MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9971 7636

December 30, 2008

Patrick Ugiagbe, Administrator
Moment of Impact
8456 Brunswick Court North
Brooklyn Park, MN 55443

Re: Results of State Licensing Survey

Dear Mr. Ugiagbe:

The above agency was surveyed on October 10, 13, and 15, 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: MOMENT OF IMPACT INC

HFID #: 24556

Date(s) of Survey: October 10, 13 and 15, 2008

Project #: QL24556003

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 _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

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** ____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

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 _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

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** _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: ___ All Indicators of Compliance listed above were met.

1. MN Rule 4668.0030 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to ensure that the Minnesota Home Care Bill of Rights clients given to clients was current for two of two clients' (#1, and #2) records reviewed. The findings include:

When interviewed October 13, 2008, the administrator confirmed the licensee did not have a copy of the most current Minnesota Home Care Bill of Rights, and that the clients had not been given a copy of the current Minnesota Home Care Bill of Rights.

2. MN Rule 4668.0030 Subp. 4

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to ensure that in addition to the Minnesota Home Care Bill of Rights, clients were given contact information for the Office of Health Facility Complaints for two of two clients' (#1, and #2) records reviewed. The findings include:

Clients #1 and #2 began receiving services June 8, 2007, and October 1, 2008, respectively. Clients #1 and #2 had been given copies of the bill of rights that lacked the telephone number, mailing address, and the current street address of the Office of Health Facility Complaints.

When interviewed October 13, 2008, the administrator confirmed the clients had been given a bill of rights that did not include the Office of Health Facility Complaints information on it.

3. MN Rule 4668.0070 Subp.2

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to maintain complete records for one of two employee's (B) records reviewed who provided medication administration. The findings include:

Employee B began employment January 30, 2007, as an unlicensed person staff providing medication administration for client #1. Employees B's training records lacked any competency qualifications for medication administration.

When interviewed October 10, 2008, employee B stated he received training before he started working with client #1 which could not be verified by his employee record.

4. 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 the client's service plan for one of two clients' (#1) records reviewed. The findings include:

Client #1's "Client Agency Service Agreement June 8, 2007" stated service to be provided was registered nurse 40 units daily =10 hours per day and Personal Care Attendant 96 units daily =24 hours per day. Client #1's "Home Health Certification and Plan of Care included 48 units of Registered Nurse daily for 365 days per year" for June 1, 2008 to May 31, 2009" (4 units per hour =12 hours per day). When interviewed, October 10, 2008, client #1 stated that he has had" the same personal care attendant for twenty four hours per day for seven days in a row – now isn't there a law against that? I get ten hours of nursing per day and don't ever see a registered nurse. I'm asking you what is going on because I can't move out of this bed and see who is doing what. Also since I am in this bed and rely on the staff I'm afraid to say something because you don't know what will happen if you say something?"

When interviewed October 13, 2008 the administrator stated there had not been a registered nurse since August 30, 2008 or so. The last documentation by the registered nurse was August 13, 2008 and the RN verified per telephone that that was her last day.

5. MN Rule 4668.0810 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to have all entries in the client record signed and dated for two of two clients' (#1 and #2) records reviewed. The findings include:

Client #1 began receiving services June 8, 2007. Client #1's "Nursing Comprehensive Admission Data Collection and Assessment" was four pages and only the first page was partially completed and it lacked

a signature. Client #1's "Nursing Comprehensive Admission Data Collection and Assessment and 24 Hour Admission Documentation" stated client #1 had a stage II ulcer on his coccyx and lacked the date, name, and title of the person making the entries. Client #2 started receiving services October 1, 2008, and every daily charting entry from October 1 to October 13, 2008 lacked authentication with the name, and title of the person making the entries.

