MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6895

August 12, 2010

William Ward, Administrator
Lakeside Assisted Living
441 William Avenue East
Dassel, MN 55325

Re: Results of State Licensing Survey

Dear Mr. Ward:

The above agency was surveyed on June 29 and 30, 2010, for the purpose of assessing compliance with state licensing regulations. State licensing orders are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me. If further clarification is necessary, an informal conference can be arranged.

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

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

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

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

Sincerely,

Patricia Nelson

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

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

01/07 CMR3199

CERTIFIED MAIL #: 7009 1410 0000 2303 6895

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

Patricia Nelson, Supervisor - (651) 201-4309

TO:	WILLIAM WARD	DATE: August 12, 2010
PROVIDER:	LAKESIDE ASSISTED LIVING	COUNTY: MEEKER
ADDRESS:	441 WILLIAM AVENUE EAST DASSEL, MN 55325	HFID: 26188

On June 29 and 30, 2010, a surveyor of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

A complaint investigation was also completed at the time of the survey. An investigation of complaint #HL26188001 was completed. The complaint is unsubstantiated.

Signed:_____ Date: _____

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

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

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

1. MN Rule 4668.0855 Subp. 3

Based on observation, interview and document review, the licensee failed to ensure that when the registered nurse delegated medication administration to unlicensed staff, that medication administration was conducted in accordance with the definition for two of two medication passes observed. The findings include:

MN Rule 4668.0003 Subp. 21a defines medication administration as “a task to ensure a client takes a medication, and includes the following tasks, performed in the following order: A. checking the client's medication record; B. preparing the medication for administration; C. administering the medication to

the client; D. documenting after administration, or the reason for not administering the medication as ordered; and E. reporting information to a nurse regarding concerns about the medication or the client's refusal to take the medication."

The medication pass was observed on June 29, 2010, at 2:45 p.m. and June 30, 2010, at 10:00 a.m. Employee B (unlicensed staff) was observed on June 29, 2010, at 2:45 p.m. to set up medications for eight clients that were scheduled to receive medications at 3:00 p.m. and 5:00 p.m. Employee B was observed to place the medications for the clients into a medication cup after checking the medication administration record for the correct dosages and times. If the client had both a 3:00 p.m. and 5:00 p.m. medication, employee B would set-up both of the client's medications and make a notation with the time on the bottom of the medication cup. Once the medication cups contained the client's medications, the medication cup was placed into a box that was partitioned into small squares. Each square had a client's name on it. The medication cups remained in this box until it was time to administer the client's medications. The medications employee B set up at 2:45 p.m. were observed to be administered to the clients between 3:30 p.m. and 5:02 p.m. This same procedure was observed on June 30, 2010 at 10:00 a.m. Employee C (unlicensed staff) was observed to set-up medications for seven clients. The medications that employee C set-up at 10:00 a.m. were administered to the clients between 11:30 a.m. and 12:15 p.m. The medications that employee B and C were observed to prepare were not administered to the client after preparing them as indicated in the definition of medication administration.

The home care provider's medication error reports were reviewed. A medication error occurred on May 31, 2010, involving a client getting the wrong medications. Documentation on the medication error report indicated that a review of the error was completed by employee A (registered nurse) and the unlicensed staff. A factor identified as causing the error was that the client's name had been moved to a different spot in the medication container, and the unlicensed staff person, when pre-setting up the client's medications placed the client's medication cup in a different client's spot. When the unlicensed staff administered the medications, she administered the medications to the wrong client.

Employee A (registered nurse) was interviewed June 29 and 30, 2010, regarding the agency's policy related to medication administration by unlicensed staff. Employee A stated she did not have a written policy on the medication administration system that was being used, but stated the way that employee B and C were observed to conduct the medication pass was the way she had taught them how to do it. Employee A stated that it was acceptable for the unlicensed staff to set up all of the clients' medications that were to be administered during that shift, at the beginning of the unlicensed staffs' shift.

TO COMPLY: A registered nurse may delegate medication administration or assistance with self-administration of medication only to a person who satisfies the requirements of part 4668.0835, subpart 2, and possesses the knowledge and skills consistent with the complexity of medication administration or assistance with self-administration of medication, only in accordance with Minnesota Statutes, sections 148.171 to 148.285.

TIME PERIOD FOR CORRECTION: Seven (7) days

2. MN Rule 4668.0865 Subp. 8

Based on observation and interview, the licensee failed to ensure that medications were kept locked and only authorized personnel had access to the keys. The findings include:

On June 29, 2010, at 5:00 p.m. employee B was observed to leave an unlocked container containing client's medications on top of an unlocked cart in the dining room unattended. Employee B stated she needed to check on a couple of clients and would be back shortly. Employee B left the medications unattended for approximately ten minutes. Ten clients were in the dining room, two family members, and the housing director at this time.

During a tour of the housing with services facility, on June 29, 2010, at 10:30 a.m., the key to the medication room was observed to be hanging on the wall in an unlocked storage closet. The storage closet was directly across the hall from the laundry facilities that were utilized by the clients.

When interviewed June 30, 2010, employee A (registered nurse) confirmed that employee B should not have left the medications unattended in the dining room on June 29, 2010. In addition, employee B stated the medication room key was stored in the unlocked storage closet so staff would have access to it if needed. Employee B acknowledged that anyone, not just staff authorized to have access to the medication room keys could take the medication room key if they knew it was there.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

3. MN Rule 4668.0865 Subp. 9

Based on observation and interview, the licensee failed to ensure that schedule II medications were stored in a locked compartment that was permanently affixed to the physical plant or medication cart for one of one medication storage area reviewed. The findings include:

When interviewed June 29, 2010, employee A (registered nurse) stated that all of the client's medications were centrally stored. On June 30, 2010, at 10:50 a.m., the central storage of schedule II medications was reviewed. Two boxes of Fentanyl patches were observed to be stored in a locked container in a cupboard in the medication room. The locked container was not permanently affixed to the physical plant or medication cart.

When interviewed June 30, 2010, employee A confirmed the container for Schedule II medications was not permanently affixed to the physical plant. Employee A stated she was not aware this was a requirement.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

4. MN Statute §144A.441

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

Clients #1 and #2 began receiving assisted living services from the licensee on February 1, 2009, and March 24, 2010, respectively. Clients #1 and #2 were provided a copy of the Minnesota Home Care Bill of Rights, but the content did not include the current language for assisted living clients in clause 16, which included the right to at least a thirty day advance notice of termination of a service by the provider.

When interviewed June 29, 2010, employee A (registered nurse) confirmed that all the clients under their Class F license received assisted living services. The RN stated she was not aware there was a version of the Home Care Bill of Rights specifically for clients that received assisted living services.

TO COMPLY: Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):

"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:
(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;
(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or
(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

TIME PERIOD FOR CORRECTION: Thirty (30) days

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