. (MN Statutes 144D.065; 144A.45, Subd. 5; MN Rules 4668.0070, 4668.0820, 4668.0825, 4668.0030, 4668.0835, 4668.0840)	Staff has received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	___ 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 is trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	___ Met _X_ Correction Order(s) issued _X_ Education provided ___ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follows any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ___ Correction Order(s) issued ___ 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:

#1	MN Rule 4668.0815, Subp.4	X	X	Based on interview and record review, the licensee failed to provide a complete service plan on 3 out of 3 client,#1,#2, #3 reviewed. The contents did not include an individualized description of services, frequency of services, persons providing services, fees for services and a plan for contingency action. The current service plans contained fees for "rates per unit" for services that were documented with abbreviated letter codes that were not defined as to what service they provided. On interview with the program director on 12/27 and 12/28/04, she stated she would review all service plans in the facility and update them as needed. **Education:** Provided
#3	MN STATUTE 144A.46, Subd. 5		X	**Education:** Provided

#7	MN Rule 4668.0835, Subp.3	X	X	Based on interview and record review, the licensee failed to provide infection control inservice training for 1 of 2 unlicensed staff #1.The finding include: Employee #1 began employment with the agency on 09/30/03. There was no record on infection training in the record. On interview with the program director on 12/28 and 12/29/04, she stated she would review the inservice schedule and add an infection control inservice on a regular basis for all staff members. **Education:** Provided

A draft copy of this completed form was left with Anne Barnwell, Program Director at an exit conference on12/30/04. 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)