MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 2475

February 13, 2009

Deen Ajibola, Administrator
Amas Incorporated
3617 77th Avenue North
Brooklyn Park, MN 55443

Re: Results of State Licensing Survey

Dear Mr Ajibola:

The above agency was surveyed on December 1, 2, 3, and 5, 2008, 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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Deb Peterson, Office of the Attorney General

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: AMAS INCORPORATED

HFID #: 24324

Date(s) of Survey: December 1, 2, 3 and 5, 2008

Project #: QL24324003

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 _X_Correction Order(s) issued X___Education Provided **Expanded Survey** ____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 X___Education Provided **Expanded Survey** ____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** ____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 X___Education Provided **Expanded Survey** ____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** ____Survey not Expanded X__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 4668.0810 Subp. 5

<u>INDICATOR OF COMPLIANCE</u>: # 4

Based on record review and interview, the licensee failed to ensure documentation identified the client, which employee provided services and recorded entries in one of one client (#1) record reviewed. The findings include:

Client #1 began receiving services September of 2007. Client #1's record contained a health history summary dated September of 2007, a "maladaptive behaviors assessment" dated December 2, 2007 and pages of client progress notes dated November 9 through December 2, 2008, that lacked the signature and title of the person(s) making the entries. There also was a weight/vital signs/blood sugar log in the client's record where oxygen saturation percentages were documented in the blood sugar column instead; client #1's name was not on the form.

When interviewed December 2, 2008, the director of residential services confirmed the client's name and the employee signatures and titles were absent on these forms in client #1 record.

2. MN Rule 4668.0815 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to have a registered nurse (RN) establish a service plan for one of one client (#1) record reviewed. The findings include:

Clients #1's service plan dated September of 2007, included medication administration and daily care services. There was no individualized evaluation of the client's needs by a registered nurse and no evidence that a registered nurse established the service plan.

When interviewed December 2, 2008, the director of residential services was unable to find any evaluation by a registered nurse. He confirmed there was no evidence of an individualized evaluation nor that a registered nurse established the service plan.

3. MN Rule 4668.0815 Subp. 4

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure service plans were complete for one of one client (#1) record reviewed. The findings include:

Client #1's current service plan dated September of 2008, included assistance with laundry, housekeeping, medication, daily cares, administration and bath/shower. The service plan did not identify the person(s) providing the service. It read "trained medication staff" or "facility staff" with no other information. There was no indication as to what "daily cares" included.

Client #1's progress notes were employee documentation of client #1's condition. The notes dated November 5, 6, 11, 14, 20, 24 and 29, 2008, read that client #1 had episodes of incontinence. During a home visit December 3, 2008, this reviewer observed a wet bedspread where client #1 was seated. There was no assistance with toileting or plan for management incontinence on client #1's service plan. The name and telephone number of the person to contact in case of a change in the client's condition or an emergency and the contingency plan for essential and non-essential services were not included in client #1 service plan.

When interviewed December 2, 2008, the director of residential services confirmed client #1 service plan was incomplete.

4. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on observation, interview and record review the licensee failed to provide written instructions and documentation of demonstrated competency for delegated nursing procedures for one of one client (#1) record reviewed that received delegated nursing procedures. The findings include:

On December 3, 2008, client #1 was observed to have oxygen administered and oxygen saturation level checked by employee B, an unlicensed staff. There were no oxygen saturation monitoring or oxygen

administration instructions at client #1's home, in his record, or at the licensee's office. There was not a competency evaluation in employee B record for oxygen saturation monitoring or oxygen administration. When interviewed December 3, 2008, employee B stated she routinely assisted client #1 with application/administration of oxygen and did oxygen saturation rate checks on client #1 as well.

