MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 0976

July 10, 2009

Debra Baker, Administrator
First Premier Home Health Care
1949 Lowry Avenue North
Minneapolis, MN 55411

Re: Results of State Licensing Survey

Dear Ms. Baker:

The above agency was surveyed on April 29, 30, May 1, 4, 5, 6, 7, and 27, 2009, for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if found, are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me, or the RN Program Coordinator. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

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

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

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

Please feel free to call our office with any questions at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Attorney General Office
Deb Peterson, Office of the Attorney General
Mary Absolon, Licensing and Certification
Stella French, OHFC

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: FIRST PREMIERE HOME HLTH CARE

HFID #: 24581

Date(s) of Survey: On April 29, 30, May 1, 4, 5, 6, 7, and 27, 2009

Project #: QL24581003

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

Indicators of Compliance	Outcomes Observed	Comments
		X Education Provided **Follow-up Survey** # ____New Correction Order issued ____Education Provided
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** X Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
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** _X_Survey not Expanded ___Met ___Correction Order(s) issued ___Education Provided **Follow-up Survey** #_ ___New Correction Order issued ___Education Provided

Indicators of Compliance	Outcomes Observed	Comments
4. The clients' confidentiality is maintained. **Expanded Survey** • MN Rule 4668.0810	• Client personal information and records are secure. • Any information about clients is released only to appropriate parties. • Client records are maintained, are complete and are secure.	*This area does not apply to a Focus Survey* **Expanded Survey** ____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
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** _X_Survey not Expanded ___Met ___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

Indicators of Compliance	Outcomes Observed	Comments
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** _X_ Survey not Expanded ___ Met ___ Correction Order(s) issued ___ Education Provided **Follow-up Survey** # ___ New Correction Order issued ___ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
8. The provider is in compliance with MDH waivers and variances **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ____Survey not Expanded ____Met _X_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 4668.0800 Subp. 3

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

Based on observation, record review and interview, the licensee failed to provide all of the services required by a client's service plan for three of three clients' (A2, C1, and C2) records reviewed. The findings include:

Client A2's medication administration records (MARS) for April and May 2009, indicated Accu-Cheks were to be done three times daily before meals per an order date of September 16, 2008. Client A2's "Blood Sugar Level" forms indicated that for April 2009 the Accu-Cheks were recorded thirty-eight times out of a possible ninety times.

When interviewed May 1, 2009, employee AE stated that approximately two weeks ago it was noted by employee AB that the Accu-Cheks, for client A2, was listed on the MAR for three times a day, before meals, and not the two times a day. However, the "Blood Sugar Level" record had documentation on April 23 and 26, 2009, for three Accu-Cheks per day. When interviewed May 1, 2009, the registered nurse (RN) stated that some of the Accu-Cheks had not been recorded.

Client C1 was admitted April 15, 2008. The client's MAR indicated he had schizophrenia and was suicidal. Client C1's service plan, dated April 15, 2008, stated "trained staff available 24 hours per day." When questioned regarding this client's needs on May 5, 2009, employee CC and CB indicated that they were unaware of the client's diagnoses and suicidal history and had not received any special training regarding the client's needs.

2. MN Rule 4668.0810 Subp. 2

INDICATOR OF COMPLIANCE: # 4

Based on observation and interview, the licensee failed to establish and implement a written procedure for secure storage of client records in the housing with services site A for four of four clients' (A1, A2, A3, and A6) records reviewed. The findings include:

During a tour of the facility client records were observed on a shelf behind an unlocked sliding closet door, in an unlocked apartment. The closet was located behind the unlocked entry door to the apartment that two clients shared. Staff, delivery people and other clients were observed to enter the unlocked apartment during the survey.

When interviewed, April 30, 2009, the RN stated the apartment doors are not locked at all times. A procedure for the security of client records was not provided to the reviewer during the survey.

3. 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 the client's evaluation and service plan annually for three of three clients' (B2, C1, and C2) records reviewed. The findings include:

Client B2 was admitted and began receiving services, including central storage of medications and assistance with self administration of medications, on April 1, 2008. The only nursing assessment and service plan for client B2 were dated, April 1, 2008 and May 9, 2008, respectively. There was no indication the RN had reviewed the service plan or did an evaluation in the past year.

Client C1's and C2s' nursing assessments and service plan were dated April 15, 2008 and April 1, 2008, respectively. There was no indication that the RN had reviewed their service plan or evaluation in the past year.

When interviewed May 7, 2009, the RN indicated that she was not aware of the requirement to review the evaluation and service plan annually.

4. MN Rule 4668.0855 Subp. 6

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure unlicensed staff only administered insulin injections; and did not determine the insulin dosage or inject other injectable medications for two of two clients' (A1 and A2) records reviewed. The findings include:

Client A1 was admitted April 1, 2009. Physician transfer orders, dated March 19, 2009, read "Lantus 100 u/ml sol (units per milliliter solution), give 11 units subcutaneous qd (everyday). The April 2009 medication administration record (MAR) indicated insulin was administered by unlicensed direct care.

