MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 2810 0001 2257 4063

February 5, 2010

Donna Johnson, Administrator
Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720

Re: Results of State Licensing Survey

Dear Ms. Johnson:

The above agency was surveyed on January 4 and 5, 2010, 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. If further clarification is necessary, an informal conference can be arranged.

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

CMR 3199

Class F Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class F home care providers (Class F). Class F licensees may also use this 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 staff, talk with clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class F Home Care services. Completing this Licensing Survey Form in advance may facilitate 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 Class F home care regulations. Any violations of Class F Home Care Provider licensing requirements are noted at the end of the survey form.

Name of CLASS F: SUNCREST ASSISTED LIVING

HFID #: 23227

Date(s) of Survey: January 4 and 5, 2009

Project #: QL23227006

Indicators of Compliance	Outcomes Observed	Comments
1. The provider only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. **Focus Survey** • MN Rule 4668.0815 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0825 Subp. 2 • MN Rule 4668.0845	• 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 understand what care will be provided and what it costs.	**Focus Survey** _X_ Met ____ Correction Order(s) issued _X_ Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes the clients' rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170 • MN Statute §144D.04 • MN Rule 4668.0870	• Clients are aware of and have their rights honored. • Clients are informed of and afforded the right to file a complaint. • Continuity of Care is promoted for clients who are discharged from the agency.	**Focus Survey** _X_ Met ____ Correction Order(s) issued ____ Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided
3. The health, safety, and well being of clients are protected and promoted. **Focus Survey** • MN Statute §144A.46 • MN Statute §626.557 **Expanded Survey** • MN Rule 4668.0035 • MN Rule 4668.0805	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Agency personnel observe infection control requirements. • There is a system for reporting and investigating any incidents of maltreatment. • There is adequate training and supervision for all staff. • Criminal background checks are performed as required.	**Focus Survey** _X_ Met ____ Correction Order(s) issued ____ Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. • Nurse licenses are current. • The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. • The process of delegation and supervision is clear to all staff and reflected in their job descriptions. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** _X_ Met ____ Correction Order(s) issued ____ Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** _X_ Met ____ Correction Order(s) issued ____ Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 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 CLASS F 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) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** _X_ Met ____ Correction Order(s) issued ____ Education Provided **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
8. The provider is in compliance with MDH waivers and variances **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ Education Provided **Follow-up Survey** #___ ____ New Correction Order issued ____ Education Provided

***Please note*: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings of the focused licensing survey may result in an expanded survey.**

SURVEY RESULTS: _X_ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

A draft copy of this completed form was left with Donna Johnson at an exit conference on January 5, 2010. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4309. After review, this form will be posted on the MDH website. Class F Home Care Provider general information is available by going to the following web address and clicking on the Class F Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

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).

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CERTIFIED MAIL #:7008 2810 0001 2258 0279

August 6, 2009

HFID 23227
Donna Johnson, Administrator
Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720

Re: Amended Licensing Order Issued August 4, 2009

Dear Ms. Johnson:

Thank-you for bringing to our attention the issues in relation to the state licensing order that was issued on May 27, 2009 in relation to your survey of March 18, 19, 20 and 24, 2009.

At the time of the survey, a correction order was issued citing **MN Rule 4668.0050 Subp. 1.** Based on a review of additional information received, this correction order is rescinded.

The amended survey, with deleted information struck-out, is enclosed. Please sign the correction order form, make a copy for your file and return the entire original form to this office when all orders are corrected.

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) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

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

Class F Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class F home care providers (Class F). Class F licensees may also use this 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 staff, talk with clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class F Home Care services. Completing this Licensing Survey Form in advance may facilitate 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 Class F home care regulations. Any violations of Class F Home Care Provider licensing requirements are noted at the end of the survey form.

Name of CLASS F: SUNCREST ASSISTED LIVING

HFID #: 23227

Date(s) of Survey: March 18, 19, 20 and 24, 2009

Project #: QL23227005

Indicators of Compliance	Outcomes Observed	Comments
1. The provider only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. **Focus Survey** • MN Rule 4668.0815 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0825 Subp. 2 • MN Rule 4668.0845	• 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 understand what care will be provided and what it costs.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes the clients' rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170 • MN Statute §144D.04 • MN Rule 4668.0870	• Clients are aware of and have their rights honored. • Clients are informed of and afforded the right to file a complaint. • Continuity of Care is promoted for clients who are discharged from the agency.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
3. The health, safety, and well being of clients are protected and promoted. **Focus Survey** • MN Statute §144A.46 • MN Statute §626.557 **Expanded Survey** • MN Rule 4668.0035 • MN Rule 4668.0805	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Agency personnel observe infection control requirements. • There is a system for reporting and investigating any incidents of maltreatment. • There is adequate training and supervision for all staff. • Criminal background checks are performed as required.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. • Nurse licenses are current. • The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. • The process of delegation and supervision is clear to all staff and reflected in their job descriptions. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 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 CLASS F 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) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** _X_Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
8. The provider is in compliance with MDH waivers and variances **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued _X_ Education Provided **Follow-up Survey** _#___ ____ New Correction Order issued ____ Education Provided

***Please note*: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings of the focused licensing survey may result in an expanded survey.**

SURVEY RESULTS: ___ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

~~**1. MN Rule 4668.0050 Subp. 1**~~

~~**INDICATOR OF COMPLIANCE: # 1**~~

~~Based on record review and interview, the licensee failed to ensure they had staff sufficient in qualification and numbers for one of three clients' (#2) records reviewed. The findings include:~~

~~Client #2's service plan dated June 24, 2008 indicated agency responsibilities as "send qualified staff." Incident/Accident report dated November 23, 2008 indicated client #2 got up from her chair to get a drink of water and fell down knocking her chair down. The report also indicated "lift assist" had been called. The unlicensed person was unable to get the client up off the floor.~~

~~When interviewed on March 18, 2009, employee E indicated there was only one unlicensed staff scheduled on the 11 p.m. to 6 a.m. shift. Employee E also stated if a client falls at night and the one staff scheduled to work is unable to get the client up off the floor they are to call for "lift help." Employee E indicated "lift help" means the unlicensed staff will call the local fire department to come help lift the client up off the floor.~~

~~2~~1. MN Rule 4668.0800 Subp. 3

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to provide all services required by a client's service plan for two of three clients' (#2 and #3) records reviewed. The findings include:

Client #2's record contained a physicians order dated December 2, 2008, for client #2 to return to see the physician on December 5, 2008, to check her fractured wrist. Client #2's record lacked evidence the client had seen the physician on December 5, 2008. Client #2's rental agreement, tenant hand book, and "RN Evaluation/Baseline Assessment" dated June 24, 2008, indicated assisted living staff would help to make appointments and would arrange transportation.