When interviewed December 2, 2008, the registered nurse (RN) stated that she had provided training on oxygen and respiratory needs and had turned it in to the licensee office. The RN stated she had trained staff to check oxygen saturation levels two times per day and document it on the vital sign sheet. When interviewed December 3, 2008, the program coordinator stated the registered nurse (RN) had taught staff how to take blood pressures, perform nebulizer treatments and oxygen saturation monitoring and watched staff do it afterwards but there were no written instructions for the procedures.

5. MN Rule 4668.0840 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed persons who performed assisted living home care services successfully completed training or demonstrated competency in the required topics, for one of one unlicensed employee (B) record reviewed. The findings include:

Employee B was hired June of 2007, as an unlicensed direct care staff. There was no record of training for observing, reporting, and documenting client status and the care or services provided; maintaining a clean, safe, and healthy environment; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family in her personnel records.

When interviewed December 2, 2008, the registered nurse stated she had not taught these topics, she thought the company had taught them to the unlicensed personnel. When interviewed December 2, 2008, the director of residential services confirmed employee B's training had not included these topics of core training.

6. MN Rule 4668.0845 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise unlicensed personnel who perform services that require supervision for one of one client (#1) record reviewed. The findings include:

Client #1 received daily medication administration from unlicensed staff since admission September of 2007. There was no evidence of RN supervisory visits that verified that the work was being performed adequately, identify problems, and to assess the medication administration provided to the client. There was a registered nurse supervisory visit dated November 28, 2008, stated that medication administration was "not applicable." There was no indication that any cares were observed.

When interviewed December 3, 2008, the resident coordinator stated that the nurse did not observe the staff do cares or give medications but instead interviewed the client and then asked the staff how much assistance was being given for daily cares.

7. MN Rule 4668.0855 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) conducted a nursing assessment of the client's functional status and need for medication administration for one of one client (#1) record reviewed. The findings include:

Client #1's service plan dated September of 2008, noted he received weekly medication set-up and medication administration. There was no evidence of a nursing assessment of the client's functional status and need for medication administration.

When interviewed December 2, 2008, the director of residential services verified that the nursing assessment had not been conducted.

8. MN Rule 4668.0855 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview, the licensee failed to provide medications that were set up by a registered nurse (RN), pharmacist or physician for the unlicensed personnel to provide medication administration for one of one client (#1) record reviewed. The findings include:

During a home visit December 1, 2008, employee B, an unlicensed direct care staff that administered medications, was observed checking client #1's medications for administration. When interviewed December 1, 2008, employee B stated that she had set up the medications for all four clients.

When interviewed December 1, 2008, the director of residential services stated employee B had set up the medications and the registered nurse (RN) had checked the medication set ups.

When interviewed December 2, 2008, the RN stated that she had come in and checked the medications after they were set up by employee B.

9. 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 one of one client (#1) record reviewed. The findings include:

Client #1 received central storage of medication and medication administration since admission September of 2007. The medication administration records (MAR) for November 1 through 30, 2008 and December 1 and 2nd, 2008, listed "Trazodone 12.5" milligrams (mg) daily. The "daily" had been crossed off and PRN (as needed) written in. There was no indication of the date the adjustment to "PRN" on the MAR was made nor was there evidence the Tazodone had ever been administered during

those dates. There was no order in client #1's record that changed the Trazodone 12.5 mg to PRN. There was no documentation in the client record as to why the medication was not given as ordered or any follow up procedures if provided.

Client #1's November 2008 MAR listed Lorazepam 1 mg tablet three times daily. "PRN" was hand written over the noon dose and "1 tablet twice daily as needed since 10/27/08" was written in by the registered nurse. Also, the Clonazepam 8 a.m. dose was documented as given thirteen times of thirty, the noon dose was not given for thirty days and the evening dose was given twenty- five days of thirty. There was no indication of the date the adjustment to "PRN" on the MAR was made. There was no order in client #1's record that changed the Clonazepam 1 mg. to PRN. There was no documentation in the client record as to why the medication was not given as ordered or any follow up procedures if provided.

