Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7003 2260 0000 9988 0378

April 15, 2005

Mr. Fred Youngstrand, President
Personal Staff Senior Care Inc
DBA Reflections Home Incorporated
2730 Greysolon Road,
Duluth, MN 55812

Dear Mr. Youngstrand,

On April 8, 2005, a reviewer from Case Mix Review made an on-site visit Reflections on Mirror Lake located at 4646 West Pioneer Road, Duluth, MN 55803 and Reflections on Greysolon located at 2730 Greysolon Road, Duluth, MN 55804.

As a result of this on-site visit, two licensing orders are being issued at MN. Rule MN Rule 4668.0810 Subp. 1 and MN Statue §144A.44 Subd. 1 (2). Please see attached correction orders.

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. Please note that if, upon re-inspection, it is found that the violations cited in the attached correction order form 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.

If you have any questions, please feel free to call me at 651-215-8010.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review
Division of Compliance Monitoring
Minnesota Department of Health
85 East Seventh Place, Suite 300, PO Box 64938
St. Paul, MN 55164-0938

Original – Facility
CC: CMR File
Mary Henderson, Program Assurance
Kelly Crawford, Minnesota Department of Human Services
Greg Anderson, St. Louis County Social Services
Fred Youngstrand, President Governing Body
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Attorney General Office

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: REFLECTIONS HOMES ASSISTED LIVING

HFID # (MDH internal use): 23099

Date(s) of Survey: 04/08/2005

Project # (MDH internal use): QL23099003

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 ___ Correction Order(s) issued ___ Education provided

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promote the clients' rights as stated in the Minnesota Home Care Bill of Rights. (MN Statute 144A.44; MN Rule 4668.0030)	No violations of the MN Home Care Bill of Rights (BOR) are noted during observations, interviews, or review of the agency's documentation. Clients and/or their representatives receive a copy of the BOR when (or before) services are initiated. There is written acknowledgement in the client's clinical record to show that the BOR was received (or why acknowledgement could not be obtained).	___ Met _X_ 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 observe infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	___ 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.	___ 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.	___ Met _X_ Correction Order(s) issued _X_ Education provided
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	___ Met ___ 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 have received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff who are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	____ Met ____ 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 are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	____ Met ____ Correction Order(s) issued ____ Education provided ____ N/A
9. Continuity of care is promoted for clients who are discharged from the agency. (MN Statute 144A.44, 144D.04; MN Rules 4668.0050, 4668.0170, 4668.0800,4668.0870)	Clients are given information about other home care services available, if needed. Agency staff follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	____ 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).	____ 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:
3	MN Statue 144A.44, Subd. 1 (2) Right to receive care and services in accordance with a suitable and up to date plan of care.	X	X	Based on record review and interview the licensee failed to ensure three of three clients (client # 1, # 2, and # 3) reviewed received care and services according to a suitable and up to date plan, and subject to accepted nursing standards. The findings include: *Client #1* A direct care staff noted in client # 1's record dated April 8, 2005, 7-3 shift that client # 1 was very quiet, seemed incoherent at times, needed assistance with walking and was "very unsteady." The note indicated that the last time staff had "toileted" client #1 was at 2:00 PM. The next note stated that client #1 seemed hot and staff took client #1's temperature and noted that it was 103.2 degrees Fahrenheit. Staff called the registered nurse (RN), left a message and documented in the April 2005 Medication Administration Record that they administered two tablets of Tylenol to client #1 at 2:48 PM. When interviewed on April 8, 2005, the 3-11 staff indicated the RN had called and told staff to "push fluids" but that they were unable to get client #1 to drink. Client #1's record lacked documentation of the RN instructions to the staff. Client #1 was observed on April 8, 2005 at 4:00 PM to be sitting in a

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				recliner chair by the fireplace in the living room. Client # 1 appeared to be sleeping. At about 5:00 PM the staff was asked by person A if they were going to get client # 1 ready for supper. Staff went over to client #1 and had a difficult time arousing client #1. Client #1was observed to be wearing a blue shirt that appeared wet. Client #1's breathing was observed to be shallow and she was very diaphoretic. Person A asked staff about client #1 condition. Staff then took client #1's temperature, which registered 101.4 degrees Fahrenheit. Person A requested that staff change client # 1's wet shirt. Two staff was observed pulling client #1 out of the recliner with difficulty and stated, "This is the weakest I have ever seen [client #1]." Client #1 was observed having difficulty walking into the bathroom and required the assistance of two staff. One staff was observed standing in front of client #1 holding both her hands and pulling her while the other staff was behind client #1 pushing her. Client #1 was observed to be unsteady on her feet. Staff left client # 1 in the bathroom alone and went into the kitchen to assist the other clients with supper. After about ten minutes, while staff were assisting the other clients with supper, person A asked staff about client # 1's whereabouts. Staff stated, "Oh she's in the bathroom." Staff then went into the bathroom, brought client #1 into the kitchen and sat client # 1 at the table in the kitchen. Staff had not changed client # 1's wet shirt. Staff did not attempt to feed client #1 or offer her fluids. Staff attempted to reach the RN at about 6:00 PM and left the RN a voice

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				message. As of 7:00 PM, the RN had not responded to the call. Interview with Person B at about 6:00 PM on April 8, 2005 indicated that person B had not been notified about client # 1's elevated temperature from the 7:00 AM – 3:00 PM staff. Person B indicated that staff were suppose to call person B with all changes in client #1's condition. Person B stated that she would come to the facility and take her to the emergency room to have her condition evaluated. As of 7:00 PM when the surveyor left the facility, the RN had not yet called the facility. Documentation in client # 1's hospital record indicated that client # 1 arrived at the hospital at 8:21 PM on April 8, 2005. Client # 1 had a rectal temperature of 104, an elevated pulse of 132, elevated blood glucose at 214, mucous membranes that appeared dry, was "profoundly hypotensive," had a urinary tract infection and bacteremia. Client #1 was diagnosed with Hypotension associated with septic syndrome, Acrocyanosis probably due to hypotension, depressed mental status, Acute Renal Failure probably due to septic process and Rhabdomylolysis. Client #1 passed away in the hospital on April 9, 2005. <u>Client #2</u> Client #2 was observed on April 8, 2005 at 4:00 PM sitting in a recliner in the corner of the living room looking out at the lake with person C at his side. Client # 2 was observed to have a dressing on his left foot. A note taped to the wall in the office,

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				was observed on April 8, 2005. The note stated: "Every one who can not move independently in bed needs to be turned every two hours, check incont. Briefs and change if wet this includes nights." Client # 2's Care Plan, revised December 13, 2004, indicated that client # 2 sometimes transfers independently, with assist of one or two. The care plan also stated that client #2 is to be toileted every two hours. The daily notes in client #2 record dated March 21, 2005 indicated that client # 2 slept most of the night, was observed "awake fishing" in bed toward ceiling at a couple bed checks." The daily notes indicated that the staff were able to change client #2's brief at roughly 2:00 AM but could not do so at 5:00 AM because he was resistive. Client # 2 was observed on April 8, 2005 from 4:00 PM until the time the surveyor left the facility at 7:00 PM (three hours). Staff did not check client#2 for incontinence or reposition him during this time. A second hand written note was observed taped to the wall above the desk in the office on April 8, 2005. The note indicated that client # 2 has a sore on his foot and that the RN had left instruction. The instructions were taped to the right had corner of the desk in the office. The instructions were dated April 2, 2005. The instructions were as follows; client # 2 has a large wound on back of left heel. It comes from always having his heel touching the bed. Blood flow is minimal. Sheering against his socks and against sheets and when putting his shoes on. (1) When in bed or in recliner put a