When interviewed March 18, 2009, employee F stated the assisted living helped clients to set up transportation to appointments. When interviewed March 19, 2009, employee A and D confirmed the client's record lacked evidence the client had been to see the physician as ordered.

Client #3's service plan dated May 1, 2008, indicated client #3 was to receive shower assist three times a week. Client #3's weekly record for March 2009 indicated she only received shower assist two times per week.

When interviewed March 19, 2009, employee A and D confirmed client #3 was only receiving shower assist two times a week.

~~3~~2. MN Rule 4668.0810 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the agency failed to ensure all entries in the client record were authenticated with the name and title of the person making the entry for three of three clients' (#1, #2, and #3) records reviewed. The findings include:

Client #1;s behavior observation sheet contained entries dated September 25 and October 20, 2008, and March 11, 2009, that were only initialed by the person making the entry. Entries on this sheet dated August 8, and September 17, 2008, and February 3, 2009, lacked the initials or signature of the person making the entry.

When interviewed on March 18, 2009 employee E confirmed these entries had not been signed with the name and title of the person making the entry.

All entries on client #2's extra visit/call log from July 1, 2008, to March 11, 2009, had only been initialed and not signed by the person making the entry.

When interviewed on March 18, 2009 employee E confirmed all entries on the extra visit/call log were only initialed and not signed by the person making the entry.

All entries on client #3's blood sugar flow sheet had not been signed by the person making the entries. Entries dated September 5, November 30, December 2 and 3, 2008, and January 23 and March 10, 2009, on client #3's behavior observation sheet were only initialed by the person making the entry. All entries on client #3's extra visit/call log dated November 8, 2008, to March 16, 2009, were only initialed by the person making the entry

When interviewed on March 18, 2009, employee E confirmed the entries were not signed by the person making the entry and did not include their title.

~~4~~3. MN Rule 4668.0810 Subp. 6

INDICATOR OF COMPLIANCE: # 4

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

Client #1's March 5, 2009, nurse's notes included "HHA instructed on R ear drops for infection in R ear." Client #1's record lacked any further documentation or assessment of the condition of the client's right ear.

When interviewed on March 19, 2009, employee A and D confirmed there was no further documentation about the client's right ear.

Accident and incident reports indicated client #2 fell on November 23, 2008, and on February 7, 2009. Client #2's record lacked documentation pertaining to these falls.

When interviewed on March 19, 2009, employee A and D confirmed there was no documentation pertaining to these falls in the client's record.

Client #3's "Extra Visit/Call Log" indicated on November 15, 2008 she was "having chest pain." There was no further assessment of the client's condition documented in the client's record.

When interviewed on March 19, 2009, employees A and D confirmed this was the only documentation in the client's record pertaining to the chest pain. Employee D was able to find documentation in the staff communication book which indicated the client had chest pain, vital signs had been taken, nitroglycerin had been given and the registered nurse had been called on November 15, 2008. Employee A indicated that the communication book was not saved and the information did not become part of the client's permanent record.

~~5~~4. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed personnel demonstrated to the registered nurse that they were competent to perform the delegated procedure for two of three clients' (#1 and #3) records reviewed. The findings include:

Client #1 record contained an order dated March 5, 2009, for Ciprodex three drops in right ear two times a day for ten days. The "HHA/Homemaker Client Weekly Record" indicated employee B administered the ear drops to client #1 on March 6, 9,10,11, and 12, 2009, and employee C administered the ear drops to client #1 on March 7 and 8, 2009.

When interviewed on March 18, 2009, regarding if employee B and C had been trained by a registered nurse prior to administering the ear drops, employee D handed the surveyor a clipboard with the written procedure for ear drops for client #1 on. On the top of the type written procedure, the following was hand written and initialed by employee A, "Everyone please read & sign." Employee B signed that she had read the procedure on March 6, 2009, and employee C signed that she had read the procedure on March 10, 2009, which was after she had administered the ear drops to client #1. Employee D confirmed the unlicensed staff only read the procedure and had not demonstrated to the registered nurse they were able to administer the ear drops appropriately.

Client #3's "HHA/Homemaker Client Weekly Record" indicated unlicensed personnel assisted client #3 with Accu-Chek three times a day. Employee B assisted client #3 with Accu-Cheks on March 7, 13, and 14, 2009, and employee C assisted on March 9, 10, 11, and 12, 2009. There were no written instructions in the client's record for how the unlicensed personnel were to perform the Accu-Cheks.

Employee B's and C's records lacked evidence they had been instructed by a registered nurse on performing Accu-Cheks.

When interviewed on March 19, 2009, employee B indicated she had been instructed by a registered nurse about five months ago on how to do Accu-Cheks, but she had not done a return demonstration to the registered nurse.

When interviewed March 19, 2009, regarding training unlicensed staff on how to do Accu-Cheks employee E provided the surveyor a document called "Doing an Accucheck." Attached to the document was a signature sheet indicating the undersigned had been instructed and were competent. The sheet was only signed by two employees, one being employee C. Employee E indicated the procedure was not individualized for client #3.

~~6~~5. MN Rule 4668.0835 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure unlicensed personnel, who have not performed assisted living home care services for a period of 24 consecutive months, demonstrated competency to a registered nurse for one of two unlicensed person's (B) records reviewed. The findings include:

Employee B was hired on October 14, 2008. Employee B's record had evidence she had completed competency training in 1999.

When interviewed on March 19, 2009, employee B stated she had worked at another assisted living that had been owned by the same company in 1999. Employee B also stated she had worked at a nursing home from approximately 2005 until October 14, 2008, and she had not provided assisted living services for greater than 24 months.