When interviewed April 30, 2009, client A1 stated that staff dialed the insulin pen (determined the amount of insulin to be given) for her sometimes, about five times per week. She said they don't have to, but it speeds things up. When interviewed April 30, 2009, the registered nurse indicated that staff do not draw up or dial the insulin pens. The reviewer informed the RN that staff was dialing the pens; she stated that they were not supposed to be dialing the insulin pens.

On December 4, 2008, a physician order for client A2 read, Rebif (not insulin), forty-four micrograms injected subcutaneously (SQ) three times weekly. The April and May 2009 MAR indicated unlicensed direct care staff administered the injections seven times of the fourteen possible times.

When interviewed April 29, 2009, unlicensed direct care staff employee, AC stated she gave client A2 the Rebif injection on April 27, 2009, for the first time. Employee AC also stated employee AB, unlicensed direct care staff, had also given client A2 the Rebif injections.

5. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that medications were administered and documented as prescribed for five of five clients' (A1, A2, B1, B2 and C2) records reviewed. The findings include:

Client A2's record contained the following dated physician orders: June 16, 2008, for BuSpar 15 milligrams (mg.) three times a day; September 20, 2008, for Baclofen 10 mg. in the morning and 20 mg. at bedtime and for Pepcid 20 mg. one time daily; November 19, 2008, for Ditropan 5 mg. to be increased from three to four times daily. The November and December 2008, medication administration sheets (MARs) listed Ditropan as administered three times daily instead of four times as ordered on November 19, 2008. The January 2009, MAR indicated Ditropan was administered to client A2 thirty three times out of a possible one hundred twenty four doses. The February 2009, MAR indicated Ditropan was not administered one time and a line was drawn through the initials for sixteen doses out of a possible one hundred twelve times it was to be administered. The March 2009, MAR indicated that the dose of BuSpar was changed from 15 mg three times daily to 150 mg twice daily after the March 18 dose was documented, also written after the March 18 dose was "see other listing"; the record, however, lacked any physician order for this change and there was no other listing for BuSpar on the MAR. There was a listing for Bupropion 150 mg twice a day. The March 2009, MAR indicated the BuSpar was not administered at all; and the May, 2009 MAR indicated that BuSpar was set up from

May 1 through 4, 2009, three times a day at 8 a.m., 12 noon, and 8 p.m. On observation May 4, 2009, it was noted that the medication dose boxes that had been set up by employee AD for May 4, 2009, 12 noon and 8 p.m. and May 5, 2009, 8 a.m. did not contain the BuSpar. The April and May 2009, MARs indicated Baclofen 10 mg. was setup to be given at 4 p.m. instead of the a.m., as ordered; and Pepcid was not listed on the April and May 2009, MARs at all. The MARs lacked documentation as to why the medications were not set up and administered as ordered.

Client B1 was admitted and began receiving services April 1, 2008. An unsigned physician order sheet, dated March 9, 2009, read Cardizem CD 240 mg 1 cap daily, calcium carbonate 500 mg/vit D 200 IU (international unit) tab 1 twice per day, and ibuprofen 800 mg, 1 tab four times per day. The April 2009 MAR indicated Cardizem was not given on April 11, 12, 13, 14, and 15, 2009; calcium was not given twice per day April 16 through 24, 2009 and April 27 through 30, 2009. A physician order, dated March 9, 2009, read, "Boost 1-2 cans per day as a supplement." Boost was not administered in April 2009; the May 2009 MAR listed Boost to be administered, however, lacked documentation of administration. A physician order, dated April 24, 2009, read, "Ensure 1 can a day." Ensure was not administered in April 2009. An unsigned and undated clinic order read "stop ferrous sulfate, take ferrous gluconate 1 pill twice per day," "stop diltiazem take Toprol 1 pill once a day." The April 2009, MAR has "discontinued" written across the spaces where ferrous gluconate would have been documented as administered. Diltiazem CD 120 mg one capsule was administered April 25 to May 5, 2009. Toprol Tartrate 25 mg tablet, ½ tab, was administered April 9 through 14, 2009 and April 25 and 26, 2009, and none in May 2009. There was a different order, dated April 7, 2009, for Toprol 25 mg ½ tablet daily. Due to the undated and unsigned aforementioned order the surveyor was unable to determine the correct medications and dosages. Staff did not seek further clarification from the physician.

Client B2's MAR for February 2009 indicated client B2 was to receive cyclobenzaprine HCl 10 mg, one tablet three times daily or as needed; the MAR indicated client B2 received the medication twice per day from 8:00 p.m. on February 19, 2009 through 8:00 a.m. February 25, 2009. Client B2's record did not have a physician order for cyclobenzaprine HCl. An unsigned clinic visit/physician order sheet from client B2's April 30, 2009, physician visit, indicated that client B2's current medication orders were: aspirin 81 mg oral tablet by mouth daily; ibuprofen 600 mg by mouth every six hours as needed for pain; and glucosamine 500 mg by mouth daily. Client B2's May 2009 MAR indicated she was to receive glucosamine 500 mg daily and ibuprofen 600 mg by mouth four times daily. On May 6, 2009, client B2's MAR indicated she had received glucosamine 500 mg daily and ibuprofen 600 mg twice daily and did not list the aspirin 81 mg as a medication to be administered. On May 7, 2009 client B2's MAR indicated client B2 had received the glucosamine 500 mg daily, ibuprofen 600 mg twice daily and the aspirin was documented as being given daily from May 1-7, 2009, although, on May 6, 2009, the MAR lacked documentation of the aspirin being given at all for May 2009. The MAR lacked any indication that it was a "late entry."

