MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7298

May 27, 2010

Rohitha Perera, Administrator
Hawthorne House
PO Box 27482
Golden Valley, MN 55427

Re: Results of State Licensing Survey

Dear Ms. Perera:

The above agency was surveyed on April 19, 20, 21, 22, and 30, 2010, for the purpose of assessing compliance with state licensing regulations. State licensing orders are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me. If further clarification is necessary, an informal conference can be arranged.

A final version of the Correction Order form is enclosed. This document will be posted on the MDH website.

Also attached is an optional Provider questionnaire, which is a self-mailer, which affords the provider with an opportunity to give feedback on the survey experience.

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

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

Sincerely,

Patricia Nelson

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

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

01/07 CMR3199

CERTIFIED MAIL #: 7009 1410 0000 2303 7298

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

Patricia Nelson, Supervisor - (651) 201-4309

TO:	ROHITHA PERERA	DATE: May 27, 2010
PROVIDER:	HAWTHORNE HOUSE	COUNTY: HENNEPIN
ADDRESS:	6931 COUNTRY CLUB DRIVE GOLDEN VALLEY, MN 55427	HFID: 23104

On April 19, 20, 21, 22, and 30, 2010, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed:_____ Date: _____

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

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items may be considered lack of compliance and subject to a fine.

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

1. MN Rule 4668.0040 Subp. 1

Based on interview and policy and procedure review, the licensee failed to provide clients with a complaint procedure. The findings include:

On April 22, 2010, employee AA/Housing Manager was queried regarding the home care provider's (HCP) complaint procedure. Employee AA stated that there was no policy on a complaint procedure. She indicated that the complaint procedure was included in the HCP's Vulnerable Adult Policy and that employee BA/registered nurse gave the policy to the clients. The Vulnerable Adult Policy was reviewed and it did not contain a system for receiving, investigating, and resolving complaints from the clients.

When interviewed April 22, 2010, employee AA stated she did not give the clients a complaint procedure and/or Vulnerable Adult Policy, but gave the client a copy of the bill of rights. Employee AA indicated the bill of rights contained the phone numbers of the ombudsman and OHFC (Office of Health Facility Complaints).

TO COMPLY: A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0065 Subp. 1

Based on interview and record review, the licensee failed to ensure that tuberculosis screening was completed for one of one employee (AA) reviewed who had a positive tuberculosis screening. The findings include:

Employee AA was hired on May 1, 2004, to provide direct care to clients. The employee's personnel record contained a Mantoux test, dated September 13, 2002, with a reading of 14 millimeters (positive Mantoux). The employee's record lacked evidence that a chest x-ray had been completed. When interviewed April 22, 2010, employee AA/housing manager stated she had a negative chest x-ray, but did not have a copy of the report in her record.

TO COMPLY: No person who is contagious with tuberculosis may provide services that require direct contact with clients. All individual licensees and employees and contractors of licensees must document the following before providing services that require direct contact with clients:

A. the person must provide documentation of having received a negative reaction to a Mantoux test administered within the 12 months before working in a position involving direct client contact, and no later than every 24 months after the most recent Mantoux test; or

B. if the person has had a positive reaction to a Mantoux test upon employment or within the two years before working in a position involving direct client contact, or has a positive reaction to a Mantoux test in repeat testing during the course of employment, the person must provide:

(1) documentation of a negative chest x-ray administered within the three months before working in a position involving direct client contact; or

(2) documentation of a negative chest x-ray administered each 12 months, for two years after the positive reaction to a Mantoux test or documentation of completing or currently taking a course of tuberculosis preventative therapy;
or

C. if the person has had a positive reaction to a Mantoux test more than two years before working in a position involving direct client contact, the person must provide documentation of a negative chest x-ray taken within the previous 12 months or documentation of completing or currently taking a course of tuberculosis preventative therapy.

In this subpart, "Mantoux test" means a Mantoux tuberculin skin test.
or

The licensee may request in writing to follow Minnesota Department of Health (MDH) Tuberculosis Prevention and Control Guidelines: Home Care as outlined in MDH Informational Bulletin 09-04

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0810 Subp. 2

Based on interview and policy and procedure review, the licensee failed to ensure clients' records were kept secure at all times. The findings include:

When interviewed April 19, 2010, regarding the home care provider's (HCP) procedure for electronically transmitted orders and registered nurse (RN) notification of a facsimile (fax), employee BB/unlicensed staff stated that the faxes go to the other house (another assisted living residence) next door.
When interviewed April 20, 2010, about the fax procedure, employee BA/RN and employee AA/housing manager stated the RN had a fax machine at her house. Employee AA stated the prescribers send the orders to the RN's home fax machine or if the orders come to the residence the housing manager faxes them to the RN. When interviewed April 28, 2010, employee BA stated the fax machine was kept in an office in her home, which she shared with her husband.

The HCP's policies and procedure related to security of client records did not address the security of clients' records in employee BA's personal residence.

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

A. the use of client records;

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

C. the criteria for release of client information.

TIME PERIOD FOR CORRECTION: Thirty (30) days

4. MN Rule 4668.0810 Subp. 5

Based on observation, interview and record review, the licensee failed to ensure documentation of the services provided were in the client's record no later than two weeks after the service was provided for one of two clients' (C1) records reviewed in housing with services site C. The findings include:

Client C1 had a prescriber's order for Cytra K crystal packets to be administered twice daily. The client's April 2010 medication administration record (MAR) and observations during a medication administration pass on April 20, 2010, revealed the Cytra K packets had not been administered since

April 5, 2010. When interviewed April 21, 2010, employee BA/registered nurse, indicated the client ran out of the medication the first part of April and that she was working with the client's insurance for payment of this medication. Employee BA stated the medication was currently on hold. There was no

notation in the client's record regarding the medication being on hold or that employee BA was working with the client's insurance company for payment. Employee BA stated she had notes with her that were not part of the client's record, as she didn't realize that they needed to be part of the record. On April 22, 2010, employee BA faxed progress notes to the surveyor for client C1 which were written by employee BA dated April 3, April 4, April 5, April 9, April 12, April 19 and April 21, 2010, regarding the Cytra K packets. These progress notes were not part of the client's record when reviewed on April 21, 2010.

TO COMPLY: Except as required by subpart 6, items F and G, documentation of a class F home care service must be created and signed by the staff person providing the service no later than the end of the work period. The documentation must be entered into the client record no later than two weeks after the end of the day service was provided. All entries in the client record must be:

A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or

B. recorded in an electronic media in a manner that ensures the confidentiality and security of the electronic information, according to current standards of practice in health information management, and that allows for a printed copy to be created.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

5. MN Rule 4668.0815 Subp. 1

Based on interview and record review, the licensee failed to have a registered nurse (RN) complete an individualized evaluation of the client's needs and establish a service plan no later than two weeks after initiation of assisted living home care services for one of two clients' (C2) records reviewed in housing with services site C. The findings include:

Client C2 began receiving services October 31, 2006, which included assistance with activities of daily living. The client's record did not contain a service plan. Employee AA was asked during the survey for the client's service plan; however it was not provided to the surveyor.