When interviewed on March 19, 2009, employee E confirmed employee B had not completed competency training since her hire on October 14, 2008. Employee E was not aware employee B needed to complete competency testing again.

~~7~~6. MN Rule 4668.0855 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure a registered nurse (RN) documented the specific instructions for performing procedures in the client's record for each client and the unlicensed staff person demonstrated to a registered nurse their ability to assist with or administer the medications for one of two clients' (#1) records reviewed who received medication administration. The findings include:

Client #1's service plan, dated September 26, 2008, indicated that an unlicensed staff person was to assist the client with self-administration of medications three times a day. Client #1's record indicated that employees B and C, both unlicensed staff, assisted the client with self-administration of her medications. There were no specific written instructions in the client's record for the unlicensed staff to follow when performing the procedure. In addition, there was no documentation that employees B and C had demonstrated to a registered nurse their ability to competently perform assistance with self-administration of medications. The competency instruction sheet for assistance with self administration of medication for client #1 did not include employee B's name. This same sheet did include employee C's name and date however the sheet was not signed by a registered nurse.

When interviewed on March 19, 2009, employee B stated a registered nurse had instructed her on medication administration for the client but she had not demonstrated to a registered nurse her ability to perform assistance with medication administration. When interviewed on March 19, 2009, employee A and D confirmed there were not specific instructions for medication administration in the client's record and verified there was no documentation of return demonstration for medication administration.

~~8~~7. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to have complete medication records for two of two clients' (#1 and #3) records reviewed who received assistance with medication administration. The findings include:

Client #1's medication list used for documenting medications administration listed the following medications: Calcium with vitamin D 600/400 mg twice a day, metformin XR 1000mg twice a day, ASA 81 mg daily, citalopram 30 mg daily, omeprazole 20 mg daily, Synthroid 0.05 mg daily, clonidine 0.1 mg twice a day, furosemide 20 mg daily, lisinopril 20 mg daily, vitamin C 500 mg daily, MVI 1 tab daily, FeSO4 325 mg daily, Melatonin 1 mg at bedtime, and Tylenol PM at bedtime. The medication list did not include the method of administration for these medications.

Client #2's medication list used for documenting medication administration listed the following medications: Fosomax 70 mg per protocol, Norvasc 7.5 mg at bedtime, Lasix 40 mg every a.m.,

Ativano0.25 mg daily, potassium 20 mg twice a day, Lantus 10 units at bedtime, Prilosec 20 mg daily AM, Vasotec 10mg daily in AM, prednisone 5 mg every AM, Imdur ER 60 mg every AM, Synthroid 0.075 mg daily, Cardizem 120 mg daily, and Aricept 5 mg daily. The list lacked the method of administration for the medications.

When interviewed on March 19, 2009 employee A and D confirmed the method of administration was not included for the medications on the medication list.

~~9~~8. MN Rule 4668.0860 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the agency failed to have current prescriber orders for medications for one of three clients' (#3) records reviewed. The findings include:

Client #3's blood sugar flow sheet indicated on February 4, 10, 18, 23, and 28 2009, and March 2, 4, 4, 11, 13, 16, and 18 that her blood sugar was 506, 305, 355, 323, 340, 367, 312, 335, 302, 395, 333, and 333 respectively. The blood sugar flow sheet indicated client #3 received 8 units of Novolog insulin for each of the above blood sugars over 300.

The physicians orders dated September 25, 2008, indicated client #3 was to receive 4 units of Novolog insulin for a blood sugar of 80 to 150, 6 units of Novolog insulin for a blood sugar of 151 to 200, 7 units of Novolog insulin for a blood sugar of 201 to 250, and 8 units of Novolog insulin for a blood sugar of 251 to 300. There was no physician's order for how much insulin was to be given if client #3's blood sugar was above 300.

When interviewed on March 19, 2009 employee A, D, and E confirmed there was no physicians order for how much insulin was to be given if the blood sugar was above 300. Employee A indicated the physician did not want her to have more than 8 units of sliding scale insulin and there was no documentation in the client's record to support this.

~~10~~9. MN Rule 4668.0860 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview the licensee failed to ensure medications were administered as ordered by the physician for two of two clients' (#1 and #3) records reviewed who received medication administration assistance. The findings include:

Client #1 had a physicians order dated March 5, 2009, which included Ciprodex three drops in right ear two times a day times 10 days (total of 20 doses). Client #1's "HHA/Homemaker Client Weekly

Record" indicated the she received the ear drops one time on March 5 and 12, 2009, and two times on March 6, 7, 8, 9, 10, 11, 13, and 14, 2009. Thus client #1 only received 18 of the prescribed 20 doses.

Client #1 also had a physicians order dated October 10, 2008, for vitamin B12 500 mg daily. Client #1's medication set up list indicated the registered nurse set up vtamin B12 1000 mg in her medications administration boxes on January 5, 12, 19 and 26, 2009, and on March 2, 9, and 16, 2009.

When interviewed on March 19, 2009, employee A and D confirmed client #1 had not received the ear drops as ordered. Employee A stated she thought they had not signed that they gave the medication. Employee A also confirmed that the documentation indicated that Vitamin B12 1000 mg had been set up in the client's medication boxes.

Client #3 "Extra Visit/Call Log" indicated on November 15, 2008, she was "having chest pain". Client #3 had a physicians order dated November 4, 2008, that stated nitroglycerin 0.3 mg under the tongue as needed for chest pain. There was no documentation in the client's record indicating she received the nitroglycerin as ordered.

When interviewed on March 19, 2009, employee A and D confirmed they could not tell if the client had received the nitroglycerin or not.

~~11~~10. MN Rule 4668.0865 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure a registered nurse developed a service plan for the provision of central storage of medications for two of two clients' (#1 and #3) records reviewed who received central storage of medications. The findings include:

Observation of the medication storage cupboard on March 19, 2009, and the current client roster provided by the agency indicated clients #1 and #3 each received central storage of medications. Client #1's and # 3's service plans dated respectively March 9, 2009, and May 1, 2008, did not include central storage of medications.