Client C2's MAR was blank for May 1, 2, 3, 4 and 5, 2009. The May 2009 MAR listed client C2's medications as the following: Claritin 10 mg. daily, trazodone 200 mg. daily and 300 to 450 mg. at bedtime, Isopto atropine 3 drops twice daily, metoprolol 12.5 mg twice daily, Prevacid 30 mg. twice daily, ranitidine 150 mg twice daily, Senokot 8.6 mg. twice daily, bisacodyl l5 mg. daily, Wellbutrin SR 100 mg daily and Clozaril 250 mg at bedtime.

When interviewed April 30, 2009, unlicensed direct care staff, AB, stated that several of the unlicensed direct care staff setup the medications from bubble packs to medication dose boxes for other unlicensed

direct care staff to administer. At the time of the setup, the unlicensed staff document on the MAR, by their initials, the days and times of the medications that they have set up. At the time of administration, of the preset up medications, the unlicensed staff does not document the administration. When interviewed April 30, 2009, the RN stated staff needs to document if the client refused medications. During an interview on May 4, 2009, the RN stated she would have to check into the discrepancies of the physician orders versus the documented administration of the medications.

During an interview on May 6, 2009, employee AB, an unlicensed direct care staff, did not know why medications were not given as ordered. During an interview on May 6, 2009, employee BA, indicated she could not find the physician order for client B2's cyclobenzaprine HCl that had been documented as administered in February. During an interview May 6, 2009, client B2 stated she had not received any cyclobenzaprine HCl in February. On May 6, 2009, employee BA also indicated client B2 received the last dose of aspirin from the bottle in the a.m. and client B2 had called the pharmacy to order more, however, she had forgotten to document the administration of aspirin on the May 2009 MAR. When interviewed May 7, 2009, the RN stated the medications were given and wasn't aware the medication administration was not documented for client C2.

6. MN Rule 4668.0860 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that there were prescriber's orders for five of five clients' (A2, B2, A4, C1 and C2) records reviewed. The findings include:

Client A2 began receiving central storage of medication and medication administration May 1, 2008. The service plan, dated May 6, 2008, listed medication administration up to four times daily and medication set up by the registered nurse (RN) one time weekly. A physician order dated, August 11, 2008, was for metformin, 850 milligrams (mg) daily. The April 2009 medication administration record (MAR) listed metformin, 850 mg twice daily, but then listed times for administration as 8:00 a.m., 12 noon and 8:00 p.m. which were all signed by staff as administered; not once daily as ordered. There were no other orders for metformin in the client's record.

During observation of central storage of medications on May 6, 2009, it was noted that client B2 had central storage of medications. The April 2009 MAR for client B2, indicated client B2 was to receive glucosamine 500 mg daily, ibuprofen 600 mg four times a day and aspirin 81 mg daily. The record contained an unsigned clinic visit form, dated, April 30, 2009, which listed current medications as aspirin 81 mg by mouth daily; ibuprofen 600 mg oral every six hours as needed for pain; and glucosamine 500 mg by mouth daily. The record did not contain signed physician orders for the medications.

Client A4 was readmitted May 4, 2009, and received medication management, set up, and administration. During record review May 8, 2009 there were no prescriber's orders for client A4's Cymbalta, spironolactone, docusate sodium, omega 3 fish oil, oyst-cal, simvastatin, Flonase nasal spray, Provigil, Aviane, ranitidine, Certa-Vite, Detrol LA, Triglide, baclofen, TriCor, and Oxybutynin Cl ER, which were all being administered according to the May 2009 MAR.

Clients C1 and C2 were both admitted and began receiving services April 2008, for medication set up, management and administration. Client C1's record, reviewed May 5, 2009, lacked prescriber's orders

for benztropine, lorazepam, clozapine, lisinopril and Prolixin, which were being administered daily according to the April and May 2009 MAR. During record review May 6, 2009, there were no prescribers orders for client C2 for bisacodyl, bupropion, loratadine, Prevacid, Lamictal, clozapine, metoprolol, benztropine, senna laxative, atropine sulfate, Metamucil, Flonase, trazodone, docusate sodium and Abilify; which were being administered daily according to the May 2009 MAR.

When interviewed May 1, 2009, the RN had the pharmacy send by facsimile (fax), the September 2008, increase for Metformin to 850 mg, twice a day, for client A2. When interviewed May 6, 2009, employee BA indicated client B2 received assistance with medication administration and central storage of medications and she was unable to find physician orders for the medications that were being administered. When interviewed May 8, 2009, the RN stated she didn't always receive orders when clients were admitted from the nursing homes or hospital.