When interviewed December 1, 2008, employee B, an unlicensed staff stated that she had written PRN on client #1's MAR's, crossed out the pharmacy label changing the Clonazepam 1 mg from three times per day, to PRN at the nurses' direction.

10. MN Rule 4668.0860 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview the licensee failed to have written prescriber orders for medications for one of one client (#1) record reviewed. The findings include:

Client #1's medication administration records (MAR) for November and December 2008 indicated the client received medication administration from facility staff. The medications administered included Methadone 30 to 40 milligrams (mg) daily, Depakene 1000 mg. twice daily and clonazepam 1 mg. twice daily with and additional PRN dose at noon.

Client #1's November 2008 MAR was typed to read "Methadone 10 mg. tablets take four tablets by mouth every morning." The 40 mg. dose was crossed out by hand and 30mg. was written with a date of September 29, 2008, as the date of the order change, and was signed by the registered nurse. The December 2008 MAR read "Methadone 10 mg. tablets take four tablets by mouth every morning" and had Methadone 40 mg. daily signed as administered on December 1, 2 and 3rd, 2008. December 1, 2008, the reviewer observed the medications for client #1 and Methadone 30 mg. was provided as liquid solution in small bottles for daily administration and not Methadone 40 mg. as was initialed on the medication administration record. There were no physician's orders for Methadone 40 mg or 30 mg per day in tablet or liquid form.

The November and December 2008 MAR 's listed Depakote ER 500 mg. two tablets (1000 mg.) twice daily was given for a total of 2000 mg. daily. The last physician's order that was in client #1's record, faxed from the pharmacy October 15, 2008, was for Depakene 250 mg. take 3 capsules (750mg.) three times daily which would equal 2250 mg. daily. Hand written over the faxed order was "1000 BID" (twice daily) with no date or signature of who made the addition. The client also had a physician orders sheet that was discharge orders faxed to the facility December 2, 2008. The orders read "New Discharge Med Orders. Medications Prior To Admission- To Be Resumed." There was no order for Depakote included.

Client #1's November 2008 medication administration record had listed Clonazepam 1 mg tablet three times daily. PRN was written over the noon dose and "1 tablet twice daily as needed since 10/27/08" had been written in by the registered nurse. There was no corresponding physician's order in the record for the change from Clonazepam 1 mg PRN. The client's physician orders sheet that was discharge orders faxed to the facility December 2, 2008, that read "New Discharge Med Orders. Medications Prior To Admission- To Be Resumed" contained an order for Clonazepam 1 mg. three times daily. The prior order faxed from the pharmacy October 15, 2008, was for Clonazepam 1 mg twice daily PRN. Hand written over the faxed order was "0.5 mg BID as needed" (twice daily) with no date or signature of who made the addition. Added in hand writing that was unsigned but dated December 2, 2008, was "1 mg P.O. T.I.D." (By mouth, three times daily.)

When interviewed December 2, 2008, the registered nurse (RN) stated she had not realized there were no current orders for Methadone, Depakote or Clonazepam.

11. MN Rule 4668.0865 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview, the licensee failed to have a registered nurse (RN) conduct a nursing assessment of the client's need for central medication storage for one of one client (#1) record reviewed. The findings include:

Client #1 received central storage, medication set up, and medication administration since admission September of 2007. Client #1's record lacked an assessment of the client's need for central storage of medication and the service plan lacked central storage of medications.

During home visit December 1, 2008, reviewer observed that client #1's medications were locked in the kitchen cabinet and this was explained as central storage. The licensee indicated that central storage was provided on the license application.

When interviewed December 2, 2008, the director of residential services confirmed there was no assessment by the registered nurse for the need for central medication storage and had not been aware of this requirement.

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 for the control of medications for one of one (#1) client record reviewed that receive central storage of medications. The findings include:

During a home visit December 1, 2008, employee B, an unlicensed direct care staff that administered medications, was observed checking client #1's medications for administration. When interviewed December 1, 2008, employee B stated that she had set up the medications for all four clients.