When interviewed on March 19, 2009 employee E confirmed the clients received central storage of medications and the service plan did not include central storage of medications.

~~12~~11. MN Rule 4668.0865 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview the facility failed to establish a system to control medications for two of two clients' (#1, and #3) records reviewed that received central storage of medications. The findings include:

Client #1's and #2's medications were observed stored in the central storage cupboard and the current client roster indicated client #1 and #3 received central storage of medications.

Client #1 had a physicians order dated March 5, 2009, which included Ciprodex three drops in right ear two times a day times 10 days (total of 20 doses). Client #1 "HHA/Homemaker Client Weekly Record" indicated the she received the ear drops one time of March 5 and 12, 2009 and two times on March 6, 7, 8, 9, 10, 11, 13, and 14, 2009. Thus client #1 only received 18 of the prescribed 20 doses.

Client #3 "Extra Visit/Call Log" indicated on November 15, 2008 she was "having chest pain". Client #3 has a physicians order dated November 4, 2008 that stated nitroglycerin 0.3 mg under the tongue as

needed for chest pain. There is no documentation in the client's record indicating she received the nitroglycerin as ordered.

Client #1 medication list used for documenting medications administration listed the following medications; Calcium with vitamin. D 600/400 mg twice a day, metformin XR 1000 mg twice a day, ASA 81 mg daily, citalopram 30 mg daily, omeprazole 20 mg daily, synthroid 0.05 mg daily, clonidine 0.1 mg twice a day, furosemide 20 mg daily, lisinopril 20 mg daily, vitamin C 500 mg daily, MVI 1 tab daily, FeSO4 325 mg daily, Melatonin 1 mg at bedtime, and Tylenol PM at bedtime. The method of administration for the above medications was not indicated.

Client #2's medication list used for documenting medication administration listed the following medications; Fosomax 70 mg per protocol, Norvasc 7.5 mg at bedtime, Lasix 40 mg every a.m., Ativan 0.25 mg daily, potassium 20 mg twice a day, Lantus 10 units at bedtime, Prilosec 20 mg daily AM, Vasotec 10mg daily in AM, prednisone 5 mg every AM, Imdur ER 60 mg every AM, Synthroid 0.075 mg daily, Cardizem 120 mg daily, and Aricept 5 mg daily. The methods of administration for the above medications were not indicated.

When interviewed on March 19, 2009, employee A and D confirmed the method of administration was not included for the medication on the medication list.

~~13~~12. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview the licensee failed to ensure clients received care according to acceptable medical and nursing standards for two of three clients' (#2 and #3) records reviewed. The findings include:

Client #2 began receiving services on June 24, 2008. Client #2's nurses notes dated June 24, 2008 indicated she had a history of falls. The vulnerable adult assessment dated June 24, 2008, did not address the history of falls. Client #2's record and incident/accident reports indicated client #2 fell on November 23, 2008, at 11 p.m. when she was getting out of her chair to get a drink. The one unlicensed staff on duty was unable to get the client up off the floor and called for "lift help" (this means calling the local fire department for assistance). Client #2 complained of right wrist pain at this time. The incident/accident report indicated the right wrist "is not suspected" to be broken". The incident accident report did not indicate the registered nurse was notified of the fall until November 24, 2009, at 11 a.m. when the registered nurse wrote a note in client #2's nurses notes. The registered nurse note dated November 24, 2008, indicated she had fallen two times this past weekend in her room and her wrist was sore. The next registered nurse note dated November 27, 2008, indicated the client's wrist was swollen, bruised and sore. On November 28, 2008, a registered nurse note indicated the right wrist was still bruised and swollen and the ace was rewrapped and client #2 indicated it was still sore. On December 1, 2008, client #2's right wrist was still sore and the nurse suggested she see a physician. The nurse's note dated December 2, 2008, indicated she returned from the physicians' office and had a fractured right wrist, had a splint on her right wrist and was to return to see the physician on December 5, 2008. Client #2's record lacked evidence she went to see the physician on December 5, 2008. Client #2's behavior observation record indicated she fell on January 29, 2009. There was an incident/accident report dated February 2, 2009 indicating client #2 fell in her apartment. Client #2's behavior observation record indicated on February 17, 2009, the client again fell in her apartment and the nurses note dated March

11, 2009, indicated the client fell and was sent to the hospital and admitted because of a fractured hip. Even though the registered nurse did a month assessment and a sixty day supervisory visit the registered nurse did not do a fall assessment to evaluate the cause of the falls or develop a plan to reduce the number of fall and reduce the risk of injury.

When interviewed on March 19, 2009, employee A and D confirmed they only stated the client had fallen but did not do a fall assessment to reduce the client's risk of future falls and the record lacked evidence the client had seen the physician on December 5, 2008.

Client #3 had a diagnosis of diabetes. Client #3's blood sugar flow sheet indicated on February 4, 10, 18, 23, and 28 2009, and March 2, 4, 4, 11, 13, 16, and 18 that her blood sugar was 506, 305, 355, 323, 340, 367, 312, 335, 302, 395, 333, and 333 respectively. The blood sugar flow sheet indicated client #3 received 8 units of Novolog insulin for each of the above blood sugars over 300.

The physicians orders dated September 25, 2008, stated client #3 was to receive 4 units of Novolog insulin for a blood sugar of 80 to 150, 6 units of Novolog insulin for a blood sugar of 151 to 200, 7 units of Novolog insulin for a blood sugar of 201 to 250, and 8 units of Novolog insulin for a blood sugar of 251 to 300. There was no physician's order for how much insulin was to be given if client #3's blood sugar was above 300. It was not until the surveyor questioned if there was a physicians order for how much insulin client #3 was to receive for a blood sugar above 300 and then asked the registered nurse to clarify with the physician how much insulin client #3 should receive for a blood sugar above 300 that the registered nurse called the physician to clarify the order. On March 20, 2009, the physician faxed the agency an order for Novolog 10 units of insulin for blood sugar for over 300.

When interviewed on March 19, 2009, employees A, D, and E confirmed there was no physicians order for how much insulin was to be given if the blood sugar was above 300. Employee A indicated the physician did not want her to have more than 8 units of sliding scale insulin and there was no documentation in the client's record to support this.