7. MN Rule 4668.0860 Subp. 8

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the facility failed to implement physician orders within twenty-four hours of receipt of the order for one of one client's (A2) record reviewed. The findings include:

A physician order for client A2, dated September 15, 2008, was for Cipro 500 milligrams (mg) twice daily for ten days, for a urinary tract infection (UTI). The order was faxed by the RN to the pharmacy September 15, 2008, at 3:57 p.m. On September 19, 2008 day activity program staff called 911 (emergency), because the client was weak and confused. Client A2 was hospitalized September 19, 2008, for a UTI. Client A2 was readmitted September 20, 2008, to the licensee with a physician order to continue Cipro 500 mg twice a day for seven days. There was no evidence the client ever received a dose of Cipro from the licensee's staff from the time the order was faxed on September 15, 2008 through admission to the hospital and after readmission from the hospital on September 20, 2008, for the seven days.

A physician order, dated November 19, 2008, for client A2 read increase Ditropan to 5 mg q.i.d. (four times a day. The November 2008 and December 2008, medication administration records (MARs) for client A2 indicated client A2 was scheduled to receive Ditropan 5 mg, three times a day; the January MAR for client A2, indicated the Ditropan 5 mg. was scheduled to be administered four times a day, however, the January 2009 MAR indicated client A2 received the Ditropan 93 times of the possible 124 times it was scheduled to be administered**.**

A physician order, dated December 18, 2008, for client A2, read Keflex 500 mg. three times daily for ten days for red, swollen, cellulites of the leg. The December 2008 MAR indicated client A2 did not receive Keflex on December 18, 19 and 20, 2008. The Keflex was administered December 21 and 22, 2008, twice daily instead of three times daily as ordered. The Keflex was not administered December 23, 2008, and was given twice daily December 27 through 31, 2008.

When interviewed April 30, 2009, the registered nurse stated she did not know what had happened; however, she stated since client A2 did not always bring back papers, when returning from medical appointments, the physician would often mail the prescriptions to the licensee. On May 1, 2009, the pharmacy stated they had received a faxed order from the physician and also from the licensee on

September 15, 2008, for twenty tablets of Cipro. They indicated they filled and delivered the Cipro on September 16, 2008 and again on September 25, 2008, they filled and delivered fourteen tablets as per physician order on September 20, 2009. On May 1, 2009, the pharmacy also stated they had received a faxed order for Keflex 500 mg, thirty capsules, on December 18, 2008, and had delivered the Keflex to the licensee on December 19, 2008.

8. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on observation and interview, the licensee failed to provide care and services according to an acceptable medical or nursing standard for three of three clients' (B1, C1 and C2) records reviewed. The findings include:

Client B1 was admitted and began receiving central storage of medications and medication administration on April 1, 2008. Progress notes, dated December 7, 2008, by an unlicensed direct care staff stated, "I set up (client's) meds. There were 8 pills. I went downstairs to make a phone call. When I came back up 2 pills were missing off the counter (1 citalopram & 1 clonazepam). I called and left a message on (RN's) cell phone as to how to handle this."

Client B1's physician order, dated March, 9, 2009, read ibuprofen 800 milligrams (mg) four times per day. The April 2009 MAR indicated Ibuprofen 800 mg. was not given four times a day as ordered April 7 through April 24, 2009. On April 24, 2009 client B1 saw a physician for knee pain and received an order for ibuprofen 600 mg every eight hours as needed for one week. The 600 mg of ibuprofen was given one time April 25 and 30, 2009 and two times from April 26 through April 29, 2009. The ibuprofen 800 mg four times a day was not administered. No clarification was obtained from the physician. On May 1, 2009, the facility received an order for Vicodin 5 mg/500 mg, one tablet every four hours as needed. The Vicodin was never ordered or administered.

When the locked medication kitchen cupboard was observed, in site B housing with services, it was noted that client B1 had a Calcium W/D bottle which contained a small, oblong, white, scored tablet, which did not appear to be calcium. It was also noted that three medication bottles were labeled with client's names, who were no longer clients in the housing with services. One of those medication bottles had a label torn off and it contained seven long white pills and 6 little round white pills. The narcotic locked box was not secured to the building and was easily removed to the kitchen counter.

When interviewed May 6, 2009, employee BA, an unlicensed direct care staff, indicated the pill found in the Calcium bottle was a blood pressure medication, and she did not know what the other 13 pills were or whose they were. When interviewed May 6, 2009, client B1 indicated she had never received the Vicodin, but she had been on it before and it had worked for her. She said she still had knee pain.

During a facility tour May 5, 2009, the smoke alarm in the hallway ceiling was observed to be open revealing that there were no batteries. The smoke alarm on client C2's ceiling was beeping.

The smoke alarm battery had been replaced in C2's bedroom; however, the battery in the hallway's smoke alarm had not been replaced.