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				pillow under his "calfs" (of his left) so his heels do not touch anything. (2) When in bed for more than two hours he should be turned side to side. Don't be afraid to use pillows to prop him. (3) Every day his legs/feet should be lotioned and massaged to increase blood circulation. April 3, 2005 use gauze with Neosporin on heel no socks or shoes on left foot "change every day by Nurse." The April 2005 Home Health Aide Treatment and Procedure flow sheet lacked documentation that the dressing to client # 2's foot had been changed daily or that lotion had been applied as stated above. The April 2005 Medication record also lacked documentation that the dressing changes had been done daily by the Nurse. The Aide Care Plan and the Aide Care Notes did not address the need to change the dressing to client # 2'w foot. During interview on April 8, 2005 person (C) stated that the unlicensed staff had changed the dressing on client # 2's left foot on April 8, 2005. *Client #3* A "Concern Complaint Form" dated April 4, 2005 indicated that on April 3, 2005, client #3 was found to have a open "bed sore." The report indicated that although the night staff were told of the problem and instructed to reposition client # 3 throughout the night, client # 3 was found in the same position "I left her in the night before" when the staff who left the instructions returned to work the next day. Documentation in the "Concern Complaint Form" indicated that staff

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				did not reposition client # 3 all night and that this incident was not the first time client # 3 was not repositioned. On April 8, 2005, a hand written note was observed taped to the wall above the desk in the office. This note indicated that client #3 's "bedsore" was "worse than ever." The note indicated that client # 3 needed to be turned every two hours. The Care Plan for client #3 indicated that client #3 was to receive DuoDERM to the "bedsore" and be kept off the "bedsore" area. The March 2005 Home Health Aide Treatment and procedure sheet indicated that the DuoDERM, which was to be applied to the "bedsore" was to be changed every 48 hours. The DuoDERM was changed on March 25, 2005 and was not changed again until March 29, 2005. Client # 3's record lacked documentation that client # 3 was turned every two hours. Client # 3's Home Care Service Agreement stated that client # 3 was to be re-positioned every 2 hours. Client # 3's record also lacked documentation that a nursing assessment of the bed sore on client # 3's buttocks had been completed Education: Provided
5	MN Rule 4668.0810, Subp.1 Client Record	X	X	Based on record review and interview, the licensee failed to ensure that one of four clients (client # 4) record was readily accessible. The findings include: Person B stated during an interview on April 8, 2005 at 6:00 PM that on April 7, 2005 person B was told that client #4 was receiving treatment for a "yeast infection." The April 2005 Medication Administration Record and the April

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				2005 Home Health Aide Treatment and Procedure Flow sheet did not contain any documentation that would indicate that client # 4 had received treatment for a "yeast infection." When staff was asked for client # 4's medical record, staff stated that they were unable to locate it, indicating that registered nurse at times takes client's records home. Education: Provided

A copy of this completed form was MAILED on APRIL 15, 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)

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 2951

March 17, 2005

Ron Alvar, Administrator
Reflections Homes Assisted Living
2730 Greysolon Road
Duluth, MN 55814

Re: Licensing Follow Up Revisit

Dear Mr. Alvar:

This is to inform you of the results of a follow-up visit conducted by staff of the Minnesota Department of Health, Licensing and Certification Program, on February 23, 24 and 28, 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.

X MDH Correction Order and License 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: Fred Youngstrand, President Governing Board
Program Assurance, Licensing and Certification
Case Mix Review File
Jocelyn Olson, Assistant Attorney General, Attorney General's Office

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #7004 1160 0004 8714 2951

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOLLOWING A SUBSEQUENT REINSPECTION FOR ASSISTED LIVING HOME CARE PROVIDERS

March 17, 2005

Ron Alvar, Administrator
REFLECTIONS HOMES ASSISTED LIVIVING
2730 Greysolon Road
Duluth, MN 55814

RE: QL23099002

Dear Mr. Alvar:

1. On February 23, 24 and 28, 2005, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on August 30, 2004, received by you on September 23, 2004 and found to be uncorrected during an inspection completed on December 9, 10, 13, and 15, 2004.

As a result of correction orders remaining uncorrected on the December 9, 10, 13 and 15, 2004 re-inspection, a penalty assessment in the amount of $1050.00 was imposed on February 2, 2005.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on February 23, 24 and 28, 2005.

1. MN Rule 4668.0815, Subp. 2 **$500.00**

Based on observation, record review, and interview, the agency did not revise a client's service plan when there was a change in the client's condition that required a change in the service plan for one of three active clients (#3) reviewed in housing with services site A.

Client #3 had diagnoses of end stage Alzheimer's Disease, and severe venous stasis. Client #3's services began April 14, 2004. Since admission client #3 has had a decline in function. The aide care plan June 3, 2004 was used as an extension of the service plan dated April 14, 2004. It indicated client #3 was ambulatory, required assistance of one to transfer, walked with a walker and used a wheel chair for outings, toilet every two hours while awake, assist with pulling pants up and down when toileting, apply incontinent briefs at night, feed if overly tired, cut foods to bite sized, and set up and use finger foods. Client #3 was observed to be totally fed mashed or ground food when this reviewer was in the agency on August 25 and 27, 2004. The client was observed in bed or in her wheelchair at all times during the survey. Client #3 was non-ambulatory and required assist of two to transfer. During an interview August 27, 2004, direct care staff #7 and #8 stated client #3 wore briefs during the day because of incontinence. During an interview August 27, 2004 with the agency registered nurse (RN) she confirmed the service plan did not reflect the increased care client #3 was receiving. When interviewed August 30, 2004 the

client's representative stated she was aware the service plan had not been updated and that she had requested the services be reflected on the record for follow through by all caregivers.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 500.00.

4. MN Rule 4668.0865, Subp. 3 $600.00

Based on observation, interview and record review, the agency failed to maintain a system that assures the control and handling of medications and treatments according to physician orders for two of two active clients reviewed in housing with services site B (Client # 1 and 2) and three of three active clients reviewed in housing with services site C (client # 8, 9, and 10).

Client #1 has a physician's order dated July 21, 2004, which states, Coumadin 3mg on Monday, Wednesday and Friday and 4mg on all other days. On August 12, 2004 the physician ordered the dose of Coumadin to remain the same. Review of the Medication Administration Record for August 2004 indicated that the client received Coumadin 4mg on Monday, Wednesday, and Friday and 3mg on all other days. On August 25, 2004 the reviewer checked the Coumadin container prepared by the pharmacy. The label on the Coumadin container stated "Take 2 (4mg) Monday and Friday and 1 ½ tabs (6mg)". An interview August 27, 2004 with Register Nurse (RN) confirmed that the pharmacy had set up the wrong dose of Coumadin and that the client had not been receiving the coumadin as ordered.

Client #2 had a physician order August 9, 2004 for blood sugar testing twice daily. The client's blood sugar ranged from 46 to 362. The August 2004 "Home Health Aide Treatment and Procedure Sheet" indicated that the client #2's blood sugar was to be tested at 8:00 am and at HS (hour of sleep). The August 2004 Home Health Aide Treatment and Procedure sheet indicated that August 11, 2004 staff were "unable times 2 to do the blood sugar", August 12, 2004 "could not take B.S. no strips." On August 17 and 18, 2004 at 8:00 AM and August 20 and 21, 2004 at HS blood sugar testing was not documented. When interviewed August 25, 2004 the RN indicated that she had retrained the Home Health Aides on blood sugar testing and testing had been completed but not documented.

Client # 8 had a physician order for Digoxin 0.125mg one tablet by mouth on Monday, Wednesday and Friday. The Medication Administration Record (MAR) for client #8 directed staff to "take client's pulse before giving Digoxin, give only if the client's pulse is 60 or above, document the client's pulse under your initials, and if pulse is below 60 call the registered nurse" (RN). Client #8's MAR indicated the client's pulse was below 60 on August 11, 13, 16, 18, 20, 23, 25, and 27, 2004. The MAR did not indicate if the medication had been held or administered to the client. There was no documentation the Registered Nurse had been notified of the pulse below 60. On August 27, 2004 the client's pulse was recorded at 46. On August 27, 2004, the home health aide stated that she had not given the Digoxin. The home health aide stated the RN had not been notified. On August 27, 2004 this reviewer observed the Digoxin medication container. August 20, 25, and 27, 2004 were the only days, which still contained Digoxin. The days when the client's pulse was documented as below 60 were empty. On August 27, 2004 the RN stated the instructions on the MAR were to be followed. She said had not been notified of the client's pulse below 60.