~~1~~413. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to complete an accurate vulnerable adult assessment for one of three clients (#2) records reviewed. The findings include:

Client # 2 started receiving services on June 24, 2008. The nurse's note dated June 24, 2008, indicated client #2 had a history of falls. The vulnerable adult assessment dated June 24, 2008, did not address the history of falls. Client #2's record and incident reports indicated she had fallen on November 23, 2008, January 29, 2009, February 2 and 17, 2009 and March 11, 2009. Client #2's December 19, 2008, and February 19. 2009, assessments indicated the client had fallen but there was no assessment of vulnerability or plan of how to prevent further falls.

A draft copy of this completed form was left with Donna Johnson at an exit conference on March 24, 2009. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. Class F Home Care Provider general information is available by going to the following web address and clicking on the Class F Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

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).

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 0617

May 28, 2009

Donna Johnson, Administrator
Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720

Re: Results of State Licensing Survey

Dear Ms. Johnson:

The above agency was surveyed on March 18, 19, 20, and 24, 2009, 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 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) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

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

01/07 CMR3199

Class F Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class F home care providers (Class F). Class F licensees may also use this 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 staff, talk with clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class F Home Care services. Completing this Licensing Survey Form in advance may facilitate 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 Class F home care regulations. Any violations of Class F Home Care Provider licensing requirements are noted at the end of the survey form.

Name of CLASS F: SUNCREST ASSISTED LIVING

HFID #: 23227

Date(s) of Survey: March 18, 19, 20 and 24, 2009

Project #: QL23227005

Indicators of Compliance	Outcomes Observed	Comments
2. The provider only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. **Focus Survey** • MN Rule 4668.0815 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0825 Subp. 2 • MN Rule 4668.0845	• 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 understand what care will be provided and what it costs.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes the clients' rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170 • MN Statute §144D.04 • MN Rule 4668.0870	• Clients are aware of and have their rights honored. • Clients are informed of and afforded the right to file a complaint. • Continuity of Care is promoted for clients who are discharged from the agency.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
3. The health, safety, and well being of clients are protected and promoted. **Focus Survey** • MN Statute §144A.46 • MN Statute §626.557 **Expanded Survey** • MN Rule 4668.0035 • MN Rule 4668.0805	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Agency personnel observe infection control requirements. • There is a system for reporting and investigating any incidents of maltreatment. • There is adequate training and supervision for all staff. • Criminal background checks are performed as required.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs (or contracts with) qualified staff. **Focus Survey** • MN Rule 4668.0065 • MN Rule 4668.0835 **Expanded Survey** • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0840 • MN Rule 4668.0070 • MN Statute §144D.065	• Staff have received training and/or competency evaluations as required, including training in dementia care, if applicable. • Nurse licenses are current. • The registered nurse(s) delegates nursing tasks only to staff that are competent to perform the procedures that have been delegated. • The process of delegation and supervision is clear to all staff and reflected in their job descriptions. • Personnel records are maintained and retained. • Staff meet infection control guidelines.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 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 CLASS F 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) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** _X_Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
8. The provider is in compliance with MDH waivers and variances **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued _X_ Education Provided **Follow-up Survey** _#___ ____ New Correction Order issued ____ Education Provided

<u>Please note</u>: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings of the focused licensing survey may result in an expanded survey.

<u>SURVEY RESULTS:</u> ___ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0050 Subp. 1

<u>INDICATOR OF COMPLIANCE</u>: # 1

Based on record review and interview, the licensee failed to ensure they had staff sufficient in qualification and numbers for one of three clients' (#2) records reviewed. The findings include:

Client #2's service plan dated June 24, 2008 indicated agency responsibilities as "send qualified staff." Incident/Accident report dated November 23, 2008 indicated client #2 got up from her chair to get a drink of water and fell down knocking her chair down. The report also indicated "lift assist" had been called. The unlicensed person was unable to get the client up off the floor.

When interviewed on March 18, 2009, employee E indicated there was only one unlicensed staff scheduled on the 11 p.m. to 6 a.m. shift. Employee E also stated if a client falls at night and the one staff scheduled to work is unable to get the client up off the floor they are to call for "lift help." Employee E indicated "lift help" means the unlicensed staff will call the local fire department to come help lift the client up off the floor.

2. MN Rule 4668.0800 Subp. 3

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to provide all services required by a client's service plan for two of three clients' (#2 and #3) records reviewed. The findings include:

Client #2's record contained a physicians order dated December 2, 2008, for client #2 to return to see the physician on December 5, 2008, to check her fractured wrist. Client #2's record lacked evidence the client had seen the physician on December 5, 2008. Client #2's rental agreement, tenant hand book, and "RN Evaluation/Baseline Assessment" dated June 24, 2008, indicated assisted living staff would help to make appointments and would arrange transportation.

When interviewed March 18, 2009, employee F stated the assisted living helped clients to set up transportation to appointments. When interviewed March 19, 2009, employee A and D confirmed the client's record lacked evidence the client had been to see the physician as ordered.

Client #3's service plan dated May 1, 2008, indicated client #3 was to receive shower assist three times a week. Client #3's weekly record for March 2009 indicated she only received shower assist two times per week.

When interviewed March 19, 2009, employee A and D confirmed client #3 was only receiving shower assist two times a week.

3. MN Rule 4668.0810 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the agency failed to ensure all entries in the client record were authenticated with the name and title of the person making the entry for three of three clients' (#1, #2, and #3) records reviewed. The findings include:

Client #1;s behavior observation sheet contained entries dated September 25 and October 20, 2008, and March 11, 2009, that were only initialed by the person making the entry. Entries on this sheet dated August 8, and September 17, 2008, and February 3, 2009, lacked the initials or signature of the person making the entry.

When interviewed on March 18, 2009 employee E confirmed these entries had not been signed with the name and title of the person making the entry.

All entries on client #2's extra visit/call log from July 1, 2008, to March 11, 2009, had only been initialed and not signed by the person making the entry.

When interviewed on March 18, 2009 employee E confirmed all entries on the extra visit/call log were only initialed and not signed by the person making the entry.