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

6. MN Rule 4668.0815 Subp. 2

Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) reviewed and revised each client's evaluation and/or service plan at least annually for six of six clients' (A1, B1, B2, C1, C2 and D1) records reviewed. The findings include:

Client C2 was admitted and began receiving services October 31, 2006. Client C2's last nursing evaluation was dated October 25, 2008. On April 20, 2010, employee CB/unlicensed staff indicated that about three weeks ago she found out that client C2 had been to the physician and had\ had a 30 pound weight loss. On March 15, 2010, staff began to document the client's intake at meals. Observations of the food client C2 was served on April 20, 2010, revealed the following: At 8:15 a.m. employee CA/unlicensed staff served client C2 his breakfast. Employee CA served the client a snack pack size of chocolate pudding and a bowl of animal crackers. Client C2 was observed to feed himself the pudding and animal crackers and ate it all. When interviewed April 20, 2010, regarding whether the pudding and animal crackers were his choice for breakfast, client C2 stated no, that he would rather have cereal, toast and juice. Client C2 was observed on April 20, 2010, at approximately 12:30 p.m. to be served his lunch. The client was served approximately one and a half cup of a pasta/hamburger dish and a cup of water. The client ate the entire pasta/hamburger dish and then ate a bowl of potato chips. When interviewed April 20, 2010, employee BA/registered nurse stated she was not aware of the client's visit to the physician or of the weight loss.

Client C1 began receiving services December 30, 2004, which included assistance with activities of daily living, medication administration, gastrostomy tube feedings, and suprapubic catheter irrigations. Client C1's service plan was established December 30, 2004. There was no reevaluation of the client's service plan since it was established in December 2004. When interviewed April 21, 2010, employee BA/registered nurse confirmed client C1's service plan had not been reviewed on an annual basis. Client C1 was observed on April 20, 2010, to have an open area on his left buttock and employee CA/unlicensed staff was observed to apply ointments and creams to the area. When interviewed April 20, 2010, employee CA stated that he had applied the ointments and creams to the client's buttocks for approximately the last two months. There was no reevaluation of the client's skin condition by the RN when the client developed the need to have the ointments and creams applied. The last RN evaluation in the client's record was dated April 17, 2009, and the area titled "skin problems/interventions," was blank. When interviewed April 21, 2010, employee BA/registered nurse stated she was not aware of the client's open area, or that staff were applying creams and ointments to the client's buttocks.

Client B1 began receiving total care due to quadriplegia April 14, 2009. Since admission client B1 had difficulty sleeping, three urinary tract infections, medication changes, new pressure areas, shortness of breath with nebulizer treatments, hospitalization for intravenous medications, and episodes of yelling, talking nonsense, confusion and agitation. The service plan, dated April 14, 2009, indicated personal care services per the rental agreement and an assessment. There was no reevaluation of the service plan when there were changes in the client's condition.

Client A1 began receiving services October 31, 2004, which included total care. The client's RN evaluation was last reviewed by the RN on April 15, 2008. When interviewed April 20, 2010, employee BA/registered nurse stated she had not reviewed the clients RN evaluation since April 15, 2008.

Client B2 began receiving total care due to cerebral palsy April 28, 2006. The registered nurse's reevaluation was dated April 15, 2007. When interviewed April 20, 2010, employee BA/RN knew that the service agreement was late and had not been reevaluated when there was a change in the client's condition.

Client D1 was admitted May 11, 2009. There was no evaluation by the registered nurse noted in his record. A request was made during the survey for client D1's evaluation, however none was provided by employees BA and AA/housing manager.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

7. MN Rule 4668.0815 Subp. 4

Based on interview and record review, the licensee failed to provide a complete service plan for two of four clients' (B1 and C1) records reviewed. The findings include:

Client B1 began receiving services April 14, 2009. Client B1's service plan, dated April 14, 2009, only stated "personal care services," and did not include a description of the personal care services to be provided. Observations, interview and record review throughout the survey revealed that the client received total assistance with all of his activities of daily living, medication administration, wound care, and behavior management. These services were not listed on the service plan. Documentation in the client's record indicated the registered nurse (RN) set up the client's medications in a medi-set container every three weeks. This service was also not included on the client's service plan. Client B1's resuscitation status on March 7, 2010, was listed as cardio pulmonary resuscitation. The client's contingency action plan did not include the circumstances in which emergency medical personnel were not to be summoned. When interviewed April 20, 2010, employee BA/a registered nurse asked what should be documented on the service plan for services and didn't realize that a full code status had been requested by client B1.

Client C1 began receiving services December 30, 2004. Client C1's service plan dated December 30, 2004, only indicated "Personal Care Services" and did not include a description of the personal care services to be provided. Observations, interview and record review throughout the survey revealed the client received assistance with all of his activities of daily living, medication administration, gastrostomy tube feedings, and suprapubic catheter irrigations by unlicensed staff. These services were not listed on the service plan. Documentation in the client's record indicated the registered nurse (RN) set up the client's medications in a medi-set container every three weeks. This service was also not included on the client's service plan. When interviewed April 21, 2010, employee BA\registered nurse, confirmed client C1's service plan was not complete and did not include a description of all the services that were provided.

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

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

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

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

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

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

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

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

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

8. MN Rule 4668.0825 Subp. 4

Based on observation, interview and record review, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for four of four employees' (BC, BB, CA and CB) records reviewed. The findings include:

Client B1 began receiving total care due to quadriplegia April 14, 2009. Unlicensed direct care staff notes dated February 2, 4, and 5, and April 8, 2010, indicated digital stimulation and manual removal (of feces) was completed and on February 4 and March 6, 2010, wound care was completed by unlicensed staff. The client's care plan, dated March 7, 2010, indicated a Dulcolax suppository was to be inserted daily and digital stimulation was to be done 1 hour after giving the suppository if there were no results from the suppository. The client's care plan also indicated to follow the directions from the wound care nurse to keep the wounds dry and free from feces. Employee BC/unlicensed staff did not have any training or documentation of competency in digital stimulation, manual removal of feces or wound care nor was there documentation that a RN had instructed or competency tested the unlicensed staff on the procedures. Communication log notes, dated November 26, 2009, and January 6, 2010,

signed employee BC/unlicensed staff indicated if any staff had questions or would like training on B1's bowel cares to direct their questions to employee AA/housing manager, employee BC/unlicensed staff, or another staff person. When interviewed April 20, 2010, employee BA/RN indicated she did not know that the unlicensed staff were performing digital stimulation and manual removal of feces and stated she did not want them doing manual removal of feces. When interviewed April 22, 2010, employee BC/unlicensed staff indicated she had performed the procedures during a previous employment.