6. MN Rule 4668.0810 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed ensure complete client records for one of two clients' (#2) records reviewed. The findings include:

Client #2's "Weekly Charting and Flow Sheet" had space to document services for bathing, dressing, grooming, oral hygiene, peri cares and nail care to hands and feet by the unlicensed staff for which there was no documentation for October 6, 11 and 12, 2008. Client #2, a diabetic, had no staff signature for the diabetic hand or foot nail care but "hands & feet" was documented. Client #2's October 1, 2008, service plan included medication and activity of daily living assistance multiple times daily. When interviewed, October 10, 2008, the licensed practical nurse (A) stated she didn't know that there were blanks on the forms and verified the client record was incomplete.

7. MN Rule 4668.0815 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview the licensee failed to ensure that a registered nurse (RN) completed an individualized evaluation of the client's needs no later than two weeks after initiation of assisted living home care services for two of two clients' (#1 and #2) records reviewed. The findings include:

Client's #1 and #2 began receiving services on June 8, 2007, and October 1, 2008, respectively. There was no evidence of individualized evaluations of the client's needs completed by a registered nurse. Client #1's "Nursing Comprehensive Admission Data Collection and Assessment" was four pages long and only the first page was partially completed and lacked a signature. Client #1's "24 Hour Documentation Begins 4 Hours After Admission" was partially completed and had a place for a nurse signature which was blank and not dated.

Client #2 had a "Moment of Impact, Inc Initial RN Assessment/Evaluation for Home Care Services" signed by the licensed practical nurse October 1, 2008.

When interviewed October 13, 2008 the licensed practical nurse stated that the administrator asked for her help with training, medication setups, and the service plans until he hired a new registered nurse and verified that she had done assessments during this time. When interviewed October 13, 2008, the administrator stated there had not been a registered nurse since August 30, 2008 or so. The last documentation by the registered nurse was August 13, 2008 and the RN verified per telephone that that was her last day.

8. MN Rule 4668.0815 Subp. 4

INDICATOR OF COMPLIANCE: # 1

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

Clients #1 had a service plan without any date or any signatures and lacked who would supervise the delegated nursing tasks, the fees and the action to be taken if essential services could not be provided. Client #1 also had a service "agreement" dated June 8, 2007, which did not identify what services were provided or what persons provided the services or the frequency of supervision or monitoring of delegated nursing tasks and lacked a complete contingency plan.

Client #2 service plan dated October 1, 2008, lacked the frequency of each service, who was to provide the service, the schedule of supervision and the action to be taken if essential services could not be provided.

When interviewed October 13, 2008 the administrator confirmed the service plans were incomplete.

9. MN Rule 4668.0835 Subp. 2

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to ensure that unlicensed persons who provided direct care were qualified for two of two employees' (B and D) records reviewed. The findings include:

Employee B began employment January 30, 2007, and employee D began employment September 26, 2008, as direct care staff providing medication administration and bathing for client #1 and client #2 respectively. Employees B and D's training records lacked evidence of any training and competency in the required curriculum: observation, reporting and documentation of client status and care or services provided, basic infection control, maintenance of a clean safe and health environment, basic elements of body functioning and changes in body function to report to health care professionals, physical, emotional and developmental needs of clients, ways to work with clients who have problems in these areas including respect for client's property and the client's family.

When interviewed October 10, 2008, employee B stated he received training before he started working with client #1 for this licensee (which could not be verified by his employee record).

When interviewed October 13, 2008, employee D stated she had received training from the licensed practical nurse who taught her about the care needs for client #2 (which could not be verified by her employee record).

When interviewed October 13, 2008 the administrator said the "registered nurse left August 30, 2008 or so let's just say" and we have not had a registered nurse (RN) until today. The last documentation the reviewer found by the RN was August 13, 2008. When interviewed per telephone October 14, 2008 the previous RN verified her last day of employment was August 13, 2008.

10. MN Rule 4668.0835 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to ensure eight hours of in-service training was completed for one of two unlicensed employees' (B) records reviewed who provided direct care. The findings include:

Employee B began employment January 30, 2007, and there were no records of inservice training available on October 13, 2008.

When interviewed October 13, 2008, the administrator stated he was unaware of this requirement and did not have a copy of the home care rules.