Client # 9 had a physician order July 13, 2004 for Calcium with vitamin D 500mg twice daily and Senakot 5mg twice daily. The August 2004 Medication Administration Record indicated that the client received the Calcium with vitamin D 500mg once daily and Senakot 5mg once daily. The August 2004 home health aide Treatment and Procedure sheet indicated that client #9 was to have her blood sugar checked before breakfast and at bedtime. The blood sugar was not documented as being done before breakfast on August 12, 14, and 15, 2004 or at bedtime on August 2, 11, and 15, 2004. On August 25, 26, and 27, 2004 it was documented that the blood sugars were not done because there were no test strips. On August 27, 2004 the home health aide stated the registered nurse (RN) had been told they were out of test stripes. When interviewed, August 27, 2004 the RN confirmed that they were out of test stripes and she had just received them that day. She stated the staff did not tell her until they used the last one. She also stated the Calcium with vitamin D and Senakot should have been given twice daily as ordered.

The August 2004 Treatment and Procedure sheet indicated that Client # 10 was to receive hydrocortisone cream 1% to both legs twice daily and then wrap the legs with Kerlex bandages. The treatment record for August 2004 indicated that the treatment was not done August 1 and 19, 2004 and once daily August 2, 4, 6, 7, 8, 10, 11, 13, 16, 17, and 21, 2004. On August 27, 2004 the registered nurse confirmed the client was to receive the treatment twice a day.

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.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 600.00.

2. On February 23, 24 and 28, 2005, a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders issued as a result of a survey completed on December 9, 10, 13, and 15, 2004 which were received by you on February 5, 2005.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on February 23, 24 and 28, 2005.

1. MN Rule 4668.0800, Subp 3 **$350.00**

Based on record review and interview the licensee failed to provide services required by a client's service plan for three of three clients (B2, C2, and C4) reviewed receiving catheter care or blood sugar monitoring. The findings include:

ClientB2's service plan dated August 9, 2004 indicated Accu checks (blood sugar monitoring) were to be done before breakfast and at bedtime. Client B2's November 2004 home health aide treatment and procedure flow sheet indicated that the client was to have Accu checks (blood sugar monitoring) before breakfast and at bed time. On November 13, 14, and 28, 2004 the home health aide treatment and procedure flow sheet lacked documentation to indicate that the Accu checks were completed before breakfast. On November 21, 22, and 28, 2004 the home health aide treatment and procedure flow sheet lacked documentation to indicate that the Accu checks were completed at bedtime. There was no documentation as to why the Accu checks were not done as ordered or that any follow up was done.

Client C2's service plan dated August 3, 2004 indicated an Accu Check (blood sugar monitoring) was to be done before breakfast. Client C2's October 2004 and November 2004 home health aide treatment and procedure flow sheet indicated the client was to have an Accu Check before breakfast. On October 8, 29, and 30, 2004 and November 7 and 19, 2004 the home health aide treatment and procedure flow sheet lacked documentation to indicate the client's Accu Checks had been done. Client C2's December 2004 medication administration record (MAR) indicated the client was to receive Lopressor 25 mg ½ tablet by mouth two time a day, Metformin 500 mg one tablet by mouth two times a day, and Vitamin E 1000 IU one tablet two times a day. On December 5, 2004 the MAR lacked documentation to indicate the client received the Lopressor at 1700, Metformin 500 mg at 1000 and 1800, and Vitamin E was not documented as given at all. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client C4's's service plan dated July 1, 2004 indicated catheter care was to be done twice daily. Client C4's November 2004 home health aide treatment and procedure flow sheet indicated the client was to have catheter care done twice daily. The home health aide flow sheet documentation indicated the catheter care had been completed one time per day on November 1, 3, 4, 6, 9, 12, 13, 15, 17, 18, 19, 21, 22, 25, 26, 27, 28, 29, and 31, 2004. Client C4 developed a urinary tract infection and had a physicians order November 18, 2004 for Cipro 250 mg one tablet two times a day for ten days to treat the infection. There was no documentation as to why the treatment was not given as ordered or that any follow up was done.

TO COMPLY: An assisted living home care provider licensee must provide all services required by a client's service plan under part 4668.0815.
Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 350.00

2. MN Rule 4668.0805, Subp. 1 **$300.00**

Based on observation and interview the facility failed to assure that one of one licensed staff reviewed (#4) received orientation to home care requirements before giving home care services to the clients. The findings include:

During the survey a notice in the office at housing with service site A indicated that a Registered Nurse (RN), employee #4, contracted from a staffing agency was on call December 10, 11, and 12, 2004. This same information was also found in housing with services sites B and C.
On December 10, 2004 employee #4 arrived at site B while the surveyor was present. She was observed to have direct client contact and provide nursing services while at the agency. When interviewed December 10, 2004, employee #4 stated that she had not had any orientation to home care. She said that until the call that day she was unaware that she would have to come to the housing with services sites. It was her understanding that she would only be in contact with the housing with services sites by phone.

When interviewed December 10, 2004, the unlicensed staff in housing with services site B indicated they had called employee #4 because they used the last syringe of insulin and there was not any insulin set up for the next day. The unlicensed staff indicated when they called employee #4 who was on call. When interviewed, December 15, 2004, the owner indicated that he had a contract with a staffing agency to provide RN coverage until December 13, 2004 when the new RN would be starting. The owner stated he was unsure if the RN had been oriented to home care.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $300.00

3. MN Rule 4688.0855, Subp. 9 $300.00

Based on record review, and interview, the facility failed to administer medication as prescribed for one of four clients (client # B1) reviewed in housing with services site B. The findings include:

Client B1 October 2004 Medication Administration Record indicated that the client received Tylenol 1000 mg two tablets on October 11, 2004 at 1:00 AM, 6:00 AM, and 8:00 AM for pain in their right foot. The physicians order dated June 28, 2004 was as follows; Tylenol 1000 mg two tablets per mouth every AM. There was a standing order in the client's record for Acetaminophen 325 mg one or two tablets PRN (as needed) for mild pain or fever (every four hours). There was no order for Tylenol 1000 mg two tablets to be given more than one time per morning. There was no documentation as to why the medication was not given as prescribed or that any follow up was done. When interviewed December 10, 2004 the Registered Nurse confirmed Tylenol 1000 mg two tablets had not been given as ordered.
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.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $300.00

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**)** and MN Rule 4668.0800, Subparts 6 and 7**, the total amount you are assessed is**: **$ 2050.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division MN Department of Health,** and **sent to** the Department of Health [Attention: Mary Henderson] 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, Health Policy 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 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.

If you have any questions, please feel free to give me a call at 651-215-8810.

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Jocelyn F. Olson, Assistant Attorney General, Health Division
Fred Youngstrand, President Governing Board
Kelly Crawford, Minnesota Department of Human Services
Saint Louis County Social Services
Mary Henderson, Program Assurance Unit
Licensing and Certification File
Case Mix Review File
Deborah Peterson, Assistant Attorney General, MA Fraud Division

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

INFORMATIONAL MEMORANDUM

PROVIDER: REFLECTIONS HOMES ASSISTED LIVING

DATES OF SURVEY: February 23, 24, and 28, 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: Fred Youngstrand, President, Stacey Malley, RN, Maranda Clark HAA, Jim Hencinski HHA, Barbara Wagner HHA, Heather Streu HAA, Lisa Lundeen, Director Home Health Services.