When interviewed December 1, 2008, the director of residential services stated employee B had set up the medications and the registered nurse (RN) had checked the medication set ups.

When interviewed December 2, 2008, the RN stated that she had come in and checked the medications after they were set up by employee B.

Client #1 received central storage of medication and medication administration since admission September 19, 2007. The medication administration records (MAR) for November 1 through 30, 2008 and December 1 and 2nd, 2008, listed "Trazodone 12.5" milligrams (mg) daily. The "daily" had been crossed off and PRN (as needed) written in. There was no indication of the date the adjustment to "PRN"on the MAR was made nor was there evidence the Tazodone had ever been administered during those dates. There was no order in client #1's record that changed the Trazodone 12.5 mg to PRN. There was no documentation in the client record as to why the medication was not given as ordered or any follow up procedures if provided.

Client #1's November 2008 MAR listed Lorazepam 1 mg tablet three times daily. "PRN" was hand written over the noon dose and "1 tablet twice daily as needed since 10/27/08" was written in by the registered nurse. Also, the Clonazepam 8 a.m. dose was documented as given thirteen times of thirty, the noon dose was not given for thirty days and the evening dose was given twenty- five days of thirty. There was no indication of the date the adjustment to "PRN"on the MAR was made. There was no order in client #1's record that changed the Clonazepam 1 mg. to PRN. There was no documentation in the client record as to why the medication was not given as ordered or any follow up procedures if provided.

Client #1's November 2008 MAR was typed to read "Methadone 10 mg. tablets take four tablets by mouth every morning." The 40 mg. dose was crossed out by hand and 30mg. was written with a date of September 29, 2008, as the date of the order change, and was signed by the registered nurse. The December 2008 MAR read "Methadone 10 mg. tablets take four tablets by mouth every morning" and had Methadone 40 mg. daily signed as administered on December 1, 2 and 3rd, 2008. December 1, 2008, the reviewer observed the medications for client #1 and Methadone 30 mg. was provided as liquid solution in small bottles for daily administration and not Methadone 40 mg. as was initialed on the medication administration record. There were no physician's orders for Methadone 40 mg or 30 mg per day in tablet or liquid form.

The November and December 2008 MAR 's listed Depakote ER 500 mg. two tablets (1000 mg.) twice daily was given for a total of 2000 mg. daily. The last physician's order that was in client #1's record, faxed from the pharmacy October 15, 2008, was for Depakene 250 mg. take 3 capsules (750mg.) three times daily which would equal 2250 mg. daily. Hand written over the faxed order was "1000 BID" (twice daily) with no date or signature of who made the addition. The client also had a physician orders sheet that was discharge orders faxed to the facility December 2, 2008. The orders read "New Discharge Med Orders. Medications Prior To Admission- To Be Resumed." There was no order for Depakote included.

Client #1's November 2008 medication administration record had listed Clonazepam 1 mg tablet three times daily. PRN was written over the noon dose and "1 tablet twice daily as needed since 10/27/08" had been written in by the registered nurse. There was no corresponding physician's order in the record for the change from Clonazepam 1 mg PRN. The client's physician orders sheet that was discharge orders faxed to the facility December 2, 2008, that read "New Discharge Med Orders. Medications Prior To Admission- To Be Resumed" contained an order for Clonazepam 1 mg. three times daily. The prior order faxed from the pharmacy October 15, 2008, was for Clonazepam 1 mg twice daily PRN. Hand written over the faxed order was "0.5 mg BID as needed" (twice daily) with no date or signature of who

made the addition. Added in hand writing that was unsigned but dated December 2, 2008, was "1 mg P.O. T.I.D." (By mouth, three times daily.)

When interviewed December 1, 2008, the director of residential services confirmed there was not an effective system to control medications.