11. 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 performed services that require supervision for two of two clients' (#1 and #2) records reviewed. The findings include:

Client's #1 and #2 began receiving services that required supervision including medication administration on June 8, 2007, and October 1, 2008, respectively. There was no documentation in client #1's record of an RN supervisory visit within 14 days after initiation of services. Client #1 had three RN supervisory visits October 11, 2007, March 15, 2008 and April 15, 2008. The March 15 and April 15, 2008 visits supervised personal cares and rapport with the client and did not supervise medication administration according to the documentation.

There was no documentation in client #2's record of a supervisory visit by an RN within 14 days after initiation of services.

When interviewed October 13, 2008, the licensed practical nurse (A) stated that the administrator asked her to help him until he got a registered nurse (RN) since the RN left in August 2008.

When interviewed per telephone October 14, 2008, the previous RN verified her last day of employment was August 13, 2008.

12. MN Rule 4668.0855 Subp. 4

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure unlicensed staff received instruction by a registered nurse related to medication administration for one of two unlicensed employees' (D) records reviewed who administered medications. The findings include:

Employee D began employment September 26, 2008 as a direct care staff providing medication administration for client #2. Employees D's training records lacked any competency qualifications for medication administration.

When interviewed October 13, 2008, employee D stated she received training from the licensed practical nurse (LPN) before she started medication administration. When interviewed, October 13, 2008, the LPN stated that the agency had not had a registered nurse since August 2008.

13. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE: # 6

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

Client #1, #2 and #3's October 2008 medication administration records had blank spaces where medication administration were to be documented and there was no documentation regarding the medications not being administered.

Client #1 was missing documentation of Lasix 160 mg on October 5, 6, and 9, 2008, vitamin C 500 mg one dose on October 7 and two doses on October 9, 2008 and nystatin powder twice daily application was not documented on October 2, 3, 4, 5, 6, 7, 8, 9 and 10, 2008, no medication administration was documented for September 13, 2008, and ten doses of medication for 4:00 p.m. and 8:00 p.m. were not documented for September 14, 2008. When interviewed October 10, 2008, the licensed practical nurse (C) stated sometimes client #1 doesn't let us do his medications and he yells or throw things.

Client #2's October 2008 medication administration record lacked documentation nine times for the NovoLog Insulin 8 units between October 1 and October 13, 2008. When interviewed October 13, 2008, the licensed practical nurse stated she didn't know that there were blanks on the forms for client #2.

Client #3's October 2008 medication administration record lacked documentation for baclofen 20 mg three times per day, baclofen 10mg daily and Adderall 20 mg daily from October 1 to 13, 2008. When interviewed October 13, 2008, the licensed practical nurse stated she didn't realize they missed transcription of the baclofen and Adderall to the October 2008 medication administration record for Client #3 and therefore didn't realize Client #3 was not receiving the medications prescribed.

14. MN Rule 4668.0860 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview the licensee failed to have written prescriber orders for medications for two of three clients' (#2 and #3) records reviewed. The findings include:

Clients #2 and #3 stated they received medications daily from the personal care attendants (PCA) or the licensed practical nurse (LPN). Clients #2 and #3's medication administration records document daily medication administration by the PCA and LPN since admission October 1, 2008, and September 20, 2008, respectively.

Client #2 had physician's orders from the prior nursing home stay dated August 25, 2008, "these orders are good for 45 days." Client #2 received anti-spasmodic, anti-anxiety medications and sliding scale insulin.

Client #3's physician's orders were dated September 16, 2008, and were a faxed copy from a family medicine clinic with no indication how long they were valid. Client #3 received anti-depressant, anti-hypertensive, bladder and spasm control medications, vitamin and mineral supplements. When client #3's record was reviewed, the LPN (A) stated she was not sure if the clinic fax was client #3's physician's orders as she had not admitted her.

When interviewed October 13, 2008, the licensed practical nurse (LPN) said the pharmacy gets orders from where the client's have come from and that is how we get our medications.

15. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide care according to acceptable nursing standards and did not have all medications correctly set up and administered for two of three clients' (#2 and #3) records reviewed. The findings include:

Client #2 had physician's orders dated October 1, 2008 for vaginal suppositories to be given for three days (October 1, 2, and 3, 2008). During reviewer home visit October 13, 2008 all 3 suppositories were observed in client #2's medication storage box and the medication set up box was noted to have four less pills (1:Baclofen 20 mg and 3: Senna laxative 8.6 mg tablets) for October 14, 2008 than every other day of the week. When interviewed October 13, 2008 the licensed practical nurse (LPN) stated she had not seen the admission order for these suppositories and therefore the order was not written on client #2's medication administration record which was how they were missed and the LPN stated that she had missed putting those four pills in the medication set-up container.

When interviewed, client #2 requested to be given the vaginal suppository stating, "I feel itchy I think I have a yeast infection I want the doctor to know I would like it." Reviewer requested that the LPN call the physician and report the medication error of failure to give the vaginal suppositories and the client's desire to receive them**.**

Client #3 had physician's orders from a clinic dated September 16, 2008, which included eighteen oral medication prescriptions of which sixteen prescription medications were given daily and two prescriptions were for pro re nata (p.r.n.) medications. When observed during a home visit October 13, 2008, all of client #3's medications had been received from the pharmacy and were in the medication storage box. The medications were set up for the week in a plastic container with four spaces for holding medications for each day and the reviewer noted there were five less pills than she should have daily. The reviewer matched the pills with the medication cards and noted it was Baclofen 10mg dose was missing once per day, Baclofen 20mg dose was missing three times per day and Adderall 20mg tab daily was missing.

When interviewed, October 13, 2008, the licensed practical nurse (LPN) stated the baclofen and Adderall medications were not written on client #3's medication administration record which was how they were missed. She further stated that there appeared to be pages missing as there was no medication administration record page for either of these medications or for the p.r.n. medications and therefore client #3 had not received either medication for October.

When interviewed, client #3 and she requested that the physician be notified that she wasn't sure if she wanted the Adderall as she didn't feel different without it for two weeks but that her left side was her weaker side and her left hand was more contracted since she had not received the baclofen for two weeks. Reviewer requested that the LPN call the physician and report the medication errors of failure to give the baclofen and Adderall medications which had not been written on client#3's medication administration record.

When interviewed October 15, 2008, the LPN (A) stated that she had administered the medications to Client #2 and #3 after contacting the physicians and getting new orders for the vaginal suppositories for client #2 and baclofen and Adderall for client #3. The new telephone orders and the medication administration records for Client #2 and Client #3 were reviewed and the new telephone orders had been transcribed to the medication administration records.

16. MN Statute §144A.46 Subd. 5(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure background studies were completed for one of two employees' (C) records reviewed who provided direct client care. The findings include:

There was no evidence of a background study for employee C available.

When interviewed October 13, 2008, the administrator stated he had not been aware the background study was missing for employee C.

17. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to develop an individual abuse prevention plan for one of two clients (#2) records reviewed. The findings include:

Client #2's record included a blank Individual Abuse Prevention Assessment and Plan. When interviewed October 13, 2008, the licensed practical nurse verified the assessment of vulnerability had not been completed.

A draft copy of this completed form was left with Patrick Ugiagbe, Administrator, at an exit conference on October 15, 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

Certified Mail # 7004 1350 0003 0567 0278

September 10, 2007

Patrick Ugiagbe, Administrator
Moment of Impact Inc
8456 Brunswick Court North
Brooklyn Park, MN 55443

Re: Results of State Licensing Survey

Dear Mr. Ugiagbe:

The above agency was surveyed on July 30, 31, and August 2 and 6, 2007, 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.