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: Second Follow-up

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 August 25, 27, and 30, 2004 and the follow up visit on December, 9, 10, 13, and 15, 2004. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the Correction orders issued as a result of the August 25, 27, and 30, 2004 visit that were received by the facility on September 23, 2004 and found not corrected during the December, 9, 10, 13, and 15, 2004 are as follows:

1. MN Rule 4668.0815 Subp. 2 Not Corrected –Second penalty assessment recommended.

Based on record review and interview, the licensee failed to revise one of three clients (client # A2) service plan when there was a change in the client's condition. The findings include:

Client # A2's record contained a progress note on January 7, 2005 by the Registered Nurse (RN) which stated that client # A2 had "+2" pitting edema on both her ankles. Client #A2's record contained a physician's order dated January 7, 2005 for Lasix 20mg orally every day for two weeks. The record contained a physician's order dated January 24, 2005 to increase the Lasix to 40 mg every day, call with an update in two weeks, and for client A2 to use support stockings. Client # A2's record did not contain an updated service plan to include the support stocking. The

Registered Nurse [RN] verified during an interview on February 23, 2005 that the service plan had not been modified to include the support stockings.

3. MN Rule 4668.0860 Subp. 8 Corrected

4. MN Rule 4668.0865 Subp. 3 Not Corrected –Second penalty assessment recommended.

Based on record review and interview the licensee failed to assure a system that failed to maintain a system that handles medications according to physician orders for one of four clients (client # B1) reviewed. The findings include:

Client #B1's record contained a physician's order dated December 22, 2004 for Ocean Spray saline, two sprays in each nostril three times a day. The February 2005 Medication Administration Record (MAR) indicated the client received the Ocean Spray once a day on February 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, and 23, 2005. The MAR also indicated the client did not receive the Ocean Spray on February 5 and 12, 2005. The February 2005 MAR stated "Nasal Spray 0.65% as directed Pro re nata (PRN). When interviewed on February 24, 2005, the Registered Nurse stated that she thought the nasal spray was to be administered PRN but could not find a physician's order other than the order dated December 22, 2004 which indicated that the Ocean Spray saline was to be given three times daily.

The status of the Correction orders issued as a result of the December 9, 10, 13 and 15, 2004 follow-up visit and received by the facility on February 5, 2005 are as follows:

1. MN Rule 4668.0800, Subp. 3 Not Corrected –penalty assessment recommended.

Based on record review and interview, the licensee failed to provide services as required by the client's service plan for five of eleven clients (client # A2, # B1, #B2, #C4, and #C5) reviewed. The findings include:

Client #A2's nursing assessment, dated September 21, 2004, indicated that client #A2 has Alzheimer's Disease, is incontinent of bladder two to four times a day, wears depends and receives Imodium daily for diarrhea. Client #A2's current service plan, dated 9/22/04, indicated that client #A2 is to be taken to the toilet every two hours. Client #A2's record did not contain any documentation to reflect that she is taken to the toilet every two hours. The night shift staff document on a form called an "Additional Daily Aide Notes." When reviewed, these notes did not contain documentation that client #A2 was taken to the toilet every two hours during the night shift on February 9, and 11, 2005. These notes stated that client #A2, "slept the whole night." Documentation in the daily notes from the 7:00 a.m. to 3:00 p.m. shift on February 11. 2005, stated that client #A2 " woke up full of BM." When interviewed on February 23, 2005, the Registered Nurse indicated that she was aware that staff were not taking client #A2 to the toilet every two hours.

Client # B1's Service plan, revision date of September 17, 2004, indicated that client #B1was to be weighed daily as requested by his physician. The "Home Health Aide Treatment Procedure Flowsheet" for February 2005 did not contain documentation to indicate that client #B1 was

weighed on February 3, 5, 12, 13, 19, and 20, 2005. When interviewed on February 24, 2005, the Registered Nurse stated that the weights had not been done.

Client #B2's Service plan, dated August 9, 2004, indicated client #B2 was to have her blood sugar tested two times a day. The February 2005 Home Health Aide Treatment and Procedure Flow sheet did not contain documentation to reflect that client #B2's blood Sugar was checked on February 11, 2005. The Registered nurse confirmed the findings during a February 24, 2005 interview.

Client #C4's start of service date was August 1, 2003. The client had physician's orders dated November 18, 2004 and December 9, 2004 for Cipro 250 mg one tablet per mouth twice a day times ten days to treat a urinary tract infection. On January 7, 2005 the client was admitted to the hospital. Client #C4 was discharged from the hospital on January 17, 2005 with a diagnosis of Pneumonia and Chronic Urinary Tract Infection. The client had a follow up visit with the physician on January 27, 2005, which indicated the client's right foot ulcer was healing and the sacral ulcer "needs work". The client's record also indicated the client was brought to the emergency room by the Registered Nurse on February 15, 2005. The client returned to the facility with a physician's order for Cipro 250 mg one tablet twice a day times 10 days. The client's service plan dated February 15, 2005, indicated the client was too have catheter care provided twice a day, foot care to the right foot daily, and wound care "bottom exposed to fan-lay on side in bed" one hour every AM and PM. The February 2005 Home Health Aide Treatment and Procedure Flow sheet indicated the following: The client did not receive wound care to sacral area on February 17, 2005 on the PM shift, the client did not receive daily foot soaks on February 16, 2005 and did not receive catheter care on February 20, 2005 in the AM. During interview on February 24, 2005 the Registered Nurse confirmed the above.

Client#C5's service plan, dated May 10, 2004 and February 15, 2005, indicated that the client's blood sugar is to be tested twice a day. The February 2005 Home Health Aide Treatment and Procedure Flow sheet indicated that the client's blood sugar was only tested one time a day. During interview on February 24, 2005 the Registered Nursed confirmed the above.

2. MN Rule 4668.0805, Subp. 1 Not Corrected – Penalty assessment recommended.

Based on personnel record review and interview, the licensee failed to ensure that one of one new employee [employee #1] received orientation to home care prior to providing direct care to the clients. The findings include:

Employee #1's personnel record indicated that the employee received orientation to home care on February 21, 2005. During interview on February 23, 2005 at 12:45 P.M. employee #1 stated that she started working with clients on Saturday, February 19, 2005. During interview on February 24, 2005 at 12:25 P.M. the Registered Nurses confirmed that employee #1 started providing services to clients on February 19, 2005 before receiving the required orientation to home care.

3. MN Rule 4668.0855, Subp. 9 Not Corrected – Penalty assessment recommended
Based on record review and interview, the licensee failed to ensure that the medication record for three of eleven client's (client #B2, #C3, and #C4) reviewed contained the signature of the person who provided assistance with medication administration. The findings include:

Client #B2 had physician's orders dated October 15, 2004 for the client to receive the following medications; Glucotrol 5 mg by mouth every day, HCTZ 25mg by mouth every day, Lopressor 25 mg by mouth twice a day, Metformin 500mg by mouth twice a day, Colace 100mg by mouth every hour of sleep as needed (PRN), Vitamin E 10000 IU by mouth twice a day, and, Vitamin C 500mg by mouth every AM. The February 2005 Medication Administration Record (MAR) did not contain documentation to indicate that client #B2 received the 8AM dose of Glucotrol 5 mg, HCTZ 25mg, Metformin 500 mg, Lopressor 50 mg, Vitamin E 1000 IU, and Vitamin C 500 mg on February 21, 2005. During interview, on February 24, 2005, the Registered Nurse stated she was sure the medications were given and not documented.

Client #C3 had physician's orders dated August 31, 2004 for Pravachol 20mg by mouth every AM and a physician's order dated February 8, 2005 for Risperdal 1mg two times a day. The February 2005 MAR did not contain documentation to indicate that the Pravachol 20mg was given on February 7 and 21, 2005 at 8 AM and the Risperdal 1mg was given at 8 AM on February 21, 2005. During interview, on February 24, 2004 the Registered Nurses confirmed that the record lacked documentation to reflect that these medications were given.

Client #C4's record indicated that client #C4 had returned from the hospital on January 17, 2005 with the diagnosis of pneumonia and chronic urinary tract infection. The record contained a physician order dated January 27, 2005 for Nystatin 1% powder daily to peri area and an order dated February 15, 2005 for Cipro 250mg one tablet by mouth twice a day for 10 days. Daily notes dated February 15, 2005 indicated that on that same day, the Registered Nurse took client #C4 to the emergency room. The February 2005 MAR lacked documentation to reflect that client #C4 received Cipro 250 mg on February 21, 2005 at 8 AM or Nystatin 1% powder to the peri area on February 21, 2005. The Registered Nurse confirmed the findings in a February 24, 2005 interview.