When interviewed May 5, 2009, employees CB and CC agreed there were no batteries in the hallway smoke alarm and the battery was low causing the beeping in C2's bedroom.

9. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to complete a vulnerable adult assessment and/or develop an abuse prevention plan for three of four clients' (A1, B1, and C1) records reviewed. The findings include:

Client A1's admission assessment summary, dated April 10, 2009, identified vulnerabilities in the areas of mobility, pain, falling, smoking and relationship issues. No plan was identified to minimize the risk of abuse in the identified areas. When interviewed April 30, 2009, the registered nurse stated she hadn't yet reviewed the client's record for completion (contained the required information).

Client B1's record contained a blank vulnerable adult and RN evaluation/assessment form. Client B1 had a history of chest pain, dizziness, shortness of breath, falls, suicide ideations and attempts, and not feeling comfortable with the staff. When interviewed May 6, 2009, employee BA stated she did not know why the vulnerable adult assessment form had not been completed for client B1.

Client C1's record contained an RN assessment, dated April 15, 2008, which listed "Suicide precaution" as an area of vulnerability, no plans of intervention. Client C1's diagnoses on the medication administration records for April and May 2009 indicated the client had schizophrenia, chronic obstructive pulmonary disease and was suicidal. Client C1 received antipsychotics: (fluphenazine 15 milligrams (mg) twice/day and 25 mg at bedtime, clozapine 500 mg daily, quetiapine 50 mg. daily; antidepressants: (mirtazapine 30 mg daily, trazodone 200 mg daily, citalopram 60 mg daily; anti-anxiety medication: (lorazepam 1 mg daily; and anticonvulsant medication: (divalproex sodium 750 mg daily). Client C1 was hospitalized January 22, 2009, for being "suicidal and had a plan to jump into traffic."

When interviewed May 6, 2009 employee CB was asked what the suicide prevention plan was for client C1 and stated "what do you mean? We don't let him stand in the kitchen; we always put cleaning equipment away."

When interviewed May 6, 2009, client C1 stated "I've thought about a knife … to cut my wrists, there are several in the drawer….in the kitchen. I feel bad. I could use that kitchen knife today, want to hurt myself." The reviewer reported client C1's statements to the licensee's RN. The RN called client C1's physician and then client C1 left the facility by ambulance for the hospital.

10. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that personnel providing services requiring direct contact with clients had evidence of tuberculosis screening prior to providing services. The findings include.

Employee AB was hired March 10, 2008 and began providing direct care services March 19, 2008. Documentation indicated she had Tuberculosis screening on February 2, 2009, and that her last Mantoux test had been "about 15 years ago."

During an interview on May 5, 2009, employee AB verified that she has started providing care to a client in March 2008.

11. MN Rule 4668.0030 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide a copy of the current Minnesota Home Care Bill of Rights for assisted living clients to one of six clients' (A2) records reviewed. The findings include:

Client A2 was admitted May 1, 2008. The client's record contained an undated and unsigned copy of the home care bill of rights, which did not include the most recent additions effective January 1, 2007 to MN Statute §144A.44, Subd.1 (16), for clients residing in assisted living facilities. When interviewed April 30, 2009, the registered nurse stated she was unaware of the changes to the bill of rights and verified that client A2 had not been provided with the updated version.

12. MN Rule 4668.0030 Subp. 5

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to obtain written acknowledge of the client's receipt of the Minnesota Home Care Bill of Rights for assisted living for one of one client (A1) record reviewed. The findings include:

Client A1 was admitted and began receiving services April 1, 2009. There was no evidence of written acknowledgment of the receipt of the bill of rights or a reason why acknowledgement was not obtained.

When interviewed April 30, 2009, the RN stated she hadn't reviewed the client's chart for completion.

13. MN Rule 4668.0220 Subp. 1

INDICATOR OF COMPLIANCE: # 7

Based on record review and interview, the licensee failed to provide information in a timely manner to the commissioner regarding the licensee's services to clients for seven of seven clients' (A1, A2, A3, A6, B1, B2, and C1) records reviewed. The findings include:

On April 29, 2009, the reviewer asked for the medication error reports, incident reports and client rosters for all three housing with services. The reviewer requested the information several times during the survey. The client roster was provided on May 5, 2009, but none of the other requested documents were provided during the survey.

On May 6, 2009, employee BA stated she had been working since April 28, 2009, at 6 a.m., because the other employee, for housing with services site B had a family emergency. Timesheets for the last two weeks were requested on the same day. Employee BA could not provide any time sheets and said there were none at the housing with services site and she would request them from the registered nurse. The reviewer did not receive the time sheets during the survey.