Employee BB/unlicensed staff, was observed emptying client B2's ileostomy bag April 20, 2010. Client B2's care plan, dated April 28, 2009, and signed by employee BA/RN stated ileostomy cares:

empty ileostomy bag as needed and change bag every evening. There was no evidence of any training for employee BB in the procedure for client B2's ileostomy care. When interviewed April 20, 2010, employee BA/RN stated she had not done any training on ileostomy care for the unlicensed staff.

Client C1 began receiving services December 30, 2004, which included supra pubic urinary bladder irrigation, care of the supra pubic urinary catheter and a skin treatment. Employee CB/unlicensed staff was observed on April 20, 2010, to conduct a treatment around client C1's supra pubic catheter and irrigate the client's bladder. There were no written instructions for the unlicensed staff on how to perform the bladder irrigation, except for a notation in the medication administration record (MAR) that indicated, "Irrigate SP (supra pubic) with saline (60 cc) 2 x daily)." Employee CB was observed to irrigate client C1's supra pubic catheter with two 60 cubic centimeters (cc) syringes of normal saline. In addition, employee CB was observed to attempt to withdraw the normal saline from the bladder by pulling back on the plunger of the syringe after she had instilled each 60 cc syringe of normal saline into the client's bladder. Each time employee CB was able to only get 10 cc's back in the syringe. According to the facility's policy and procedure titled "Catheter Irrigation," staff are to "disconnect the syringe from catheter and allow fluid to flow into the drainage pan" after instilling the solution into the bladder. When interviewed April 21, 2010, employee BA/registered nurse stated she had not provided written instructions for the unlicensed staff to follow for bladder irrigation. She also stated she had not provided training for the staff on bladder irrigation and care around the supra pubic catheter site, nor had they demonstrated competency to her, their ability to perform the bladder irrigation and care of the supra pubic urinary catheter site.

Employee CA/unlicensed staff was observed on April 20, 2010, to provide a skin treatment to client C1's buttocks. Employee CA was observed to apply a large amount of bacitracin ointment covered with a large of amount of Lantiseptic cream to the client's entire buttock area. The client was observed to have a small open area on his left buttock that was bleeding. There were no written instructions for the unlicensed staff to follow on how to perform the skin treatment for client C1. When interviewed April 20, 2010, employee CA stated that he had been doing this treatment in this manner for approximately two months. He stated that another unlicensed staff showed him how to do this procedure. When interviewed April 21, 2010, employee BA/registered nurse stated she was not aware client C1 had an open area, or that staff were performing a skin treatment to his buttocks. Employee BA confirmed she had not provided training for the staff on the skin treatment. She also said there were no written instructions for staff to follow on how to perform the skin treatment, and staff had not demonstrated competency to her on how to perform the skin treatment.

Client C2 had a prescriber's order, dated October 15, 2009, for a "standing frame" (a device which would allow the client to be in a standing position). The "Assisted Living Home Health Aide Care Plan," dated October 15, 2009, did not include the use of the "standing frame." Employee CA/unlicensed staff was observed on April 20, 2010, to assist client C2 into a standing frame. There were no written instructions for staff to follow on how to perform the procedure, nor was there evidence that employee CA had demonstrated competency to the registered nurse on how to perform the procedure. When interviewed April 21, 2010, employee BA/registered nurse confirmed there were no written instructions on how to place the client in the standing frame. Employee BA confirmed employee CA had not demonstrated his ability to competently perform the procedure.

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

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

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

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

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

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

9. MN Rule 4668.0835 Subp. 3

Based on interview and record review, the licensee failed to ensure that unlicensed personnel who performed home care services, received eight hours of inservice training for each twelve months of employment for four of four employees' (AA, AB, BB and CA) records reviewed, and failed to provide competency testing for one of one employee (AC) reviewed who had not provided home care services for 24 consecutive months. The findings include:

Employee AA's in-service training record indicated she was hired on May 28, 2004, as a home health aide. The employee's in-service training record indicated she only had four hours of training in 2008 and one hour of inservice training in 2009. When interviewed April 22, 2010, employee AA/ home health aide/housing manager confirmed she did not have eight hours of inservice training for each twelve months of employment.

Employee AB was hired on October 5, 2008, as a home health aide. The employee's in-service training record indicated she only had three hours of in-service training in 2009. When interviewed April 20,

2010, employee BA/registered nurse stated she was not aware employee AB had not completed the eight hours of in-service training.

Employee BB was hired to provide direct care to clients on January 22, 2008. The employee's in-service training record indicated she only had two hours of in-service training for 2009. When interviewed April 20, 2010, employee BA/registered nurse confirmed employee BB only had 2 hours of inservice training in 2009.

Employee CA was hired on September 17, 2006, as a home health aide. The employee's in-service training record indicated she only had one hour of in-service training for 2009. When interviewed on April 20, 2010, employee BA/registered nurse stated she was not aware the employee had not completed the eight hours of in-service training.

Employee AC returned to work on March 10, 2010, as a home health aide after being on leave of absence for two years. The employee's personnel record lacked evidence she had demonstrated

competency to the registered nurse (RN) on the required areas when she returned to work on March 10, 2010. When interviewed April 20, 2010, employee AA/housing manager and employee BA/RN stated they were unaware employee AC would have to demonstrate competency again after being away from work for two years.

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

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

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

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

10. MN Rule 4668.0855 Subp. 4

Based on observation, record review and interview, the licensee failed to ensure that unlicensed personnel who administered medications to clients were competent to administer medications for one of one unlicensed staff (CA) reviewed who was observed to administer medications in housing with services site C. The findings include:

Based on interview with employee AA/housing manager on April 22, 2010, employee CA/unlicensed staff began working with clients in housing with services site C in June 2009. Documentation in employee CA's personnel file indicated he was not trained in medication administration until February 11, 2010. Although documentation indicated employee CA was trained in medication administration in February 2010, problems were noted during an observation of the medication pass. Employee CA was observed on April 20, 2010, at 7:00 a.m. to open the central storage of medication closet in the lower level of the facility, take client C1's pills out of a medi-set container and put the pills in a medication cup. At the same time, employee CA was observed to remove client C3's medications from her medi-set container and place the pills in another medication cup. Employee CA took the two medication cups that contained client C1's and C3's medications and brought them upstairs to the kitchen. Employee CA was observed to set client C3's medication cup on the window ledge in the kitchen. Employee CA took client C1's medications out of the medication cup, crushed the pills, added water to the crushed pills and placed the liquid substance in a 60 cubic centimeter (cc) syringe. Employee CA left the syringe on the counter in the kitchen while he went to provide personal care to client C2. At 8:20 a.m., employee CA was observed to administer client C1's medications that were prepared and placed into a 60 cc syringe earlier, into the client's gastrostomy tube. At 10:15 a.m. employee CB (a different unlicensed staff) was observed to administer client C3's medications that had been set-up and placed on the window ledge in the kitchen at 7:00 a.m. by employee CA. Employee CA and CB were not observed to use the medication administration record (MAR) at any time during the medication

administration procedure. The home care provider's (HCP) policy and procedure titled, "Medication Administration" indicated the MAR was to be used to cross check and see how many tablets were to be given at that particular time. The HCP's policy and procedure also indicated that staff was to sign the MAR immediately after setting up or administering the medications. When interviewed April 20, 2010, employee CA stated he would document in the MAR at the end of his shift.