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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

01/07 CMR3199

Class F Home Care Provider

LICENSING SURVEY FORM

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HFID #: 24556

Date(s) of Survey: July 30, 31 and August 2 and 6, 2007

Project #: QL24556002

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** __X__ Met ____ Correction Order(s) issued ____ 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** ____ 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** ____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 ____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 4668.0065 Subp. 1

<u>INDICATOR OF COMPLIANCE</u>: # 5

Based on record review and interview, the licensee failed to ensure that tuberculosis screening was completed for two of four employees (C and D) records reviewed. The findings include:

Employee C began employment and direct care June of 2007. Her record contained documentation of Mantoux testing given February 6, 2006. There were no documented negative or positive results in the record.

Employee D began employment and direct care August of 2006. His record indicated he had a positive reaction to a Mantoux test in 1998 and contained a copy of a chest x-ray report dated February 24, 2000, which was negative for tuberculosis. There were no other chest x-ray reports in the record.

On interview August 2, 2007, the administrator and the registered nurse confirmed the findings and stated they would began the process of obtaining required documentation to ensure tuberculosis screening are documented accurately on each employee. .

2. MN Rule 4668.0070 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview the licensee failed to provide a job description for four of four employees' (A, B, C and D) records reviewed. The findings include:

Employees A and C were hired July of 2007 and June of 2007 respectively. Both functioned as a licensed direct care staff and did not have job descriptions available. When interviewed July 31, 2007, employee A stated she did not realize she needed to have a job description.
Employees B and D were hired May of 2007 and August of 2006, respectively as direct care staff. Employee B performed client care duties only and employee D preformed direct care and administrative duties. When interviewed July 31, 2007, the administrator confirmed that no job descriptions were available.

3. MN Rule 4668.0805 Subp. 1

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that each employee received orientation to home care requirements before providing home care services to clients for three of four employees' (A, B and C) records reviewed. The findings include:

Employees A, B, and C were hired July of 2007, May of 2007 and June of 2007, respectively.
There was no documentation that employee's A, B or C had received orientation to home care requirements prior to providing home care services. There were no training and personnel records for employee A, B and C indicating that they had received the complete orientation before providing home care services. When interviewed, July 31, 2007, the administrator confirmed that employees A, B and C had not received any orientation.

4. MN Rule 4668.0810 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to ensure a discharge summary was completed for one of one discharged clients' (#1) records reviewed. The findings include:

Client #1 began services May of 2006. The last progress note documented in the record was dated May of 2007. It indicated the client was discharged with medications and ventilator functioning well with his girl friend, his power of attorney. Staff assisted with tracheotomy care and activities of daily living cares before discharge. There was no documentation of when services were discontinued, the reason for the initiation and discontinuation of services, nor was there documentation of the client's condition at the time of discharge.

When interviewed, July 31, 2007, the administrator stated that client #1 had been discharged from services May of 2007. He confirmed that there was not a discharge summary of the client's discontinuation of services that included the reason for the initiation and discontinuation of services nor was there documentation of the client's condition at the time of discharge.

5. MN Rule 4668.0815 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and revised each client's evaluation and service plan at least annually or more frequently when there was a change in the client's condition that required a change in service for one of three clients' (#2) records reviewed. The findings included.

Client #2 began receiving services June of 2006. Client #2s' record contained an "Admission Assessment" dated June of 2006 that only indicated diagnoses and language spoken. The "Care Plan" dated June of 2006 indicated the client needed assistance with peri-care, dressing lower legs, and transfers, and that the client used an electric wheelchair for mobility. Client #2 received dialysis three times a week which was not mentioned in the assessment, care plan or service plan. His service plan dated June of 2006, documented that "PCA" services were provided "daily." There was no further information regarding what "PCA" services actually were nor was there mention of any of the previously identified needs. There was no evidence a registered nurse (RN) had ever reviewed and revised the service plan.

When interviewed August 3, 2007, the administrator and the RN confirmed the service plan had not been reviewed and revised.