Client A3 was admitted and began receiving central storage of medications and medication administration May 1, 2009. The "med setup sheet," dated May 2009, and reviewed May 7, 2009, in the morning, indicated none of the ten routinely scheduled medications, which included amitriptyline, had been documented as setup. When the reviewers returned at 5:55 p.m. on May 7, 2009, a new set of "med assistance/administration sheets" (MARS) was in place. It was noted that all scheduled medications May 1, 2009 through May 6, 2009, had been blacked out where unlicensed direct care staff would have signed for administration of medications. On May 7, 2009, at 6:00 p.m., the reviewers inquired where the May 2009 MARS that had been observed in the a.m. had gone? The RN indicated she had these sheets; however, she had to finish reviewing them. When the MAR was reviewed it was noted that the amitriptyline was documented as being setup by the RN, with her initials appearing in the boxes from May 1-6, 2009 and the remaining regularly scheduled medications remained blank. The record lacked any notation of "late entry" for this documentation. When interviewed May 7, 2009, the RN stated the computer blacks out the dates prior to when it was printed.

14. MN Rule 4668.0810 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name and title of the person making the entry for four of four clients' (A2, B2, C1, and C2) records reviewed. The findings include:

Client A2's record contained progress notes on April 6, 7, 8, 15, and 16, 2009, which lacked the signature and title of the employee making the entry. The entries only contained the initials of the person making the entry.

Client B2's record contained progress notes on April 14, 15, 24, and 27, 2009, which lacked the signature and title of the person making the entries.

Client C1's record contained documentation on April 21, 26, 27, 28 and 29, 2009, which lacked the signature and title of the person making the entry.

Client C2's record included a "Resident Care Data: Daily Record" for May 2009, that lacked staff signatures or titles.

When interviewed May 5, 2009, employee CB confirmed the entries in the clients' records was incomplete.

15. 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 five clients' (A1) records reviewed. The findings include:

Client A1 began receiving central storage of medication and assistance with self administration of medication on April 1, 2009. During a review of the client's record on April 30, 2009, there was no evidence of a service plan. A blank service plan was provided to the reviewer several days later.

When interviewed April 30, 2009, the RN stated she hadn't reviewed the client's record yet for completion (contained the required information).

16. MN Rule 4668.0815 Subp. 4

INDICATOR OF COMPLIANCE: # 1

Based on observation, record review and interview, the licensee failed to provide a complete service plan for four of five clients' (A2, B2, C1, and C2) records reviewed. The findings include:

Client A2's service plan, dated May 1, 2008, included medication setup and administration, bathing, assistance with activities of daily living, laundry, housekeeping, behavior management and transportation. The service plan did not indicate central storage of medications, which the client was observed to have on April 30, 2009, for client A2.

Client B2 was admitted and started receiving services, which included central storage of medications and assistance with self administration of medications on April 1, 2008. Client B2's record lacked attachment B of the service plan, which was to include the list of services and fees for those services and the category of persons who were to perform the services for the client. When interviewed May 6, 2009, client B2 stated she was not aware of the services the licensee provided or of the fees for those services.

Client C1's and C2s' service plans, both dated April 2008, included medication setup and management, central storage of medication, meal preparation, behavior monitoring, diabetic monitoring and trained staff available 24 hours per day. The service plans failed to state who would be providing the service, the frequency of the service, the schedule of supervision required by law and the fee for each service.

Clients C1 and C2 were observed receiving medications from employee CB on May 5 and 6, 2009. Their service plans lacked the service of medication administration service, who was to provide the service, the frequency of the service, the schedule of supervision required by law and the fee for medication administration.

When interviewed May 8, 2009, the registered nurse agreed the service plan content was incomplete.

17. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that training and competency testing for delegated nursing tasks was done for one of three employees' (AB) records reviewed. The findings include:

Employee AB was hired as a personal care attendant March 19, 2008, and as a home health aide January 27, 2009. When interviewed April 30, 2009, employee AB stated she had performed glucose monitoring for client A1 and stated the registered nurse (RN) had trained her in blood glucose monitoring. Employee AB's record lacked any evidence of training or competency for this task.

When interviewed April 30, 2009, the RN was asked to obtain a copy of the blood glucose monitoring training that was provided to unlicensed staff. On May 5, 2009, a facsimile of blood glucose monitoring training from an outside agency was provided to the reviewer but no documentation of competency was provided.

18. 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 five of five clients' (A1, A2, B2, C1 and C2) records reviewed. The findings include:

Client A2 was admitted and began receiving central storage of medication and assistance with self administration of medications on May 1, 2008. There was no documentation of RN supervisory visits in the record.

Client B2 was admitted April 1, 2008. During observation of central storage of medications for site B, May 6, 2009, it was noted that Client B2 had medications stored in central storage. Client B2's record lacked documentation of RN supervisory visits.

Client C1 and C2s' service plans, both dated April 2008, included medication setup and management, central storage of medication, meal preparation, behavior monitoring, diabetic monitoring, trained staff available 24 hours per day. Client C1 and C2s' records lacked documentation of RN supervisory visits.

When interviewed May 8, 2009, the RN stated she had not documented her supervisory visits for clients C1 and C2, even though she was at the assisted living sites all the time.

When interviewed April 30, 2009, client A1 stated the nurse had not been up to visit her yet. When interviewed May 7, 2009, the RN indicated supervisory visits had not been done, as the client had been with them for such a short amount of time, as she had not reviewed the chart yet for completion (contained the required information).