2) The exit conference was not tape recorded.

3) Three Additional Licensing orders were issued as a result of this second follow-up visit:
1. MN Rule 4668.0065 Subp.1
2. MN Rule 4668.0825 Subp. 4
3. MN Rule 4668.0860 Subp. 2.

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: REFLECTIONS HOMES ASSISTED LIVING

HFID # (MDH internal use): 23099

Date(s) of Survey: 02/23/2005, 02/24/2005, and 02/28/2005

Project # (MDH internal use): QL23099002

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 ___ Correction Order(s) issued _X_ Education provided

Indicators of Compliance	Outcomes Observed	Comments
2. Agency staff promote the clients' rights as stated in the Minnesota Home Care Bill of Rights. (MN Statute 144A.44; MN Rule 4668.0030)	No violations of the MN Home Care Bill of Rights (BOR) are noted during observations, interviews, or review of the agency's documentation. Clients and/or their representatives receive a copy of the BOR when (or before) services are initiated. There is written acknowledgement in the client's clinical record to show that the BOR was received (or why acknowledgement could not be obtained).	___ 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 observe infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	___ Met _X_ Correction Order(s) issued _X_ Education Provided
4. The agency has a system to receive, investigate, and resolve complaints from its clients and/or their representatives. (MN Rule 4668.0040)	There is a formal system for complaints. Clients and/or their representatives are aware of the complaint system. Complaints are investigated and resolved by agency staff.	___ 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.	___ Met ___ Correction Order(s) issued ___ Education provided
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	___ Met ___ 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 have received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff who are competent to perform the procedures that have been delegated. The process of delegation and supervision is clear to all staff and reflected in their job descriptions.	___ Met _X_ Correction Order(s) issued _X_ Education Provided
8. Medications are stored and administered safely. (MN Rules 4668.0800 Subpart 3, 4668.0855, 4668.0860)	The agency has a system for the control of medications. Staff are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	___ 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 follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	___ 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).	___ Met ___ Correction Order(s) issued ___ Education provided

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
1	MN Rule 4668.0815 Service Plans		X	Education: Discussed the need for annual review of the Service Plan with the RN.
3	MN Rule 4668.0065, Subp 1 Mantoux Testing	X	X	Based on personnel record review and interview, the licensee failed to ensure that one of one employee reviewed (employee #1), received a Mantoux test prior to providing direct care to clients. The findings include. Employee #1's personnel record indicated that she received a Mantoux Test on February 21, 2005. During interview on February 23, 2005 at 12:45 P.M. employee #1 stated that she started working with clients on Saturday, February 19, 2005. During an interview on February 24, 2005 at 12:25 P.M., the Registered Nurse confirmed that employee #1 started providing services to clients on February 19, 2005 prior to receiving her Mantoux test. **Education:** Provided
7	MN Rule 4668.0825, Subp. 4. Delegated nursing procedure training	X	X	Based on record review and interview, the licensee failed to ensure that before performing routine procedures the Registered Nurse instructs the staff doing the procedure, writes specific instructions for staff to perform the procedure, and retains documentation pertaining to the training for one of one client (Client # C5) reviewed. The findings include.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				Client # C5's record contained Home Health Aide Treatment and Procedure Flow sheets for January 2005 and February 2005 that indicated client # C5 was receiving DuoDERM to their "bottom". The record lacked written instruction for how the DuoDERM was to be applied. During interview, on February 24, 2005 the Registered Nurse indicated that she was unaware that written procedures were needed. The Registered Nurse also indicated that she showed the staff on duty, who were there at the time, how to apply the DuoDERM the first time she applied the DuoDERM for client C5, but did not instruct all staff. The Registered Nurse also confirmed that there was no record of the training. **Education:** Provided
8	MN Rule 4668.0860, Subp. 2 Medication Treatment Orders	X	X	Based on record review and interview the licensee failed to ensure there were written prescriber's orders treatments and over-the-counter supplements for 2 of 11 clients (Client # C2 and # C5) reviewed. The findings include: Client # C2's Medication Administration Record (MAR) for February 2005 indicated that client # C2 was receiving "Imu" Plus Powder mixed with eight ounces of water twice a day. The client's record lacked evidence of a physician's order for the "Imu" Plus Powder. During an interview on February 24, 2005, the Registered Nurse stated that she was unaware that she needed a physician's order for the "Imu" Powder. Client # C5's Home Health Aide Treatment and Procedure Flow sheets for January 2005 and February 2005

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				indicated client C5 was receiving a DuoDERM dressing to the "bottom". The DuoDERM was to be changed every 48 hours. The record did not contain a physician's order for the DuoDERM. During interview on February 24, 2005, the Registered Nurse confirmed the lack of a physician's order for the DuoDERM **Education:** Provided

A draft copy of this completed form was left with Fred Youngstrand at an exit conference on February 28, 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)

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 2838

February 2, 2005

Ron Alvar, Administrator
Reflections Homes Assisted Living
2730 Greysolon Road
Duluth, MN 55814

Re: Licensing Follow Up Revisit

Dear Mr. Alvar:

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 (Date).

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 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: Fred Youngstrand, President Governing Board
Case Mix Review File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #7004 1160 0004 8714 2838

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

February 2, 2005

Ron Alvar, Administrator
REFLECTIONS HOMES ASSISTED LIV
2730 Greysolon Road
Duluth, MN 55814

RE: QL23099002

Dear Mr. Alvar:

On December 9, 10, 13, and 15, 2004 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 August 30, 2004 with correction orders received by you on September 23, 2004.

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

1. MN Rule 4668.0815, Subp. 2 **$250.00**

Based on observation, record review, and interview, the agency did not revise a client's service plan when there was a change in the client's condition that required a change in the service plan for one of three active clients (#3) reviewed in housing with services site A.

Client #3 had diagnoses of end stage Alzheimer's Disease, and severe venous stasis. Client #3's services began April 14, 2004. Since admission client #3 has had a decline in function. The aide care plan June 3, 2004 was used as an extension of the service plan dated April 14, 2004. It indicated client #3 was ambulatory, required assistance of one to transfer, walked with a walker and used a wheel chair for outings, toilet every two hours while awake, assistance with pulling pants up and down when toileted, apply incontinent briefs at night, feed if overly tired, cut foods to bite size, and set up and use finger foods. Client #3 was observed to be totally fed mashed or ground food when this reviewer was in the agency on August 25 and 27, 2004. The client was observed in bed or in her wheelchair at all times during the survey. Client #3 was non-ambulatory and required assist of two to transfer. During an interview August 27, 2004, direct care staff #7 and #8 stated client #3 wore briefs during the day because of incontinence. During an interview August 27, 2004 the agency registered nurse (RN) confirmed the service plan did not reflect the increased care client #3 was receiving. When interviewed August 30, 2004 the client's representative stated she was aware the service plan had not been updated and that she had requested the services be reflected on the record for follow through by all caregivers.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 250.00.

2.MN Rule 4668.0860, Subp. 8 $500.00

Based on observation, record review, and interview, the agency did not record or forward a verbal order for medication for one of three active clients (#3) reviewed in housing with services site A.

Client #3 had a hospice telephone order August 13, 2004 for "Ativan 0.5mg to 1mg PO (by mouth) QID" (four times daily). Receipt of the order was noted in the narrative notes in the client record. The order was not transcribed to the medical order section or implemented. The August 2004 medication administration record did not include this order. On August 27, 2004 at 1:35 pm. the client's medication storage bin was observed. It did not contain Ativan set up for this dosage administration. During an interview August 27, 2004 the agency registered nurse (RN) confirmed the medication had not been received by the agency. She stated that the hospice nurse sends a hospice medication order to the pharmacy. When interviewed August 27, 2004 the hospice nurse stated that the agency orders medications, then stated that her office ordered medications, and then stated she would have to check.