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

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

(2) preparation of the medication for administration;

(3) administration of the medication to the client;

(4) assistance with self-administration of medication;

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

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

11. MN Rule 4668.0855 Subp. 5

Based on interview and record review, the licensee failed to ensure that a registered nurse (RN) was informed within 24 hours of administration when unlicensed staff administered pro re nata (PRN) or as needed medication for two of two clients' (A1 and C1) records reviewed who received PRN medications. The findings include:

Client A1's progress note, dated April 1, 2010, indicated employee AB/unlicensed personnel gave the client docusate liquid 2 teaspoons for constipation. The client had a prescriber's order, dated September 18, 2009, that read docusate sodium 50mg/5ml take two teaspoons once daily as needed. The client's record contained prescriber's orders, dated September 18, 2009, for Albuterol 0.083% Neb Solution 75 milliliters one vial every four to six hours as needed. The client's March and April 2010 medication administration records indicated the client received the Albuterol treatment several times each month for "hard" breathing. The home care provider's (HCP) policy for PRN medication administration does not include notification of the RN when PRN medications were given by unlicensed staff. When interviewed April 20, 2010, employee AB/unlicensed staff stated she gave the docusate liquid to the client when the client had not had a bowel movement for two to three days and further stated she does not notify the RN after she gives the PRN medication. When interviewed April 20, 2010, employee BA/RN stated she was not notified when PRN medications were administered by unlicensed staff and also stated she was unaware the client was receiving the nebulizer treatments.

Client C1 had a prescriber's order for Rozerem (a medication given for insomnia) 8 milligrams, one tablet per gastrostomy tube as needed. The client's April 2010 medication administration record indicated the client received Rozerem every night from April 1 through April 20, 2010. There was no evidence that the registered nurse (RN) was notified of the client receiving this medication on a PRN basis. When interviewed April 20, 2010, employee CA/unlicensed staff stated he was not aware that he needed to notify the RN when giving a PRN medication. When interviewed April 22, 2010, employee BA/registered nurse stated she was not aware of what the policy was on PRN medications.

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

A. the medications are regularly scheduled; and

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

(1) within 24 hours after its administration; or

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

12. MN Rule 4668.0855 Subp. 7

Based on interview and record review, the licensee failed to ensure that the registered nurse (RN) documented in the client's record, the specific instructions for performing the procedures for each client, and the unlicensed staff person demonstrated to an RN their ability to assist with or administer the medications for one of one client (A1) record reviewed receiving nebulizer treatment. The findings include:

Client A1's record indicated employee AB/unlicensed staff had administered Albuterol nebulizer treatments to the client on April 1, 2, 5, 6, 7, 8, and 10, 2010. The client's record did not contain written instructions for the nebulizer treatment. Employee AB's personnel file contained a form titled Nebulizer Training that was dated February 13, 2010, and the only thing written on the form was the employee's name. The form was not signed by the person who provided the training nor did it indicate the employee had demonstrated competency to perform the procedure. When interviewed April 20, 2010, employee BA/RN stated she had not trained the unlicensed staff on the nebulizer treatment.

TO COMPLY: A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

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

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

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

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

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

13. MN Rule 4668.0855 Subp. 9

Based on interview and record review, the licensee failed to have complete medication records for two of six clients' (B1 and C1) records reviewed. The findings include:

Client B1 began receiving total care including medication administration on April 14, 2009. Flagyl (amebicide) 500 mg. (milligrams) was started three times a day for 8 days on April 16, 2010. During observation of the medication pill box on April 22, 2010, at 4:00 p.m., it was noted that medications which were set up by employee BA\registered nurse (RN) did not include the Flagyl on Thursday, April 22, 2010, at 5:00 p.m. and 8:00 p.m. nor Friday at 8p.m. There was a large, white, oval pill set up for Friday and Saturday April 23 and 24, 2010, at 8:00 a.m. and 5:00 p.m., however there was not an original pill bottle found to verify the name of the pill. When interviewed April 22, 2010, employee BA/registered nurse indicated the bottle was gone, because the medication was done being dispensed, but identified the Flagyl as a large, white, oval pill. When informed that it was not set up to give on Thursday, April 22, 2010, at 5:00 p.m. or 8:00 p.m., employee BA indicated it should have been in the pill box for Thursday April 22, 2010.

Client C1 had a prescriber's order dated January 18, 2010, for Fosamax 35 milligrams to be administered weekly. The label from the pharmacy on the client's bottle of liquid Fosamax read take 35 milligrams (37.5 milliliters) per gastrostomy tube weekly. Employee CA/unlicensed staff was observed on April 20, 2010, to measure 35 milliliters instead of 37.5 milliliters as ordered. Employee CA was observed to administer this dose to the client via his gastrostomy tube. When interviewed April 22, 2010, employee BA/registered nurse confirmed the client should have received 37.5 milliliters instead of 35 milliliters of Fosamax.

Client C1's medication administration record (MAR) dated April 2010, indicated that Macrodantin 50 milligrams was to be administered per his gastrostomy tube two times a day at 8:00 a.m. and 8:00 p.m. There were no initials on the MAR that the 8:00 a.m. dose was administered April 1 through April 19, 2010. Client C1's MAR indicated Simvastatin, 20 milligrams was to be administered per his gastrostomy tube every day at 8:00 a.m. There were no initials on the MAR that the client was administered the Simvastatin at 8:00 a.m. April 1 through April 19, 2010. When interviewed April 22, 2010, employee BA/registered nurse stated she recently noticed the lack of initials for the administration of the client's Macrodantin and Simvastatin. Employee BA stated she thought that the medications were administered and just were not documented. When questioned how frequently she checked for accuracy of the medication administration, employee BA stated every three weeks she set up the client's medications and checked for accuracy.

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

14. MN Rule 4668.0860 Subp. 2

Based on interview and record review, the licensee failed to have a current prescriber order for medications for two of six clients' (C1 and B1) records reviewed. The findings include:

Client B1 began receiving services April 14, 2009, which included medication administration. During a reconciliation of medications by the surveyor on April 20, 2010, it was noted that client B1 was receiving Sanctura XR (spasmolytic) 60 milligrams-1 cap full and Bas ac-Evac 10 milligram (suppository) everyday. The current prescriber's orders of April 16, 2010, did not include Sanctura or Bas ac-Evac. When interviewed April 20, 2010, employee BA/registered nurse was not aware there was a difference in what was ordered and what was being administered.