When interviewed May 7, 2009, RN stated she had a supervisory visit form on her new computer system, however, she had not yet completed it for client A2.

On May 7, 2009, the RN supplied a "supervision of personal care attendant" form to the reviewer, which indicated a supervisory visit was completed for client B2 on December 4, 2008. The RN also supplied a computer form titled "Supervisory Visit Worksheet," which contained the name of client B2 and assessment information. However, the form was not dated nor signed.

When interviewed May 6, 2009, client B2 stated she sees the RN "every three months."

19. MN Rule 4668.0855 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview, the licensee failed to ensure that the registered nurse (RN) conducted a nursing assessment of each client's functional status and need for assistance with self-administration of medication or medication administration for one of five clients' (B2) records reviewed. The findings include:

Client B2's care plan, dated April 1, 2008, indicated the client was independent in medication administration. On May 6, 2009, during review of the medication central storage area client B2's medications were observed and that staff was administering medications to client B2. Client B2's record lacked a nursing assessment of the client's functional status and need for assistance with self-administration or medication administration.

When interviewed May 6, 2009, employee BA did not know why the assessment had not been completed.

20. MN Rule 4668.0855 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that unlicensed persons demonstrated competency in medication administration for one of three unlicensed employees' (CA) records reviewed who performed medication administration. The findings include:

Employee CA was hired July 7, 2008 as unlicensed personnel who performed medication administration. Medication records for clients C1 and C2 indicated that employee CA administered their medications from May 1 through May 10, 2009. Employee CA's record lacked documentation of demonstrated competency to administer the medications.

When interviewed May 8, 2009, the registered nurse stated employees had medication administration training and that employee CA's record maybe was missing documentation of the competency.

21. MN Rule 4668.0865 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that no legend drug prescribed for one client was used for the use of another client for one of six clients' (A2) records reviewed. The findings include:

The staff communication book contained an entry, dated April 22, 2009, which indicated client A2 had a headache and was given an ibuprofen 600 milligram tablet from client A8's medication, because client A2 did not have her own ibuprofen.

When interviewed April 29, 2009, employee AC stated she had informed the registered nurse (RN) that client A2 did not have any ibuprofen. She stated she was then instructed by the RN to take the ibuprofen from client A8 for client A2.

22. MN Statute §144A.46 Subd. 5(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to complete a background study for one of two employee's (AB) records reviewed. The findings include:

Employee AB was hired March 19, 2008, as a personal care attendant and January 27, 2009, as a home health aide. The background study for employee AB was initiated on March 11, 2009 through the non licensed personnel care provider organization, but there was not a background study for employee AB through the licensed home care agency.

A draft copy of this completed form was left with Trena Allbritton, RN; and Marvin Baker at an exit conference on May 27, 2009. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After review, this form will be posted on the MDH website. Class F Home Care Provider general information is available by going to the following web address and clicking on the Class F Home Care Provider link:

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

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 0094

August 2, 2007

Debra Baker, Administrator
First Premier Home Health Care
1919 Lowry Avenue North
Minneapolis, MN 55411

Re: Results of State Licensing Survey

Dear Ms. Baker:

The above agency was surveyed on June 27, 28, and 29, 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.

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

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: FIRST PREMIERE HOME HLTH CARE

HFID #: 24581

Date(s) of Survey: June 27, 28 and 29, 2007

Project #: QL24581001

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 _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 _X_Met ____Correction Order(s) issued _X_Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided
3. The health, safety, and well being of clients are protected and promoted. **Focus Survey** • MN Statute §144A.46 • MN Statute §626.557 **Expanded Survey** • MN Rule 4668.0035 • MN Rule 4668.0805	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Agency personnel observe infection control requirements. • There is a system for reporting and investigating any incidents of maltreatment. • There is adequate training and supervision for all staff. • Criminal background checks are performed as required.	**Focus Survey** ____Met _X_Correction Order(s) issued _X_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 _X_Met ____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 _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 _X_Correction Order(s) issued _X_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 _X_Met ____Correction Order(s) issued _X_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

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

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

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

1. MN Rule 4668.0030 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide the current Minnesota Home Care Bill of Rights to four of four clients' (A1, A2, B1 and B2) records reviewed. The findings include:

Clients A1, A2, and B1 were admitted December of 2006 and client B2 on May 17, 2007, respectively. Their records did not contain documentation that they had received a copy of the bill of rights. When interviewed June 28, 2007, the registered nurse stated that she had not given a written copy of the bill of rights to each client.

2. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that employees had tuberculosis screening prior to providing direct care to clients for four of four employees' (A, B, C and D) records reviewed. The findings include:

Employee A began providing services September of 2006. The most recent documentation of tuberculosis screening was a negative Mantoux test dated January of 2004. Employees B, C and D began providing services on February of 2007, June of 2007 and September of 2006, respectively. Their records lacked documentation of any tuberculosis screening. When interviewed June 29, 2007, employee A verified that her Mantoux test was past due and that that there was no documentation of tuberculosis screening for employee D. She said employees B and C both have a history of a positive reaction to Mantoux testing. She stated that employee B had a negative chest x-ray in January 2006 and employee C had a negative chest x-ray in October 2006, but she had no documentation of these screenings in their files.