13. MN Rule 4668.0865 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on observation and interview, the licensee failed to provide a separate locked compartment that was permanently affixed to the physical plant for storage of schedule II drugs. The findings include:

During a tour of the medication storage area on December 1, 2008, it was observed that the schedule II drugs were placed in a separately locked container which was not permanently affixed. Methadone was observed stored in this container.

When interviewed December 1, 2008, the director of residential services confirmed that the controlled substance was not stored in a locked container that was permanently affixed.

14. MN Statute 144A.44 Subd. 1 (2)

INDICATOR OF COMPLIANCE: #2

Based on observations, record review and interview the facility failed to provide daily housekeeping for one of one client (#1) record reviewed. The findings include:

Client #1's service plan dated September of 2008, indicated daily housekeeping was to be provided by facility staff. During a home visit with client #1 December 1, 2008, this reviewer observed multiple dark brown spots and smears on the cream colored carpet, on a chair and a towel in the client's room.

When interviewed during the home visit, client #1 stated that the brown spots were "feces – I had an accident after I fell." An incident report dated November 29, 2008, indicated the client fell at 2:20 a.m. after he went to the bathroom.

When interviewed December 2, 2008, the Director of Residential Services stated he had been in client #1's room late the night before cleaning, so there was no more stool in the carpeting and chair. When observed again December 3, 2008, at 1:30 p.m. client #1's carpet contained multiple lighter brown spots, the chair and towel were absent. The bed was wet in a circular darkened spot on the bedspread about 16 inches in diameter with what appeared to be urine.

A draft copy of this completed form was left with Lamar Hodges, Director of Residential Services, at an exit conference on December 5, 2008. 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

July 28, 2008

Deen Ajubola, Administrator
Amas Incorporated
3617 77th Avenue North
Brooklyn Park, MN 55443

Re: Telephone Interview

Dear Mr. Ajubola:

The information discussed during a telephone interview conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on April 29, 2008 is summarized in the enclosed documents listed below:

Telephone Interview and Education Assessment form
A summary of the items discussed during the phone interview and a listing of the education provided during the interview

Resource Sheet for Home Care Providers
A listing of web-sites and documents useful to home care providers in assuring compliance with home care regulations

Please note, it is your responsibility to share the information contained in this letter and the information from this interview with your direct care staff and the President of your facility's Governing Body.

If you have any questions, please feel free to call our office at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

CMR TELEPHONE 03/08

Class A and Class F Home Care

Telephone Interview and Education Assessment

Registered nurses from the Minnesota Department of Health (MDH) use this form to document telephone interviews and education of newly licensed Class F and Class A (licensed only) Home Care Providers as well as other providers who have not been surveyed by Case Mix Review staff.

Licensing requirements listed below were reviewed during a telephone interview. Information from this interview along with other data will be considered when making decisions regarding the timing of an on site survey. The noted topics were discussed during the telephone interview and education was provided in the checked areas.

Name of Home Care Licensee: Amas Incorporated

HFID #: 24324 Type of License: Class F Home Care

Date of Interview: April 29, 2008

Interview Topic	Item Discussed	Education Provided
Access to information	☒ Home Care Rules and Statutes	☒ Web address for Home Care Rules and Statutes was sent (MN Statute §144A and MN Rule 4668) ☒ Web address for Vulnerable Adult Act was sent (MN Statute §626.557) ☐ Web address for Maltreatment of Minors Act was sent (MN Statute §626.556) ☒ Board of Nursing web address was sent Sent via: E-mail ☒ Basic Education Provided
Client Needs	☒ Care needs of clients	☐ Home Care licensee is required to have staff sufficient in qualifications and numbers to meet client needs (MN Rule 4668.0050) ☒ Basic Education Provided