Client C1 began receiving services December 30, 2004, which included medication administration. Client C1 had a prescription bottle of Vicodin (a schedule II narcotic medication) that was observed to be stored in the medication closet. The client's progress notes were reviewed from February through April 2010 and it was noted that on four occasions, February 21, 2010, March 11, 2010, April 10, 2010, and April 20, 2010, the client was administered one tablet of Vicodin. There was no prescriber's order for the Vicodin in the client's record. When interviewed April 22, 2010, employee BA/registered nurse was not aware the client had a bottle of Vicodin or that the staff were administering it to him. Employee BA confirmed there was not a prescriber's order for the Vicodin in client C1's record.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

15. MN Rule 4668.0865 Subp. 2

Based on observation, interview and record review, the licensee failed to have the registered nurse (RN) conduct an assessment of the client's functional status and need for central medication storage and develop a service plan for the provision of central storage of medications for two of four clients (A1 and C1) who received central storage of medications. The findings include:

Client A1's medications were observed on April 19 and 20, 2010, to be stored in the medication storage room in housing with services site A. The client's service plan, dated October 5, 2009, did not include central storage of medications. When interviewed April 20, 2010, employee BA/RN confirmed the client's service plan did not include central storage of medications.

Client C1 began receiving services December 30, 2004, which included medication administration. Observations on April 20, 2010, revealed that client C1's medications were centrally stored in a closet in the lower level of housing with services site C. Client C1's record did not contain an assessment by the RN of the client's need for central storage of medications, nor did the client's service plan include central storage of medications. When interviewed April 21, 2010, employee BA/registered nurse confirmed client C1's medications were centrally stored, that his assessment did not include the need for central storage of medications and that the client's service plan did not include this service. Employee BA stated she was not aware of this requirement.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

16. MN Rule 4668.0865 Subp. 3

Based on observation, interview and record review, the facility failed to maintain a system to control the distribution and storage of medications at one of four housing with services sites (C) reviewed. The findings include:

Client C1 had a prescription bottle of Vicodin (a schedule II narcotic medication) that was observed to be centrally stored in the medication closet along with other clients' medications. There was no prescriber's order for the Vicodin in the client's record. The prescription label for the Vicodin read: 1-2 tablets orally every four-six hours PRN (pro re nata or whenever necessary) for headache. The prescription label indicated that thirty tablets were dispensed on February 5, 2010. The bottle was observed to have fourteen tablets left in the bottle as of April 22, 2010. The client's medication administration record for February, March and April 2010 were reviewed and did not list the Vicodin. Progress notes were reviewed from February through April 2010, and it was noted that on four occasions, February 21, 2010, March 11, 2010, April 10, 2010, and April 20, 2010, client C1 was administered one tablet of Vicodin. Twelve tablets of the Vicodin were unaccounted for. When interviewed April 22, 2010, employee BA/registered nurse was not aware the client had a bottle of Vicodin or that the staff were administering it to him.

Observations of the clients' central storage of medications on April 20, 2010, revealed a thirty-two ounce can of Wood Finish stain to be stored on the shelf with client's medications. An eight ounce stock bottle of liquid Senna Syrup expired in February of 2009. When interviewed April 22, 2010, employee BA/registered nurse confirmed the wood stain should not be stored with the medications, and stated she was not aware of the expired medications.

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

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

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

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

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

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

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

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

17. MN Rule 4668.0865 Subp. 8

Based on observation and interview, the facility failed to assure that all medications were stored in locked compartments in three of four housing with services sites (A, B, and C) surveyed. The findings include:

On April 19, 2010, at 2:55 p.m. in client A1's room there was a bottle of docusate sodium liquid, Wal-tussin Cough syrup, and liquid acetaminophen on a table by her bed. On a cart by the client's bed there was a tube of Neosporin ointment and a jar of Triamcinolone 0.1% cream. On April 20, 2010, in client A1's room at 7:45 a.m. the bottle of docusate sodium liquid and liquid acetaminophen were still observed on a table by her bed. When interviewed April 20, 2010, employee AB/unlicensed staff stated the medications were always kept at the client's bed side.

On April 19, 2010, at 3:00 p.m. in housing with services site A the keys to the medication storage room were observed to be hanging in the lock on the door. On April 20, 2010, from 7:45 a.m. to 9:15 a.m., the keys to the medication storage room were observed to be hanging in the lock on the door. During this time client A3 was observed to wheel himself in his wheel chair past the keys hanging in the lock. When interviewed on April 19, 2010, employee AA/housing manager stated the keys were not to be left in the lock on the door.

During the survey on April 19, 20, 21, and 22, 2010, the medication keys were observed to be stored in an unlocked drawer to the right of the dishwasher in housing with services site B. Client B3 was observed on April 20, 2010 to pull this unlocked drawer open to obtain a pencil.

All three clients at housing with services site Cs' medications were centrally stored in a closet in the lower level of the facility. Observations throughout the day on April 20, 2010, revealed the medication storage key was left in the key hole and the medication closet was unlocked. Client C1's liquid docusate Sodium bottle was observed on April 20 and April 22, 2010, to be stored on a shelf in an unlocked cupboard in the kitchen. When interviewed April 20, 2010, as to why the client's docusate

sodium was stored in an unlocked cupboard in the kitchen, employee CA/unlicensed staff stated that the client received this medication three times a day, and it was more convenient for staff to access it when it was kept in the cupboard in the kitchen. Two bottles of liquid lansoprazole (Prevacid) that belonged to client C1 were observed on April 20, 2010, to be stored in an unlocked refrigerator in the kitchen on a shelf with condiments. When interviewed April 22, 2010, employee BA\registered nurse stated she was not aware that staff were storing client C1's docusate sodium in an unlocked kitchen cupboard. Employee BA also confirmed the client's liquid lansoprazole was stored in the common use refrigerator unlocked.

TO COMPLY: A class F home care provider licensee providing central storage of medications must store all drugs in locked compartments under proper temperature controls and permit only authorized nursing personnel to have access to keys.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

18. MN Rule 4668.0865 Subp. 9

Based on observation and interview, the licensee failed to ensure controlled drugs were stored appropriately in two of two housing with services sites (B and C) reviewed who stored controlled drugs. The findings include**:**

During the survey of April 19 through April 22, 2010, Fentanyl patches (pain medication) and Dilaudid (opioid analgesic) for client B4 were observed locked in a central storage metal cupboard in the basement in housing with services site B, which was not permanently affixed to the physical plant. When interviewed April 21, 2010, employee BB/unlicensed staff did not know schedule II drugs had to be locked separately and permanently affixed to the building.

All three clients at housing with services site C had medications that were centrally stored in a closet in the lower level of the facility. A metal box that was attached to the wall inside the medication closet was observed to be used for storage of schedule II narcotic medications. On April 20, 2010, at 2:00 p.m., the metal box was observed to be unlocked and contained several bottles of morphine sulfate, and Fentanyl patches. In addition, client C1 had a bottle of Vicodin, a schedule II narcotic that was observed to be stored with other client's medications that were not Schedule II drugs, on a shelf in the medication closet. When interviewed April 22, 2010, employee BA/registered nurse stated the metal box should be locked at all times and she was not aware that client C1 had a bottle of Vicodin.