All entries on client #3's blood sugar flow sheet had not been signed by the person making the entries. Entries dated September 5, November 30, December 2 and 3, 2008, and January 23 and March 10, 2009,

on client #3's behavior observation sheet were only initialed by the person making the entry. All entries on client #3's extra visit/call log dated November 8, 2008, to March 16, 2009, were only initialed by the person making the entry

When interviewed on March 18, 2009, employee E confirmed the entries were not signed by the person making the entry and did not include their title.

4. MN Rule 4668.0810 Subp. 6

INDICATOR OF COMPLIANCE: # 4

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

Client #1's March 5, 2009, nurse's notes included "HHA instructed on R ear drops for infection in R ear." Client #1's record lacked any further documentation or assessment of the condition of the client's right ear.

When interviewed on March 19, 2009, employee A and D confirmed there was no further documentation about the client's right ear.

Accident and incident reports indicated client #2 fell on November 23, 2008, and on February 7, 2009. Client #2's record lacked documentation pertaining to these falls.

When interviewed on March 19, 2009, employee A and D confirmed there was no documentation pertaining to these falls in the client's record.

Client #3's "Extra Visit/Call Log" indicated on November 15, 2008 she was "having chest pain." There was no further assessment of the client's condition documented in the client's record.

When interviewed on March 19, 2009, employees A and D confirmed this was the only documentation in the client's record pertaining to the chest pain. Employee D was able to find documentation in the staff communication book which indicated the client had chest pain, vital signs had been taken, nitroglycerin had been given and the registered nurse had been called on November 15, 2008. Employee A indicated that the communication book was not saved and the information did not become part of the client's permanent record.

5. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed personnel demonstrated to the registered nurse that they were competent to perform the delegated procedure for two of three clients' (#1 and #3) records reviewed. The findings include:

Client #1 record contained an order dated March 5, 2009, for Ciprodex three drops in right ear two times a day for ten days. The "HHA/Homemaker Client Weekly Record" indicated employee B administered the ear drops to client #1 on March 6, 9,10,11, and 12, 2009, and employee C administered the ear drops to client #1 on March 7 and 8, 2009.

When interviewed on March 18, 2009, regarding if employee B and C had been trained by a registered nurse prior to administering the ear drops, employee D handed the surveyor a clipboard with the written procedure for ear drops for client #1 on. On the top of the type written procedure, the following was hand written and initialed by employee A, "Everyone please read & sign." Employee B signed that she had read the procedure on March 6, 2009, and employee C signed that she had read the procedure on March 10, 2009, which was after she had administered the ear drops to client #1. Employee D confirmed the unlicensed staff only read the procedure and had not demonstrated to the registered nurse they were able to administer the ear drops appropriately.

Client #3's "HHA/Homemaker Client Weekly Record" indicated unlicensed personnel assisted client #3 with Accu-Chek three times a day. Employee B assisted client #3 with Accu-Cheks on March 7, 13, and 14, 2009, and employee C assisted on March 9, 10, 11, and 12, 2009. There were no written instructions in the client's record for how the unlicensed personnel were to perform the Accu-Cheks.

Employee B's and C's records lacked evidence they had been instructed by a registered nurse on performing Accu-Cheks.

When interviewed on March 19, 2009, employee B indicated she had been instructed by a registered nurse about five months ago on how to do Accu-Cheks, but she had not done a return demonstration to the registered nurse.

When interviewed March 19, 2009, regarding training unlicensed staff on how to do Accu-Cheks employee E provided the surveyor a document called "Doing an Accucheck." Attached to the document was a signature sheet indicating the undersigned had been instructed and were competent. The sheet was only signed by two employees, one being employee C. Employee E indicated the procedure was not individualized for client #3.

6. MN Rule 4668.0835 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure unlicensed personnel, who have not performed assisted living home care services for a period of 24 consecutive months, demonstrated competency to a registered nurse for one of two unlicensed person's (B) records reviewed. The findings include:

Employee B was hired on October 14, 2008. Employee B's record had evidence she had completed competency training in 1999.

When interviewed on March 19, 2009, employee B stated she had worked at another assisted living that had been owned by the same company in 1999. Employee B also stated she had worked at a nursing home from approximately 2005 until October 14, 2008, and she had not provided assisted living services for greater than 24 months.

When interviewed on March 19, 2009, employee E confirmed employee B had not completed competency training since her hire on October 14, 2008. Employee E was not aware employee B needed to complete competency testing again.

7. MN Rule 4668.0855 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure a registered nurse (RN) documented the specific instructions for performing procedures in the client's record for each client and the unlicensed staff person demonstrated to a registered nurse their ability to assist with or administer the medications for one of two clients' (#1) records reviewed who received medication administration. The findings include:

Client #1's service plan, dated September 26, 2008, indicated that an unlicensed staff person was to assist the client with self-administration of medications three times a day. Client #1's record indicated that employees B and C, both unlicensed staff, assisted the client with self-administration of her medications. There were no specific written instructions in the client's record for the unlicensed staff to follow when performing the procedure. In addition, there was no documentation that employees B and C had demonstrated to a registered nurse their ability to competently perform assistance with self-administration of medications. The competency instruction sheet for assistance with self administration of medication for client #1 did not include employee B's name. This same sheet did include employee C's name and date however the sheet was not signed by a registered nurse.

When interviewed on March 19, 2009, employee B stated a registered nurse had instructed her on medication administration for the client but she had not demonstrated to a registered nurse her ability to perform assistance with medication administration. When interviewed on March 19, 2009, employee A and D confirmed there were not specific instructions for medication administration in the client's record and verified there was no documentation of return demonstration for medication administration.

8. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to have complete medication records for two of two clients' (#1 and #3) records reviewed who received assistance with medication administration. The findings include:

Client #1's medication list used for documenting medications administration listed the following medications: Calcium with vitamin D 600/400 mg twice a day, metformin XR 1000mg twice a day, ASA 81 mg daily, citalopram 30 mg daily, omeprazole 20 mg daily, Synthroid 0.05 mg daily, clonidine 0.1 mg twice a day, furosemide 20 mg daily, lisinopril 20 mg daily, vitamin C 500 mg daily, MVI 1 tab daily, FeSO4 325 mg daily, Melatonin 1 mg at bedtime, and Tylenol PM at bedtime. The medication list did not include the method of administration for these medications.