3. MN Rule 4668.0800 Subp. 1

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the agency failed ensure delegated nursing services were provided only in a registered housing with services establishment for two of four clients (B1 and B2) records reviewed. The findings include:

During an interview June 27, 2007, the owner stated that two of their four clients (B1 and B2) were moved to site B over the past weekend. The owner did not have a copy of the HWS registration certificate for site B. She said that she had applied for a HWS registration for site B, but has not received the registration certificate back in the mail yet. She said that she spoke with a man at the Minnesota Department of Health who stated that it was okay to go ahead and admit clients since she had her class F license. On July 25, 2007 staff with the Minnesota Department of Health Licensing and Certification Program stated that they did not have an application for a HWS registration at site B and would not have advised the agency that clients could be admitted before the registration was approved. Client B1 and B2 were receiving medication administration from agency staff.

4. MN Rule 4668.0805 Subp. 1

INDICATOR OF COMPLIANCE: # 3

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

Employees A and D began working for the provider September of 2006 and employees B and C February of 2007 and June of 2007, respectively. Their records lacked documentation that they had received orientation to home care requirements. When interviewed June 28, 2007, the registered nurse verified that the employees had not received orientation to home care requirements.

5. 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 four of four clients' (A1, A2, B1 and B2) records reviewed. The findings include:

Clients A1, A2, and B1 were admitted December of 2006 and client B2 on May 17, 2007, respectively.

Their records lacked service plans. When interviewed June 28, 2007, the RN confirmed that the clients did not have completed service plans and that she was working on a service plan format.

6. MN Rule 4668.0825 Subp. 2

INDICATOR OF COMPLIANCE: # 1

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 nursing services before delegating nursing services for four of four clients' (A1, A2, B1 and B2) records reviewed. The findings include:

Clients A1, A2, and B1 were admitted December of 2006 and client B2 on May 17, 2007, respectively. The clients received delegated nursing services, including medication administration. There was no documentation that the RN had conducted a nursing assessment of each client's functional status and need for nursing services before initiating services. When interviewed June 28, 2007, the RN stated that she performs a pre-admission assessment of each client, however the assessment notes are not retained as part of the record. She stated that she is working on a functional status assessment form.

7. MN Rule 4668.0835 Subp. 2

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure unlicensed persons performing delegated nursing services had completed the training and passed a competency evaluation for three of three unlicensed employees (B, C and D) reviewed. The findings include:

Employees B, C and D were hired February of 2007, June of 2007 and September of 2006, respectively as unlicensed direct care staff. There was no documentation of training and competency evaluations in their records. When interviewed June 29, 2007, the registered nurse verified that there was do documentation of training or competency evaluations for any of the unlicensed staff. She stated that she had trained each unlicensed person in the cares for each client, but did not document the training. When interviewed June 29, 2007, employees B and C stated they had been trained by the nurse for each clients' cares and medication administration.

8. MN Rule 4668.0845 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to assure registered nurse (RN) supervisory visits were conducted for four of four clients' (A1, A2, B1 and B2) records reviewed. The findings include:

Clients A1, A2, and B1 were admitted December of 2006 and client B2 on May 17, 2007, respectively. All four clients received services that required supervision including medication administration. There was no documentation of an RN supervisory visit in any of the client records within 14 days after initiation of services or of any supervisory or monitoring visits thereafter. When interviewed June 29, 2007, the RN stated she is at the housing with services establishment Monday through Friday and is

continually supervising the unlicensed staff, however she had not been documenting the supervisory visits in the clients' records. The RN indicated she had developed a form for supervisory visits, but had not implemented it yet.

9. MN Rule 4668.0855 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on observation, record review and interview, the licensee failed to retain documentation of competency of medication administration performed by unlicensed staff for two of three unlicensed personnel (B and C) reviewed. The findings include:

The medication administration records for clients A1 and A2, dated June 2007, indicated that employee B had administered medications to them and the medication administration record for clients B1 and B2, dated June 2007, indicated that employee C had administered medications to them. There was no documentation of training in medication administration in employee C or Bs' files. When interviewed June 28, 2007, the registered nurse (RN) stated that she had trained each employee (B and C) on medication administration, but did not document the training. When interviewed June 29, 2007, employees B and C stated they had been thoroughly trained and competency tested by the RN on medication administration before they were allowed to pass medications.

10. MN Statute §144A.46 Subd. 5(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview the licensee failed to assure background studies were completed on two of four employees (B and C) reviewed. The findings include:

Employee B was hired February of 2007 and employee C was hired June of 2007. There records lacked documentation of a background study. When interviewed June 29, 2007, the nurse stated she had submitted the study requests via the internet, but had some problems with the site. She has not received the studies back yet on either employee. She stated that the two employees are working under her direct supervision.

A draft copy of this completed form was faxed to Trena Allbritton at an exit conference on July 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).