6. MN Rule 4668.0815 Subp. 4

INDICATOR OF COMPLIANCE: # 1

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

Client #1 began receiving services May of 2006 and stopped receiving services May of 2007. Client #1s' record contained an assessment dated May of 2006 that indicated the client needed "total assistance with ADLs "(activities of daily living) due to muscle weakness. It indicated client #1 needed blood sugar checks thrice daily, range of motion exercises, daily vital sign checks assistance with medication set- up. The record indicated the client used a ventilator. There was no service plan.

Client #2 began receiving services June of 2006. Client #2s' record contained an "Admission Assessment" dated June of 2006 that only indicated diagnoses and language spoken. The "Care Plan" dated June of 2006 indicated the client needed assistance with peri-care, dressing lower legs, and transfers, and that the client used an electric wheelchair for mobility. Client #2 received dialysis three times a week which was not mentioned in the assessment, care plan or service plan. His service plan dated June of 2006, documented that "PCA" services were provided "daily." There was no further information regarding what "PCA" services actually were nor was there mention of any of the previously identified needs.

Client #3 began receiving services June of 2007. Client #3s' record contained an assessment dated June of 2006 that indicated the client required "continuous nursing" twenty four hours daily. It indicated client #3 was bed ridden, had insulin dependent diabetes, required oxygen, had a stage II open area, was incontinent. When observed and interviewed during a home visit July 31, 2007 client #3 confirmed he

required total care in all areas except eating and grooming. He reported that unlicensed staff administered all his medications. His service plan dated June 8, 2007, documented that registered nurse (RN) supervisory visits cost $26.00 hourly but no frequency of supervision was indicated. It also indicated that "RN" cost $32.40 hourly. There was no frequency of "RN" nor was there an indication of what "RN" was to do. "PCA" services were listed as costing $15.60 hourly. But no frequency was listed. There was no further information regarding what "PCA" services actually were nor was there mention of any of the previously identified needs.

When interviewed July 31, 2007 the administrator verified the service plans were incomplete.

7. MN Rule 4668.0835 Subp. 5

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to have the registered nurse (RN) orient unlicensed personnel to each client and their services for two of two unlicensed employees (B and D) reviewed. The findings include:

Employees B and D provided client care as unlicensed staff to clients'#1, #2 and #3.

Client #1 began receiving services May of 2006 and stopped receiving services May of 2007. Client #1s' record contained an assessment dated May of 2006 that indicated the client needed "total assistance with ADLs "(activities of daily living) due to muscle weakness. It indicated client #1 needed blood sugar checks thrice daily, range of motion exercises, daily vital sign checks assistance with medication set- up. The record indicated the client used a ventilator.

Client #2 began receiving services June of 2006. Client #2s' record contained an "Admission Assessment" dated June of 2006 that only indicated diagnoses and language spoken. The "Care Plan" dated June of 2006 indicated the client needed assistance with peri-care, dressing lower legs, and transfers, and that the client used an electric wheelchair for mobility. Client #2 received dialysis three times a week.

Client #3 began receiving services June of 2007. Client #3s' record contained an assessment dated June of 2006 that indicated the client required "continuous nursing" twenty four hours daily. It indicated client #3 was bed ridden, had insulin dependent diabetes, required oxygen, had a stage II open area, was incontinent. When observed and interviewed during a home visit July 31, 2007 client #3 confirmed he required total care in all areas except eating and grooming. He reported that unlicensed staff administered all his medications.

There was no evidence that the registered nurse (RN) had oriented the employees to each client. There were no training and personnel records for employees B and D indicating that the RN had oriented the employees to each client before providing direct care services.

When interviewed August 2, 2007, the administrator and RN confirmed the orientation to the client by the RN had not occurred.

8. MN Rule 4668.0840 Subp. 4

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 two unlicensed employee (B) record reviewed. The findings include:

Employee B was hired May of 2007, as unlicensed personnel who performed assisted living home care services. There was no record of training or competency in her personnel records. When interviewed August 3, 2007, employee B stated she had received her training from another unlicensed staff while providing direct care.
When interviewed August 2, 2007, the administrator and RN confirmed that employee B had not been trained by the agency.