Client #2's medication list used for documenting medication administration listed the following medications: Fosomax 70 mg per protocol, Norvasc 7.5 mg at bedtime, Lasix 40 mg every a.m., Ativano0.25 mg daily, potassium 20 mg twice a day, Lantus 10 units at bedtime, Prilosec 20 mg daily AM, Vasotec 10mg daily in AM, prednisone 5 mg every AM, Imdur ER 60 mg every AM, Synthroid 0.075 mg daily, Cardizem 120 mg daily, and Aricept 5 mg daily. The list lacked the method of administration for the medications.

When interviewed on March 19, 2009 employee A and D confirmed the method of administration was not included for the medications on the medication list.

9. MN Rule 4668.0860 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the agency failed to have current prescriber orders for medications for one of three clients' (#3) records reviewed. The findings include:

Client #3's blood sugar flow sheet indicated on February 4, 10, 18, 23, and 28 2009, and March 2, 4, 4, 11, 13, 16, and 18 that her blood sugar was 506, 305, 355, 323, 340, 367, 312, 335, 302, 395, 333, and 333 respectively. The blood sugar flow sheet indicated client #3 received 8 units of Novolog insulin for each of the above blood sugars over 300.

The physicians orders dated September 25, 2008, indicated client #3 was to receive 4 units of Novolog insulin for a blood sugar of 80 to 150, 6 units of Novolog insulin for a blood sugar of 151 to 200, 7 units of Novolog insulin for a blood sugar of 201 to 250, and 8 units of Novolog insulin for a blood sugar of 251 to 300. There was no physician's order for how much insulin was to be given if client #3's blood sugar was above 300.

When interviewed on March 19, 2009 employee A, D, and E confirmed there was no physicians order for how much insulin was to be given if the blood sugar was above 300. Employee A indicated the physician did not want her to have more than 8 units of sliding scale insulin and there was no documentation in the client's record to support this.

10. MN Rule 4668.0860 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview the licensee failed to ensure medications were administered as ordered by the physician for two of two clients' (#1 and #3) records reviewed who received medication administration assistance. The findings include:

Client #1 had a physicians order dated March 5, 2009, which included Ciprodex three drops in right ear two times a day times 10 days (total of 20 doses). Client #1's "HHA/Homemaker Client Weekly

Record" indicated the she received the ear drops one time on March 5 and 12, 2009, and two times on March 6, 7, 8, 9, 10, 11, 13, and 14, 2009. Thus client #1 only received 18 of the prescribed 20 doses.

Client #1 also had a physicians order dated October 10, 2008, for vitamin B12 500 mg daily. Client #1's medication set up list indicated the registered nurse set up vtamin B12 1000 mg in her medications administration boxes on January 5, 12, 19 and 26, 2009, and on March 2, 9, and 16, 2009.

When interviewed on March 19, 2009, employee A and D confirmed client #1 had not received the ear drops as ordered. Employee A stated she thought they had not signed that they gave the medication. Employee A also confirmed that the documentation indicated that Vitamin B12 1000 mg had been set up in the client's medication boxes.

Client #3 "Extra Visit/Call Log" indicated on November 15, 2008, she was "having chest pain". Client #3 had a physicians order dated November 4, 2008, that stated nitroglycerin 0.3 mg under the tongue as needed for chest pain. There was no documentation in the client's record indicating she received the nitroglycerin as ordered.

When interviewed on March 19, 2009, employee A and D confirmed they could not tell if the client had received the nitroglycerin or not.

11. MN Rule 4668.0865 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure a registered nurse developed a service plan for the provision of central storage of medications for two of two clients' (#1 and #3) records reviewed who received central storage of medications. The findings include:

Observation of the medication storage cupboard on March 19, 2009, and the current client roster provided by the agency indicated clients #1 and #3 each received central storage of medications. Client #1's and # 3's service plans dated respectively March 9, 2009, and May 1, 2008, did not include central storage of medications.

When interviewed on March 19, 2009 employee E confirmed the clients received central storage of medications and the service plan did not include central storage of medications.

12. MN Rule 4668.0865 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview the facility failed to establish a system to control medications for two of two clients' (#1, and #3) records reviewed that received central storage of medications. The findings include:

Client #1's and #2's medications were observed stored in the central storage cupboard and the current client roster indicated client #1 and #3 received central storage of medications.

Client #1 had a physicians order dated March 5, 2009, which included Ciprodex three drops in right ear two times a day times 10 days (total of 20 doses). Client #1 "HHA/Homemaker Client Weekly Record" indicated the she received the ear drops one time of March 5 and 12, 2009 and two times on March 6, 7, 8, 9, 10, 11, 13, and 14, 2009. Thus client #1 only received 18 of the prescribed 20 doses.

Client #3 "Extra Visit/Call Log" indicated on November 15, 2008 she was "having chest pain". Client #3 has a physicians order dated November 4, 2008 that stated nitroglycerin 0.3 mg under the tongue as needed for chest pain. There is no documentation in the client's record indicating she received the nitroglycerin as ordered.

Client #1 medication list used for documenting medications administration listed the following medications; Calcium with vitamin. D 600/400 mg twice a day, metformin XR 1000 mg twice a day,

ASA 81 mg daily, citalopram 30 mg daily, omeprazole 20 mg daily, synthroid 0.05 mg daily, clonidine 0.1 mg twice a day, furosemide 20 mg daily, lisinopril 20 mg daily, vitamin C 500 mg daily, MVI 1 tab daily, FeSO4 325 mg daily, Melatonin 1 mg at bedtime, and Tylenol PM at bedtime. The method of administration for the above medications was not indicated.

Client #2's medication list used for documenting medication administration listed the following medications; Fosomax 70 mg per protocol, Norvasc 7.5 mg at bedtime, Lasix 40 mg every a.m., Ativan 0.25 mg daily, potassium 20 mg twice a day, Lantus 10 units at bedtime, Prilosec 20 mg daily AM, Vasotec 10mg daily in AM, prednisone 5 mg every AM, Imdur ER 60 mg every AM, Synthroid 0.075 mg daily, Cardizem 120 mg daily, and Aricept 5 mg daily. The methods of administration for the above medications were not indicated.