TO COMPLY: A class F home care provider licensee providing central storage of medications must provide separately locked compartments, permanently affixed to the physical plant or medication cart, for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

19. MN Rule 4668.0870 Subp. 3

Based on observation and interview, the licensee failed to ensure medications were disposed of properly at the time of discharge for three of three discharged clients (C4, C5, and C6) reviewed at housing with services (HWS) site C. The findings include:

Client C4 expired at the HWS on August 17, 2006. Two bottles of morphine sulfate and three boxes of Fentanyl patches that were labeled with client C4's name were observed on April 20, 2010, to still be stored in the HWS's central storage of medication closet.

Client C5 was discharged from the HWS on February 17, 2006. A tube of Accuzyme and a box of Fentanyl patches that were labeled with client C5's name were observed on April 20, 2010, to still be stored in the HWS's central storage of medication closet.

Client C6 was discharged from the HWS on July 14, 2005. A tube of Lidocaine hydrochloride Jelly that was labeled with client C6's name was observed on April 20, 2010, to be still be stored in the HWS's central storage of medication closet.

When interviewed April 22, 2010, employe BA/registered nurse, stated she was not aware these medications were stored in the medication closet and not destroyed.

TO COMPLY: A. Unused portions of a controlled substance remaining in a housing with services establishment after death or discharge of the client for whom the controlled substance was prescribed, or any controlled substance discontinued permanently, must be disposed of by contacting the Minnesota Board of Pharmacy, which shall furnish the necessary instructions and forms, a copy of which shall be kept on file by the class F home care provider licensee for two years.

B. Unused portions of a legend drug remaining in a housing with services establishment after the death or discharge of the client for whom the legend drug was prescribed, or any legend drug permanently discontinued, must be destroyed by the class F home care provider licensee or a designee of the licensee, in the presence of a pharmacist or nurse who shall witness the destruction. A notation of the destruction listing the date, quantity, name of drug, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded in the client's record.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

20. MN Statute §144A.44 Subd. 1(2)

Based on observation, record review and interview, the licensee failed to ensure clients received care and services according to a suitable and up-to-date plan and nursing standards for five of seven clients (A1, C1, D1, D2 and D3) reviewed. The findings include:

Client C1 had a diagnosis which made him totally dependent on staff for all of his cares. Documentation in the client's record indicated that he was recently hospitalized on January 18, 2010, through January 23, 2010, for a urinary tract infection. Employees CA and CB (unlicensed staff) were observed on April 20, 2010, at approximately 12:15 p.m. to clean client C1's gastrostomy feeding site and suprapubic urinary catheter site, irrigate the client's bladder, provide skin care, assist the client with dressing and provide the client with oral care without changing their gloves and washing their hands. Employee CB was observed to pour Sodium Chloride from a bottle into the cap of the container with gloved hands. Employee CB dipped a two by two piece of gauze into the Sodium Chloride that was in the cap and wipe around the client's gastrostomy feeding tube site. Employe CB dipped the same gauze again into the cap of Sodium Chloride and wiped again around the gastrostomy feeding tube site. Employee CB took dry gauze and wiped the same area, and then placed a four by four gauze around the gastrostomy

feeding tube site. Employee CB was then observed to take another two by two gauze, dip it into the same cap of Sodium Chloride and clean around the client's suprapubic urinary catheter site. Employee CB took a dry gauze and wiped the area, and placed a four by four gauze around the supra pubic urinary catheter site. Using the same gloved hands, employee CB put her gloved fingertip covering the tip of a 60 cubic centimeter (cc) syringe and poured 60 ccs of Sodium Chloride from the bottle into the syringe. Employee CB was observed to instill the Sodium Chloride into the client's supra pubic urinary catheter. Employee CB repeated this procedure, and then reattached the catheter tubing. Employee CB was observed to put the supplies she used away, opening the bedside drawer, touching the contents in the drawer, opened the client's door to his room touching the door knob, went into the bathroom across the hall, then came back into the client's bedroom to assist employee CA. Employee CA and CB were observed to put client C1's pants on around his ankles. Employee CB was observed to lift client C1's arms, adjust the client's hands and then assist in rolling client C1 over on his right side. Employee CA was observed with his gloved hands, to take a tube of bacitracin and a container of Lantiseptic cream from the client's bedside drawer and place them on the bedside table. Employee CA took the tube of bacitracin and with the tip of the tube touching the client's buttocks, squeezed four lines of the bacitracin onto the client's buttocks. Employee CA then spread the bacitracin with his gloved hands, over the client's buttocks. Employee CA was then observed with the same gloved hands, to scoop a handful of Lantiseptic cream directly from the container and spread the cream over the client's entire buttocks, covering the bacitracin. Employees CA and CB were then observed to pull the client's pants up, zip his zipper, adjust his head on the pillow, boost the client up in bed and apply special boots to the client's feet. Employee CB was observed to finally remove her gloves at this time, but did not wash her hands. Employee CB was observed to go into the kitchen and prepare lunch for client C2. Employee CA was observed to put the cream and ointment back into the client' bedside drawer, opened the client's room door touching the door knob, went into the bathroom across the hall, opened a bottle of oral rinse for client C1 and poured some into a medication cup. He then put the cap back onto the oral rinse bottle and picked up the client's tooth brush. Employee CA was observed at 12:50 p.m. on April 20, 2010, to finally remove his gloves, but did not wash his hands. Employee CA put on a new pair of gloves and assisted client C1 with oral care.

Client A1's care plan, dated October 30, 2010, indicates the client is to be turned and repositioned every two hours to prevent skin breakdown. The client was observed April 20, 2010, at 7:45 a.m. in bed on her back with the head of the bed up and a pink pillow under her head. At 8:00 a.m. employee AB/unlicensed staff was observed to remove the pink pillow from behind the client's head and place a foam wedge behind her head and feed the client breakfast in bed. At 8:30 a.m. the client completed eating breakfast, but remained sitting up in bed with the foam wedge behind her head. At 9:35 a.m. employee AB went into the client's room and removed the foam wedge from behind the client's head and replaced it with the pink pillow. The client remained in bed on her back with the head of the bed elevated. Between 9:35 a.m. and 11:10 a.m. the client remained on her back with the pink pillow behind her head. When interviewed on April 20, 2010, employee AA/housing manager stated they were not turning the client from side to side because if the head of the bed is not up the client has difficulty breathing. When interviewed April 20, 2010, employee BA/registered nurse stated she was not aware the client was not being turned and that the client was having difficulty breathing at times.

Client D1 is a paraplegic and has insulin dependent diabetes. The client's record contained documentation on April, 3, 2010, that he had fallen on the ground. The supervisor was called and with the help of the supervisor and others he was assisted back into his wheelchair. The client had "some minor injury on his leg." When interviewed on April 20, 2010, employee BA/registered nurse said that she had not been notified of client D1's fall and informed employee AA/house manager, who was also present, that she need to be notified of falls.

Documentation in client D1's record by employee BA/registered nurse, dated March 30, 2010, noted the client was seen by a physician on March 29, 2010, and would be getting home care services through North Memorial starting March 31, 2010, for rash areas in the groin. Employee BA noted she was unable to assess the client's skin at that time. Employee BA also documented on April 11, 2010, that she was unable to assess the client's skin.