TO COMPLY: When an order is received, the assisted living home care provider licensee or an employee of the licensee must take action to implement the order within 24 hours of receipt of the order.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 500.00.

3. MN Rule 4668.0865, Subp. 3 $300.00

Based on observation, interview and record review, the agency failed to maintain a system that assures the control and handling of medications and treatments according to physician orders for two of two active clients reviewed in housing with services site B (Client # 1 and 2) and three of three active clients reviewed in housing with services site C (client # 8, 9, and 10).

Client #1 has a physician's order dated July 21, 2004, which states, Coumadin 3mg on Monday, Wednesday and Friday and 4mg on all other days. On August 12, 2004 the physician ordered the dose of Coumadin to remain the same. Review of the Medication Administration Record for August 2004 indicated that the client received Coumadin 4mg on Monday, Wednesday, and Friday and 3mg on all other days. On August 25, 2004 the reviewer checked the Coumadin container prepared by the pharmacy. The label on the Coumadin container stated "Take 2 (4mg) Monday and Friday and 1 ½ tabs (6mg)". An interview August 27, 2004 with Register Nurse (RN) confirmed that the pharmacy had set up the wrong dose of Coumadin and that the client had not been receiving the coumadin as ordered.

Client #2 had a physician order August 9, 2004 for blood sugar testing twice daily. The client's blood sugar ranged from 46 to 362. The August 2004 "Home Health Aide Treatment and Procedure Sheet" indicated that the client #2's blood sugar was to be tested at 8:00 am and at HS (hour of sleep). The August 2004 Home Health Aide Treatment and Procedure sheet indicated that August 11, 2004 staff were "unable times 2 to do the blood sugar", August 12, 2004 "could not take B.S. no strips." On

August 17 and 18, 2004 at 8:00 AM and August 20 and 21, 2004 at HS blood sugar testing was not documented. When interviewed August 25, 2004 the RN indicated that she had retrained the Home Health Aides on blood sugar testing and testing had been completed but not documented.

Client # 8 had a physician order for Digoxin 0.125mg one tablet by mouth on Monday, Wednesday and Friday. The Medication Administration Record (MAR) for client #8 directed staff to "take client's pulse before giving Digoxin, give only if the client's pulse is 60 or above, document the client's pulse under your initials, and if pulse is below 60 call the registered nurse" (RN). Client #8's MAR indicated the client's pulse was below 60 on August 11, 13, 16, 18, 20, 23, 25, and 27, 2004. The MAR did not indicate if the medication had been held or administered to the client. There was no documentation the Registered Nurse had been notified of the pulse below 60. On August 27, 2004 the client's pulse was recorded at 46. On August 27, 2004, the home health aide stated that she had not given the Digoxin. The home health aide stated the RN had not been notified. On August 27, 2004 this reviewer observed the Digoxin medication container. August 20, 25, and 27, 2004 were the only days, which still contained Digoxin. The days when the client's pulse was documented as below 60 were empty. On August 27,2004 the RN stated the instructions on the MAR were to be followed. She said had not been notified of the client's pulse below 60.
Client # 9 had a physician order July 13, 2004 for Calcium with vitamin D 500mg twice daily and Senakot 5mg twice daily. The August 2004 Medication Administration Record indicated that the client received the Calcium with vitamin D 500mg once daily and Senakot 5mg once daily. The August 2004 home health aide Treatment and Procedure sheet indicated that client #9 was to have her blood sugar checked before breakfast and at bedtime. The blood sugar was not documented as being done before breakfast on August 12, 14, and 15, 2004 or at bedtime on August 2, 11, and 15, 2004. On August 25, 26, and 27, 2004 it was documented that the blood sugars were not done because there were no test strips. On August 27, 2004 the home health aide stated the registered nurse (RN) had been told they were out of test stripes. When interviewed, August 27, 2004 the RN confirmed that they were out of test stripes and she had just received them that day. She stated the staff did not tell her until they used the last one. She also stated the Calcium with vitamin D and Senakot should have been given twice daily as ordered.

The August 2004 Treatment and Procedure sheet indicated that Client # 10 was to receive hydrocortisone cream 1% to both legs twice daily and then wrap the legs with Kerlex bandages. The treatment record for August 2004 indicated that the treatment was not done August 1 and 19, 2004 and once daily August 2, 4, 6, 7, 8, 10, 11, 13, 16, 17, and 21, 2004. On August 27, 2004 the registered nurse confirmed the client was to receive the treatment twice a day.

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.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 300.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the total amount you are assessed is**: $ 1050.00. 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, Health Policy 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 F. Olson, Assistant Attorney General
Fred Youngstrand, President Governing Board
Kelly Crawford, Minnesota Department of Human Services
Saint Louis County Social Services
Mary Henderson, Program Assurance Unit
Licensing and Certification File
Case Mix Review File

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

INFORMATIONAL MEMORANDUM

PROVIDER: REFLECTIONS HOMES ASSISTED LIVING

DATE OF SURVEY: December 9, 10, 13, and 15, 2004

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: Naomi Christianson RN, Karen Healy RN, Sarah Van Holbeck LPN/House Manager, Maranda Clark HHA, Jim Henciniski HHA, Connie Matthews HHA, Barbara Wagner, HHA, Lisa Lundeen, Director Home Health Services, Fred Youngstrand, Owner, Stacey Malley RN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up _____X_____

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on August 25, 27, and 30, 2004. 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 4688.0815, Subp. 2: Not corrected Penalty assessment issued.

Based on record review and interview, the facility failed to revise a client's service plan when there was a change in the client's condition that required a change in the service plan for one of three current clients (client # A2) reviewed in housing with services site A. The findings include:

Client A2's October 20, 2004 supervisory visit documentation indicated that when the client was to weak to get up she was to be turned a minimum of "every two hours, preferably every one-half to one hour." The service plan/care plan was last revised April 14, 2004 and did not reflect the need to turn the client as stated above. When interviewed December 9, 2004 the registered nurse and the house manager confirmed the service plan had not been updated.

2. MN Rule 4688.0860, Subp. 8: Not corrected Penalty assessment issued

Based on record review and interview, the facility failed to implement a physician's order within twenty four hours of receipt of the order for one of three clients (# A1) reviewed in housing with services site A. The findings include:

Client A1's October 29, 2004 progress notes indicated a telephone call was made to the client's physician because the client was complaining about burning when she urinated. October 29, 2004 the physician ordered an urinalysis/culture if possible and Cipro 250 mg per mouth twice a day for ten days. The progress notes October 29, 30 and 31, November 1, and 2, 2004 indicated they were unable to obtain a urinalysis. On November 2, 2004 the progress note indicated Cipro was begun. When interviewed December 9, 2004 the registered nurse confirmed the Cipro was not started until November 2, 2004, five days after it was ordered.