9. MN Rule 4668.0845 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed personnel who performed services that required supervision for three of three clients' (#1, #2 and #3) records reviewed. The findings include:

Client #1 began receiving services May of 2006 and stopped receiving services May of 2007. Client #1s' record contained an assessment dated May of 2006 that indicated the client needed "total assistance with ADLs "(activities of daily living) due to muscle weakness. It indicated client #1 needed blood sugar checks thrice daily, range of motion exercises, daily vital sign checks assistance with medication set- up. The record indicated the client used a ventilator. There was no evidence any registered nurse supervisory or monitoring visits.
Client #2 began receiving services June of 2006. Client #2s' record contained an "Admission Assessment" dated June of 2006 that only indicated diagnoses and language spoken. The "Care Plan" dated June of 2006 indicated the client needed assistance with peri-care, dressing lower legs, and transfers, and that the client used an electric wheelchair for mobility. Client #2 received dialysis three times a week. There was no evidence any registered nurse supervisory or monitoring visits.

Client #3 began receiving services June of 2007. Client #3s' record contained an assessment dated June of 2006 that indicated the client required "continuous nursing" twenty four hours daily. It indicated client #3 was bed ridden, had insulin dependent diabetes, required oxygen, had a stage II open area, was incontinent. When observed and interviewed during a home visit July 31, 2007 client #3 confirmed he required total care in all areas except eating and grooming. He reported that unlicensed staff administered all his medications. There was no evidence any registered nurse supervisory or monitoring visits.

During an interview August 2, 2007, the administrator and RN confirmed that supervisory and/or monitoring visits had not been provided for each of the clients.

10. 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 assistance with medication administration for three of three clients' (#1, #2 and #3) records reviewed. The findings include:

Client #1 began receiving services May of 2006 and stopped receiving services May of 2007. Client #1s' record contained an assessment dated May 5, 2006 that indicated the client needed "total assistance with ADLs "(activities of daily living) due to muscle weakness. It indicated client #1 needed blood sugar checks thrice daily, range of motion exercises, daily vital sign checks assistance with medication set- up. The record indicated the client used a ventilator. There was no evidence of a nursing assessment of the client's need for assistance with medication administration.

Client #2 began receiving services June of 2006. Client #2s' record contained an "Admission Assessment" dated June of 2006 that only indicated diagnoses and language spoken. The "Care Plan" dated June of 2006 indicated the client needed assistance with peri-care, dressing lower legs, and transfers, and that the client used an electric wheelchair for mobility. Client #2 received dialysis three times a week. There was no evidence of a nursing assessment of the client's need for assistance with medication administration.

Client #3 began receiving services June of 2007. Client #3s' record contained an assessment dated June of 2006 that indicated the client required "continuous nursing" twenty four hours daily. It indicated client #3 was bed ridden, had insulin dependent diabetes, required oxygen, had a stage II open area, was incontinent. When observed and interviewed during a home visit July 31, 2007 client #3 confirmed he required total care in all areas except eating and grooming. He reported that unlicensed staff administered all his medications. There was no evidence of a nursing assessment of the client's need for assistance with medication administration.

When interviewed August 2, 2007, the administrator and registered nurse verified that the assessments had not been conducted.

11. MN Rule 4668.0865 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee, failed to have the registered nurse (RN) conduct an assessment of the client's functional status and need for central medication storage and develop a service plan for the provision of central storage of medication for two of three clients (#1 and #3) who received central storage of medication. The findings include:

Clients #1 and #3 began receiving central storage of medication May of 2006 and June of 2007, respectively. Client's #1 and #3 records did not include an assessment for central storage of medications. When interviewed August 2, 2007, the administrator and registered nurse confirmed that clients #1 and #3 received central storage of medications and had not been assessed for the need.

A draft copy of this completed form was faxed to Patrick Ugiagbe, Administrator, on August 6, 2007. 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).