When interviewed April 20, 2010, employee BA stated she had not seen the client's open areas. She stated North Memorial was doing the skilled nursing and that the home care agency does not leave any notes. Employee BA was not aware if the client had wound dressings or what the unlicensed staff was doing for the client.

Client D2's record included documentation by staff, dated February 17, 2010, which indicated the client was "bad" and employee AA was called. Employee AA arrived at the facility at 5:35 p.m. She checked the client's blood pressure and temperature and fed the client. At 6:35 p.m. the client was still "bad" and employee AA called 911. The client was sent to the hospital where she remained until March 22, 2010.
When interviewed on April 22, 2010, employee BA stated she was not called to do an assessment of the client on February 17, 2010, and that it was not until later that she (employee BA) had been notified of the client's condition/hospitalization.

Documentation in the facility communication log indicated that client D3 had falls on February 24, 2010, and March 23, 2010. When interviewed April 20, 2010, employee BA stated she had not been notified of client D3's falls either.

TO COMPLY: A person who receives home care services has these rights:
(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

TIME PERIOD FOR CORRECTION: Fourteen (14) days

21. MN Statute §144A.46 Subd. 5(b)

Based on interview and record review, the licensee failed to ensure employees have a background study prior to providing direct care for one of nine employees (CA) reviewed. The findings include:

Employee CA's file contained a background study completed February 11, 2010. The record did not have a date of hire for employee CA. The record noted that employee CA had completed the home health agency competency evaluation on February 11, 2010, and additional forms in the record such as the W4 and employment application were dated June 13, 2009. When questioned about the date of hire for employee CA, employee AA stated it must have been on February 15, 2010, because that was the first payroll. She also indicated that staff do not always start employment right away.

Interviews with client C2 and employee CA indicated that employee CA has been employed at least six to seven months at the facility. A review of client C2's record revealed that employee CA documented progress notes on July 21 and 29, 2009.

Employee AA was questioned again on April 22, 2010, about employee CA's date of hire. During this interview, employee AA stated that employee CA had been at the facility since last year. Employee AA stated employee CA had been learning English and was not an actual employee; however he did have client contact when at the housing with services.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

22. MN Statute §626.557 Subd. 14(b)

Based on observation, interview and record review, the licensee failed to ensure that each client had an up to date vulnerability assessment and measures to assist in reducing the client's risk of abuse for five of five clients' (A3, B1, B2, C1 and C2) records reviewed. The findings include:

Client B2 began receiving total care services due to cerebral palsy April 28, 2006. During an interview on April 20, 2010, individual (aa) indicated she had a concern related to client B2's right to be with her fiancé/client A3 (who was a client in the neighboring house). When interviewed April 20, 2010, employee AA/housing manager, was questioned why client B2 could not be with client A3. Employee AA stated staff had to be with client B2 at all times because she required so much care, like wiping her chin off. Client B2's fiduciary/guardian was interviewed on April 22, 2010. The fiduciary/guardian indicated client B2 could not visit client A3 alone because he was told by the staff that client A3 had hit client B2. The fiduciary/guardian stated this incident occurred around the time of April 4 through the 11th of 2010. When interviewed April 22, 2010, employee AA indicated client B2 was alert and oriented. Employee AA stated she did not know about any recent altercations between clients B2 and A3, but stated there had been one instance of the client A3 "hitting" client B2. Employee AA stated this incident occurred in 2006, during which client A3 had "lashed" out at client B2. Client B2 denied the incident occurred. Employee AA stated she observed this incident from the window of the house next door. When interviewed April 22, 2010, employee BC/unlicensed personnel indicated she did not know about any altercations between clients B2 and A3. Client B2's vulnerable adult assessment, dated April 28, 2006, identified vulnerabilities in orientation, environment, chronic disability, social support, central storage of medication, functional limitations, susceptible to abuse and reporting abuse, speech barriers, understanding and ability to use the telephone. Client B2's care plan identified assistance with activities of daily living and choking precautions. The assessment did not identify client B2's risk of possible abuse from client A3.

Client C2 was admitted and began receiving services October 31, 2006. The client's vulnerable adult assessment, dated October 25, 2008, indicated the client was oriented to person, place and time, was susceptible to abuse by others in home environment, including sexual abuse and was able to report abuse/neglect concerns. On April 20, 2010, client C2 brought to the attention of the surveyor a concern that he was being harassed by a staff person. The surveyor brought the concern to the attention of employee BA/registered nurse and employee AA/housing manager on April 20, 2010. Employee BA indicated that she was not aware that client C2 made up things regarding abuse and neglect in the past, although employee AA stated in interview on April 20, 2010, that the client had made accusations against staff in the past. The client's vulnerability assessment/plan did not address the client's past

behaviors.

Client B1 was admitted and began receiving total care due to quadriplegia April 14, 2009. Client B1's vulnerable adult assessment identified vulnerabilities in orientation, environment, chronic disability, social support, central storage of medication, functional limitations, susceptible to abuse and reporting abuse. There were no measures identified that would assist in minimizing the risk of abuse in these areas. When interviewed April 21, 2010, employee BA stated she did not know there had to be specific measures listed to minimize the risk of abuse for the identified vulnerabilities.

Client C1 required assistance with all of his activities of daily living, including feeding with a gastric tube, and was unable to speak verbally. The client's Vulnerability Assessment dated April 12, 2008, identified the client was vulnerable in the area of his inability to manage his finances, susceptibility to abuse by others in the home environment and inability to report abuse and neglect. There was no measures identified that would assist in minimizing the risk of abuse in these areas. When interviewed April 21, 2010, employee BA\registered nurse stated she was not aware of this requirement.

Client A3's vulnerable adult assessment, dated May 13, 2009, indicated he was vulnerable in orientation, but when interviewed April 20, 2010, employee BA/RN stated she did not understand the form and that the assessments were done incorrectly.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

TIME PERIOD FOR CORRECTION: Thirty (30) days

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 4122

October 20, 2005

Rohitha Perera, Administrator
Hawthorne House
6931 Country Club Drive
Golden Valley, MN 55427

Re: Licensing Follow Up Revisit

Dear Ms. Perera:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on October 12 and 13, 2005.

The documents checked below are enclosed.