Interview Topic	Item Discussed	Education Provided
Home Care Bill of Rights	☒ Bill of Rights given to clients	☐ Current and appropriate version of home care bill of rights required Minnesota Dept. of Health web-site ☒ Basic Education Provided
Advertising	☒ Advertising should reflect services provided	☐ Includes all forms of advertising MN Rule 4668.0019 ☒ Basic Education Provided
Unlicensed personnel (ULP) who provide direct care	☒ Training needed for ULP to be qualified to provide direct care ☒ Ongoing education needed for unlicensed personnel	☐ Initial training needed MN Rule 4668.0835 Subp. 2 (Class F) ☐ Competency testing required MN Rule 4668.0835 Subp. 3 (Class F) ☐ Inservice training MN Rule 4668.0835 Subp. 3 (Class F) ☒ Ongoing infection control training needed MN Rule 4668.0065 Subp. 3 ☒ Basic Education Provided
Unlicensed personnel (ULP) and medication administration	☒ Training required ☒ Insulin administration by unlicensed personnel	☐ Difference between medication administration and assistance with medication administration. MN Rule 4668.0003 Subp. 2a and Subp. 21a ☐ Medication reminders – a visual or verbal cue only. MN Rule 4668.0003 Subp. 21b ☐ ULP limitations with insulin administration MN Rule 4668.0855 Subp. 6 (Class F) ☐ Prescriber orders required MN Rule 4668.0860 Subp. 2 (Class F) ☒ Basic Education Provided

Interview Topic	Item Discussed	Education Provided
Role of registered nurse (RN) and licensed practical nurse (LPN)	☒ Need to verify licenses of nurses ☒ RN does assessments ☐ LPN does monitoring	☐ Difference between RN and LPN role MN Rule 4668.0820 Subp. 2 (Class F) and Minnesota Nurse Practice Act ☐ Points at which RN assessment is needed - Class F requirements ☐ RN assessment and change in condition MN Rule 4668.0845 Subp. 2 (Class F) ☒ Basic Education Provided
Supervision of unlicensed personnel (ULP)	☒ Requirements for supervision and monitoring of unlicensed personnel	☒ RN supervision and LPN monitoring of unlicensed personnel ☒ Timing of supervision and monitoring MN Rule 4668.0845 (Class F) ☒ Basic Education Provided
Service plan or agreement	☒ Contents of Service Plan or Agreement ☒ Person who prepares service plan	☐ Differentiate between licensee service plan and county service plan ☐ Required components of service plan ☐ Need to review service plan ☒ Basic Education Provided MN Rule 4668.0815 (Class F)
Protection of health, safety and well being of clients	☒ Background studies for all staff ☒ Assessment of vulnerability for all clients	☐ Background studies not transferable ☐ Only DHS background study accepted MN Statute §144A.46 Subd. 5 ☐ Plan to address identified vulnerabilities required MN Statute §626.557 Subd. 14b ☒ Basic Education Provided
Infection control	☒ Tuberculosis screening prior to direct client contact	☐ System for follow up on TB status after hire MN Rule 4668.0065 Subps. 1 & 2 ☐ Yearly infection control inservice required for all staff including nurses MN Rule 4668.0065 Subp. 3 ☒ Basic Education Provided

Interview Topic	Item Discussed	Education Provided
Assisted Living	☒ Arranged providers for assisted living required to follow 144G	☐ Uniform Consumer Information Guide must be given to all prospective clients MN Statute 144G.03 Subd. 2b9 ☒ Basic Education Provided

The data used to complete this form was reviewed with Lamar Hodges, Program Manager; Sade Adenusi, RN/DON, during a telephone interview on April 29, 2008. A copy of this Telephone Interview and Education Assessment form will be sent to the licensee. Any questions about this Telephone Interview and Education Assessment form should be directed to the Minnesota Department of Health, (651) 201-4301. This form will be posted on the MDH web-site. Home care provider general information is available by going to the following web address and clicking on the appropriate home care provider link:

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

Statutes and rules can be viewed on the internet:
http://www.revisor.leg.state.mn.us/stats - for Minnesota Statutes

http://www.revisor.leg.state.mn.us/arule/ - for Minnesota Rules