3. MN Rule 4668.0865, Subp. 3: Not corrected Penalty assessment issued

Based on record review and interview, the facility failed to maintain a system that assures the control and handling of medications for nine of eleven clients (A2, B1, B2, B3, B4, C1, C2, C3, and C4) reviewed that were assisted with medication administration. The findings include:

Client A2 had an order dated October 23, 2004 for Sinemet 25/100 orally five times daily, and Hypo tears one drop, each eye four times daily. Client A2's December 2004 medication administration record (MAR) indicated the client was to receive Sinemet 25/100 one orally five times a day and Hypotears one drop in each eye four times a day. The MAR lacked evidence the client received their Sinemet 25/100 one per mouth on December 7, 2004 at 1200 and Hypotears one drop in each eye on December 7, 2004 at 1600. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client B1 had an order dated October 23, 2003 for "Colace 1 to 2 PO "(orally) "every" (bedtime), Nortriptyline 10 mg. PO every HS, Ranitidine 150 mg. 1 PO every HS, Client B1's December 2004 medication administration record (MAR) indicated the client was to receive Colace 1-2 by mouth every HS (bedtime), Nortriptyline 10 mg by mouth at HS, Ranitidine 150 mg one by mouth every HS, and Ocean spray saline two sprays each nostril three times a day. The December 5, 2004 MAR lacked evidence the client received Colace 1-2 tablets by mouth at HS, Nortriptyline 10 mg by mouth at HS, Ranitidine 150 mg one tablet by mouth at HS and Ocean Spray saline two sprays each nostril at 0800, 1400, and 2000. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client B2 had an order dated December 3, 2004 for insulin 30 units injected every morning. On December5, 2004 client B2's medication administration record (MAR) lacked documentation to indicate that the client received Insulin 30 Units SQ (injected) in the AM, as ordered. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client B3 had an order dated August 12, 2004 for Exelon 4.5 mg one tablet by mouth two times a day and Lasix 40 mg one tablet by mouth twice a day. Client B3's October 2004 medication administration record (MAR) indicated the client was to receive Exelon 4.5 mg one tablet by mouth two times a day and Lasix 40 mg one tablet by mouth twice a day. On October 13, 2004 the MAR lacked documentation to indicate the client received Exelon 4.5 mg one tablet by mouth at 1700 and Lasix 40 mg one tablet by mouth at 1700 as ordered. The client's December 2004 MAR indicated the client was to receive Exelon 4.5 mg one tablet twice a day and Remeron 15 mg one tablet by mouth every HS (bedtime). On December 5, 2004 the MAR lacked documentation to indicate the client received Exelon 4.5 mg at 1700 and Remeron 15mg at HS. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client B4 had an order dated March 26, 2004 for Risperdal 1mg per mouth twice daily. Client B4's October medication administration record (MAR) indicated the client was to receive Risperdal 1mg per mouth twice daily. On October 17, 2004 and October 18,2004 the Risperdal 1mg was documented as not given because the medication was not available. On December 10, 2004 the agency home health aide indicated that the agency was to order medications for the client.

Client C1 had orders dated November 13, 2004 that included Vitamin D 400 IU orally twice a day Calcium Magnesium one tablet by mouth every AM, and Glucosamine Chondroitin two tables at noon and one tablet at supper time. Client C1's November 2004 medication administration record (MAR) indicated the client was to receive Vitamin D 400 IU twice a day. On November 21, 27, 28, and 29, 2004 at 0800 and November 18, 23, 24, 25, 27, 28, and 29, 2004 at 2000 the MAR lacked documentation to indicate the client received the Vitamin D 400 IU. The December 2004 MAR indicated that client was to receive Calcium Magnesium one tablet by mouth every AM, and Glucosamine Chondroitin two tables at noon and one tablet at supper time (1800). On December 4, 2004 at 0800 the MAR lacked documentation to indicate the client received the Calcium Magnesium. On December 1, and 9, 2004 the MAR lacked documentation to indicate the client received Glucosamine Chondroitin two tables at 1800. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client C2 had an order dated August 3, 2003 for Lopressor 25 mg ½ tablet by mouth two times a day, Metformin 500 mg one tablet by mouth two times a day, and Vitamin E 1000 IU one tablet two times a day. Client C2's December 2004 medication administration record (MAR) indicated the client was to receive Lopressor 25 mg ½ tablet by mouth two times a day, Metformin 500 mg one tablet by mouth two times a day, and Vitamin E 1000 IU one tablet two times a day. On December 5, 2004 the MAR lacked documentation to indicate the client received the Lopressor at 1700, Metformin 500 mg at 1000 and 1800, and Vitamin E was not documented as given at all. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client C3 had an order dated July 23, 2004 that included Aricept 10 mg one tablet by mouth everyday, Coumadin 2 mg one time per day, and Doxepin 25 mg by mouth every HS (bedtime). Client C3's December 2004 medication administration record (MAR) indicated the client was to receive Aricept 10 mg one tablet by mouth everyday, Coumadin 2 mg one time per day, and

Doxepin 25 mg by mouth every HS. On December 4, 2004 the MAR lacked documentation to indicate the client received Aricept 10 mg at 2000. On December 9, 2004 the MAR lacked documentation to indicate the client received Coumadin 2 mg and Doxepin 25 mg at HS. There was no documentation as to why the medication was not given as prescribed or that any follow up was done.

Client C4 had a physicians order November 18, 2004 for Cipro 250 mg one tablet two times a day for ten days. The November medication administration record (MAR) lacked documentation to indicate the client received Cipro November 22, and 24, 2004. There was no documentation as to why the treatment was not given as prescribed or that any follow up was done.

2) The exit conference was not tape- recorded.

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: REFLECTIONS HOMES ASSISTED LIV

HFID # (MDH internal use): 23099

Date(s) of Survey: December 9, 10, 13, and 15, 2004 Follow-up survey #1

Project # (MDH internal use): QL23099002

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 Follow-up survey #1

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).	____ Met ____ Correction Order(s) issued ____ Education provided
3. The health, safety, and well being of clients are protected and promoted. (MN Statutes 144A.44; 144A.46 Subd. 5(b), 144D.07, 626.557; MN Rules 4668.0065, 4668.0805)	Clients are free from abuse or neglect. Clients are free from restraints imposed for purposes of discipline or convenience. Agency staff observes infection control requirements. There is a system for reporting and investigating any incidents of maltreatment. There is adequate training and supervision for all staff. Criminal background checks are performed as required.	____ Met ____ 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.	____ 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.	____ Met ____ Correction Order(s) issued ____ Education provided
6. Changes in a client's condition are recognized and acted upon. (MN Rules 4668.0815, 4668.0820, 4668.0825)	A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment or reevaluation, a change in the services and/or there is a problem with providing services as stated in the service plan. Emergency and medical services are contacted, as needed. The client and/or representative is informed when changes occur.	____ Met ____ 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.	___ 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 Follow-up survey #1
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.	___ 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).	___ Met ___ Correction Order(s) issued ___ Education provided

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
1	MN Rule 4668.0800, Subp3 Fulfillment of services	X	X	Based on record review and interview the licensee failed to provide services required by a client's service plan for three of three clients (B2, C2, and C4) reviewed receiving catheter care or blood sugar monitoring. The findings include: ClientB2's service plan dated August 9, 2004 indicated Accu checks (blood sugar monitoring) were to be done before breakfast and at bedtime. Client B2's November 2004 home health aide treatment and procedure flow sheet indicated that the client was to have Accu checks (blood sugar monitoring) before breakfast and at bed time. On November 13, 14, and 28, 2004 the home health aide treatment and procedure flow sheet lacked documentation to indicate that the Accu checks were completed before breakfast. On November 21, 22, and 28, 2004 the home health aide treatment and procedure flow sheet lacked documentation to indicate that the Accu checks were completed at bedtime. There was no documentation as to why the Accu checks were not done as ordered or that any follow up was done. Client C2's service plan dated August 3, 2004 indicated an Accu Check (blood sugar monitoring) was to be done before breakfast. Client C2's October 2004 and November 2004 home health aide treatment and procedure flow sheet indicated the client was to have an Accu Check before breakfast. On October 8, 29, and