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

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

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

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

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

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

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

INFORMATIONAL MEMORANDUM

PROVIDER: HAWTHORNE HOUSE

DATE OF SURVEY: October 12 and 13, 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:
Susanthi Fernando Residence Manager Home Health Aide,
Barbara Blackwood, RN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up ____X____

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow up on the status of state licensing orders issued as a result of a visit made on March 4, 7 and 8, 2005. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference. The status of the Correction orders is as follows:

1. MN Rule 4668.0065, Subp. 1	**Corrected**
2. MN Rule 4668.0815, Subp. 4	**Corrected**
3. MN Rule 4668.0825, Subp. 4	**Corrected**
4. MN Rule 4668.0840, Subp. 3	**Corrected**
5. MN Rule 4668.0855, Subp. 4	**Corrected**
6. MN Rule 4668.0855, Subp. 5	**Corrected**
7. MN Rule 4668.0855, Subp. 9	**Corrected**

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 8345

August 16, 2005

Rohitha Perera, Administrator
Hawthorne House
6931 Country Club Drive
Golden Valley, MN 55427

Re: Results of State Licensing Survey

Dear Ms. Perera:

The above agency was surveyed on March 4 and March 7, 2005 for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if found, are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me, or the RN Program Coordinator. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

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

Also attached is an optional Provider questionnaire, which is a self-mailer, which affords the provider with an opportunity to give feedback on the survey experience.

Please feel free to call our office with any questions at (651) 215-8703.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Rohitha Perera, President Governing Body
Kelly Crawford, Minnesota Department of Human Services
Hennepin County Social Services
Sherilyn Moe, Office of the Ombudsman
CMR File

Assisted Living Home Care Provider

LICENSING SURVEY FORM

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

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

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

Name of ALHCP: HAWTHORNE HOUSE
HFID # (MDH internal use): 23104
Date(s) of Survey: March 4, and 7, 2005
Project # (MDH internal use): QL23104002

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

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

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

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
1	MN Rule 4668.0815 Subp. 1 Evaluation; documentation		X	**Education:** Provided
1	MN Rule 4668.0815 Subp. 4 Contents of service plan	X	X	Based on record review, and interview, the licensee failed to provide complete service plans for three of three clients (#1, #2, and #3) records reviewed. The findings include: Client #1 and #2's Medication Administration Records (MAR) for February and March of 2005, and client #3's July 2004 MAR indicated that unlicensed staff were providing medication administration. Client #1's service plan dated June 11, 2004, client #2's service plan dated October 30, 2004, and client #3's service plan dated May 7, 2004 did not include the service medication administration, the person or category of persons to provide the medication administration, the schedule of supervision or the fee for medication administration. When interviewed on March 4, and 7, 2005, the residence manager confirmed the preceding findings. **Education:** Provided
1	MN Rule 4668.0845 Subp. 2 Services that require supervision by a registered nurse		X	**Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
2	MN Statute 144A.44 Minnesota Home Care Bill of Rights		X	**Education:** Provided
3	MN Rule 4668.0065 Subp. 1 Tuberculosis screening	X	X	Based on record review, and interview, the licensee failed to provide documentation of tuberculosis screening prior to direct client contact for two of two unlicensed personnel (#1 and #2) records reviewed. The findings include: Employee #1 was hired to provide direct care to clients on May 28, 2004, and employee #2 was hired to provide direct care to clients on August 28, 2004. When interviewed on March 4, and 7, 2005, employee #1 confirmed there was no documentation of employee #2 and herself, having received a negative reaction to a Mantoux test in their personnel record. Employees #1 and #2 both reported having had tuberculosis screening prior to direct contact with clients. **Education:** Provided
7	MN Rule 4668.0825 Subp. 3 Nursing services delegated to unlicensed personnel		X	**Education:** Provided
7	MN Rule 4668.0825 Subp. 4 Performance of routine procedures	X	X	Based on record review, and interview, the licensee failed to ensure that unlicensed personnel demonstrated competency for routine procedures for two of two unlicensed personnel records (#1 and #2) reviewed. The findings include: Client #1 received assistance with blood glucose monitoring from unlicensed staff. There was no evidence in client #1's record regarding the procedure for unlicensed personnel to

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				follow regarding blood glucose monitoring. Nor was there evidence that employees #1 or #2, who preformed the delegated task of blood glucose monitoring had demonstrated competency to perform the task to the registered nurse. When interviewed March 4 and 7, 2005 employee #1 confirmed that there were no instructions for the procedure and that there had been no demonstration of competency. **Education:** Provided
7	MN Rule 4668.0840 Subp. 3 Core training of unlicensed personnel	X	X	Based on record review, and interview, the licensee failed to ensure complete core training for one of two unlicensed personnel (#2) files reviewed. The findings include: Employee #2 was hired August 28, 2004 to provide direct care. Employee #2's core training record indicated communication skills, observing, reporting, and documenting client status and care, basic elements of body functioning, changes in body function that must be reported to an appropriate health care professional and physical, emotional and development needs of clients and ways to work with clients with problems in these areas were not included in her training. When interviewed March 7, 2005, the housing manager stated there was "no more information" and indicated there was no evidence employee #2 received complete core training. **Education:** Provided

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
7	MN Rule 4668.0855 Subp. 4 Training for assistance with self-administration of medication or medication administration	X	X	Based on record review, and interview, the licensee failed to ensure the registered nurse trained unlicensed personnel for assistance with self-administration of medication and medication administration for one of two unlicensed personnel records (#1) reviewed. The findings include: Employee #1's file had a Home Health Aide Competency Test dated November 28, 2001 which evaluated employee #1's competency in medication reminders. There was no evidence that employee #1 had been trained and evaluated in the procedures for assistance with self-administration of medications and medication administration, which were delegated tasks employee #1 was performing. When interviewed on March 4, and 7, 2005, employee #1 stated she had not been trained in assistance with self-administration of medication or medication administration. **Education**: Provided
8	MN Rule 4668.0855 Subp. 5 Administration of medications	X	X	Based on record review, and interview, the licensee failed to ensure that unlicensed personnel reported to the registered nurse (RN) the use of pro re nata (p.r.n.) medications for two of two clients (#2 and #3) records reviewed. The findings include: Client #2's Medication Administration Records for January, February, and March 2005 indicated that p.r.n. Tylenol was administered. Client #3's Medication Administration Record for July 2004 indicated that p.r.n. Vicodin was administered. When interviewed on March 4, and 7, 2005, employee #1 verified these findings. Employee #3 confirmed that the unlicensed staff were unaware of the need to report the

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
				p.r.n. medication use to the RN. **Education:** Provided
8	MN Rule 4668.0855 Subp. 9 Medication records	X	X	Based on record review, and interview, the licensee failed to ensure that unlicensed personnel reported to the registered nurse (RN) the use of pro re nata (p.r.n.) medications for two of two client records (#2 and #3) reviewed. The findings include: Client #2's Medication Administration Records for January, February, and March 2005 indicated that p.r.n. Tylenol was administered. Client #3's Medication Administration Record for July 2004 indicated that p.r.n. Vicodin was administered. There was no evidence the RN had been notified of the use of these medications. When interviewed March 7, 2005, the RN stated that the unlicensed staff were unaware of the need to report the p.r.n. medication use to the RN. **Education:** Provided
	CLIA Waiver		X	**Education:** Provided
	Minnesota Board of Nursing Education Module		X	**Education:** Provided
	Provider Web Site Resources		X	**Education:** Provided

A draft copy of this completed form was left with Susanthi Fernando, Residence Manager at an exit conference on March 7, 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)