When interviewed on March 19, 2009, employee A and D confirmed the method of administration was not included for the medication on the medication list.

13. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview the licensee failed to ensure clients received care according to acceptable medical and nursing standards for two of three clients' (#2 and #3) records reviewed. The findings include:

Client #2 began receiving services on June 24, 2008. Client #2's nurses notes dated June 24, 2008 indicated she had a history of falls. The vulnerable adult assessment dated June 24, 2008, did not address the history of falls. Client #2's record and incident/accident reports indicated client #2 fell on November 23, 2008, at 11 p.m. when she was getting out of her chair to get a drink. The one unlicensed staff on duty was unable to get the client up off the floor and called for "lift help" (this means calling the local fire department for assistance). Client #2 complained of right wrist pain at this time. The incident/accident report indicated the right wrist "is not suspected" to be broken". The incident accident report did not indicate the registered nurse was notified of the fall until November 24, 2009, at 11 a.m. when the registered nurse wrote a note in client #2's nurses notes. The registered nurse note dated November 24, 2008, indicated she had fallen two times this past weekend in her room and her wrist was sore. The next registered nurse note dated November 27, 2008, indicated the client's wrist was swollen, bruised and sore. On November 28, 2008, a registered nurse note indicated the right wrist was still bruised and swollen and the ace was rewrapped and client #2 indicated it was still sore. On December 1, 2008, client #2's right wrist was still sore and the nurse suggested she see a physician. The nurse's note dated December 2, 2008, indicated she returned from the physicians' office and had a fractured right wrist, had a splint on her right wrist and was to return to see the physician on December 5, 2008. Client #2's record lacked evidence she went to see the physician on December 5, 2008. Client #2's behavior observation record indicated she fell on January 29, 2009. There was an incident/accident report dated February 2, 2009 indicating client #2 fell in her apartment. Client #2's behavior observation record indicated on February 17, 2009, the client again fell in her apartment and the nurses note dated March 11, 2009, indicated the client fell and was sent to the hospital and admitted because of a fractured hip. Even though the registered nurse did a month assessment and a sixty day supervisory visit the registered nurse did not do a fall assessment to evaluate the cause of the falls or develop a plan to reduce the number of fall and reduce the risk of injury.

When interviewed on March 19, 2009, employee A and D confirmed they only stated the client had fallen but did not do a fall assessment to reduce the client's risk of future falls and the record lacked evidence the client had seen the physician on December 5, 2008.

Client #3 had a diagnosis of diabetes. Client #3's blood sugar flow sheet indicated on February 4, 10, 18, 23, and 28 2009, and March 2, 4, 4, 11, 13, 16, and 18 that her blood sugar was 506, 305, 355, 323, 340, 367, 312, 335, 302, 395, 333, and 333 respectively. The blood sugar flow sheet indicated client #3 received 8 units of Novolog insulin for each of the above blood sugars over 300.

The physicians orders dated September 25, 2008, stated client #3 was to receive 4 units of Novolog insulin for a blood sugar of 80 to 150, 6 units of Novolog insulin for a blood sugar of 151 to 200, 7 units of Novolog insulin for a blood sugar of 201 to 250, and 8 units of Novolog insulin for a blood sugar of 251 to 300. There was no physician's order for how much insulin was to be given if client #3's blood sugar was above 300. It was not until the surveyor questioned if there was a physicians order for how much insulin client #3 was to receive for a blood sugar above 300 and then asked the registered nurse to clarify with the physician how much insulin client #3 should receive for a blood sugar above 300 that the registered nurse called the physician to clarify the order. On March 20, 2009, the physician faxed the agency an order for Novolog 10 units of insulin for blood sugar for over 300.

When interviewed on March 19, 2009, employees A, D, and E confirmed there was no physicians order for how much insulin was to be given if the blood sugar was above 300. Employee A indicated the physician did not want her to have more than 8 units of sliding scale insulin and there was no documentation in the client's record to support this.

14. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to complete an accurate vulnerable adult assessment for one of three clients (#2) records reviewed. The findings include:

Client # 2 started receiving services on June 24, 2008. The nurse's note dated June 24, 2008, indicated client #2 had a history of falls. The vulnerable adult assessment dated June 24, 2008, did not address the history of falls. Client #2's record and incident reports indicated she had fallen on November 23, 2008, January 29, 2009, February 2 and 17, 2009 and March 11, 2009. Client #2's December 19, 2008, and February 19. 2009, assessments indicated the client had fallen but there was no assessment of vulnerability or plan of how to prevent further falls.

A draft copy of this completed form was left with Donna Johnson at an exit conference on March 24, 2009. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. Class F Home Care Provider general information is available by going to the following web address and clicking on the Class F Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

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).

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8714 3422

June 14, 2005

Amanda Johnson, Administrator
Suncrest Assisted Living
2400 Washington Avenue
Scanlon, MN 55720

Re: Results of State Licensing Survey

Dear Ms. Johnson:

The above agency was surveyed on April 4, 5, and 6, 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: Bill Klyve, President Governing Board
Case Mix Review File

CMR 3199 6/04

Assisted Living Home Care Provider

LICENSING SURVEY FORM

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

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

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

Name of ALHCP: SUNCREST ASSISTED LIVING

HFID # (MDH internal use): 23227

Dates of Survey: 04/04, 04/05, 04/06/05

Project # (MDH internal use): QL23227001

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.	_X_ Met ____ Correction Order(s) issued ____ Education provided

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

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

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

Survey Results:

_____ All Indicators of Compliance listed above were met.

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

Indicator of Compliance	Regulation	Correction Order Issued	Education provided	Statement(s) of Deficient Practice/Education:
#3	MN. Statute 144A.46 Subd. 5. (b) Prior criminal convictions		X	**Education:** Provided

A draft copy of this completed form was left with Donna Johnson, Director of Home Care at an exit conference on April 6, 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)