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				30, 2004 and November 7 and 19, 2004 the home health aide treatment and procedure flow sheet lacked documentation to indicate the client's Accu Checks had been done. Client C2's December 2004 medication administration record (MAR) indicated the client was to receive Lopressor 25 mg ½ tablet by mouth two time a day, Metformin 500 mg one tablet by mouth two times a day, and Vitamin E 1000 IU one tablet two times a day. On December 5, 2004 the MAR lacked documentation to indicate the client received the Lopressor at 1700, Metformin 500 mg at 1000 and 1800, and Vitamin E was not documented as given at all. There was no documentation as to why the medication was not given as prescribed or that any follow up was done. Client C4's's service plan dated July 1, 2004 indicated catheter care was to be done twice daily. Client C4's November 2004 home health aide treatment and procedure flow sheet indicated the client was to have catheter care done twice daily. The home health aide flow sheet documentation indicated the catheter care had been completed one time per day on November 1, 3, 4, 6, 9, 12, 13, 15, 17, 18, 19, 21, 22, 25, 26, 27, 28, 29, and 31, 2004. Client C4 developed a urinary tract infection and had a physicians order November 18, 2004 for Cipro 250 mg one tablet two times a day for ten days to treat the infection. There was no documentation as to why the treatment was not given as ordered or that any follow up was done. **Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
7	MN Rule 4688.0805,Subp. 1 Orientation to home care	X	X	Based on observation and interview the facility failed to assure that one of one licensed staff reviewed (#4) received orientation to home care requirements before giving home care services to the clients. The findings include: During the survey a notice in the office at housing with service site A indicated that a Registered Nurse (RN), employee #4, contracted from a staffing agency was on call December 10, 11, and 12, 2004. This same information was also found in housing with services sites B and C. On December 10, 2004 employee #4 arrived at site B while the surveyor was present. She was observed to have direct client contact and provide nursing services while at the agency. When interviewed December 10, 2004, employee #4 stated that she had not had any orientation to home care. She said that until the call that day she was unaware that she would have to come to the housing with services sites. It was her understanding that she would only be in contact with the housing with services sites by phone. When interviewed December 10, 2004, the unlicensed staff in housing with services site B indicated they had called employee #4 because they used the last syringe of insulin and there was not any insulin set up for the next day. The unlicensed staff indicated when they called employee #4 who was on call. When interviewed, December 15, 2004, the owner indicated that he had a contract with a staffing agency to provide RN coverage until December 13, 2004 when the new RN would be starting. The owner stated he was unsure if the RN had been oriented to home care. **Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
8	MN Rule 4688.0855,Subp. 9	X	X	Based on record review, and interview, the facility failed to administer medication as prescribed for one of four clients (client # B1) reviewed in housing with services site B. The findings include: Client B1 October 2004 Medication Administration Record indicated that the client received Tylenol 1000 mg two tablets on October 11, 2004 at 1:00 AM, 6:00 AM, and 8:00 AM for pain in their right foot. The physicians order dated June 28, 2004 was as follows; Tylenol 1000 mg two tablets per mouth every AM. There was a standing order in the client's record for Acetaminophen 325 mg one or two tablets PRN (as needed) for mild pain or fever (every four hours). There was no order for Tylenol 1000 mg two tablets to be given more than one time per morning. There was no documentation as to why the medication was not given as prescribed or that any follow up was done. When interviewed December 10, 2004 the Registered Nurse confirmed Tylenol 1000 mg two tablets had not been given as ordered. **Education:** Provided

A draft copy of this completed form was left with FRED YOUNGSTRAND at an exit conference on**:** December 15, 2004. 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)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9988 0484

September 20, 2004

Ron Alvar
Reflections Homes Assisted Living
2730 Greysolon Road
Duluth, MN 55814

Dear Mr. Alvar,

This letter is to notify you that page three (3) of your Correction Order Form was sent in error with writing on it. We are sending you a clean unmarked page three (3) as a replacement. Please replace your page three (3) with this updated copy. Please sign and date both green cards you receive and send back to us as receipt of delivery.

I apologize for your inconvenience. Please call me if you have any questions or concerns.

Jean M. Johnston
Program Manager
Case Mix Review

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9988 0125

September 20, 2004

Ron Alvar, Administrator
Reflections Homes Assisted Living
25 North 12th Ave. East
Duluth, MN 55805

Re: Results of State Licensing Survey

Dear Mr. Alvar:

The above agency was surveyed on August 25, 27, 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: Fred Younstrand, 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: REFLECTIONS HOMES ASSISTED LIV

HFID # (MDH internal use): 23099

Date(s) of Survey: August 25, 27, and 30, 2004

Project # (MDH internal use): QL23099002

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

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

Indicators of Compliance	Outcomes Observed	Comments
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
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 have received training and/or competency evaluations as required, including training in dementia care, if applicable. Nurse licenses are current. The registered nurse(s) delegates nursing tasks only to staff 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 are trained by a registered nurse prior to administering medications. Medications and treatments administered are ordered by a prescriber. Medications are properly labeled. Medications and treatments are administered as prescribed. Medications and treatments administered are documented.	____ 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 follow any Health Care Declarations of the client. Clients are given advance notice when services are terminated by the ALHCP. Medications are returned to the client or properly disposed of at discharge from a HWS.	_X_ Met ____ Correction Order(s) issued ____ Education provided ____ N/A

Indicators of Compliance	Outcomes Observed	Comments
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:
1	MN Rule 4668.0815, Subp.2 Revaluation of Service Plan	X	X	**Deficient Practice:** Based on observation, record review, and interview, the agency did not revise a clients' service plan when there was a change in the client's condition that required a change in the service plan for one of three active clients (#3) reviewed in housing with services site A. **Education:** Discussed with RN the need for the service plan to be updated and for the discharge criteria to be clearer. Also to evaluate services requested to be done gratis. Can the agency realistically accommodate these requests? Educated on the need to revise service plans in a timely manor. Educated the agency and hospice RNs on the need for hospice to have medication orders client receives- not just protocols in the HWS site client record. Educated the agency RN and hospice nurse on the need for the hospice plan to be at the ALHCP so they know what's going on and who is entering their building to "work with" a client.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
8	MN Rule 4668.0860, Subp. 2 Prescriber Order Required	X	X	**Deficient Practice:** Based on observation, record review, and interview, the agency did not have a prescriber order for a medication being administrated by the agency for one of three active clients (#3) reviewed in housing with services site A. Client #3 had a physician order for sulfacetamide 10% eye drops, two drops, right eye, four times daily (QID) for seven days. The discontinuation had passed. There was no other order for this medication in the record. Client #3's medication administration record indicated "sulfacetamide 10% eye drops in right eye, four times daily" was administered the month after the medication was discontinued. On August 27, 2004 at 1:30 pm. the medication was observed in the clients current medication storage bin. During an interview with the agency nurse she confirmed that there was no renewal order for this medication. **Education:** Discussed with the RN the need to have orders for medications renewed and not restarted with out an order.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
8	MN Rule 4668.0860, Subp.8 Implementation of order.	X	X	**Deficient Practice:** Based on observation, record review, and interview, the agency did not record or forward a verbal order for medication for one of three active clients (#3) reviewed in housing with services site A. Client #3 had a hospice telephone order August 13, 2004 for "Ativan 0.5mg to 1mg PO (by mouth) QID" (four times daily). Receipt of the order was noted in the narrative notes in the client record. The order was not transcribed to the medical order section or implemented. The August 2004 medication administration record did not include this order. On August 27, 2004 at 1:35 pm. the client's medication storage bin was observed. It did not contain Ativan set up for this dosage administration. During an interview August 27, 2004 the agency nurse confirmed the medication had not been received by the agency. She stated that the hospice nurse that ordered it sends a hospice medication order to the pharmacy. When interviewed August 27, 2004 the hospice nurse stated that the agency orders medications, then stated that her office ordered medications, and then stated she would have to check. **Education:** Educated the agency and hospice RNs on the need for hospice to have medication orders client receives-not just protocols in the HWS site client record. Educated the agency RN and hospice nurse on the need for the hospice plan to be at the ALHCP so they know what's going on and who is responsible for ordering hospice medication.

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice:
8	MN Rule 4668.0865, Subp. 3 Control of Medication	X	X	**Deficient Practice:** Based on observation, interview and record review, the agency failed to maintain a system that assures the control and handling of medications and treatments according to physician orders for two of two active clients reviewed in housing with services site B (Client # 1 and 2) and three of three active clients reviewed in housing with services site C (client # 8, 9, and 10). **Education:** Discussed with RN the importance for monitoring to see that medications and treatments are being done according to physician's orders. Also need for an effective system that assures the RN is promptly notified when a problem is discovered.
	CLIA Waiver		X	**Education** Gave information of how to get a CLIA Waiver to RN.

A draft copy of this completed form was left with Naomi Christansen at an exit conference on August 30, 2004. Any correction orders and the final Licensing Survey Form issued as a result of the on-site visit, and the final Licensing Survey, 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