MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9971 7810

December 22, 2008

Bridget Esslings Carlson, Administrator
Scenic Hills Alternative Care
2187 Bonnie Lane
St Paul, MN 55119

Re: Results of State Licensing Survey

Dear Ms. Carlson:

The above agency was surveyed on October 21, 22, 23, 24, 27, 30, and November 12, 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: Ramsey 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: SCENIC HILLS ALTERNATIVE CARE

HFID #: 26210

Date(s) of Survey: October 21, 22, 23, 24, 27, 30, and November 12, 2008

Project #: QL26210001

Indicators of Compliance	Outcomes Observed	Comments
1. The provider only accepts and retains clients for whom it can meet the needs as agreed to in the service plan. **Focus Survey** • MN Rule 4668.0815 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0825 Subp. 2 • MN Rule 4668.0845	• Each client has an assessment and service plan developed by a registered nurse within 2 weeks and prior to initiation of delegated nursing services, reviewed at least annually, and as needed. • The service plan accurately describes the client's needs. • Care is provided as stated in the service plan. • The client and/or representative understand what care will be provided and what it costs.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

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

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

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. **Focus Survey** • MN Rule 4668.0855 • MN Rule 4668.0860 **Expanded Survey** • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0865 • MN Rule 4668.0870	• A registered nurse is contacted when there is a change in a client's condition that requires a nursing assessment. • Emergency and medical services are contacted, as needed. • The client and/or representative is informed when changes occur. • The agency has a system for the control of medications. • A registered nurse trains unlicensed personnel prior to them administering medications. • Medications and treatments are ordered by a prescriber and are administered and documented as prescribed.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued X___Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
7. The provider has a current license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• The CLASS F license (and other licenses or registrations as required) are posted in a place that communicates to the public what services may be provided. • The agency operates within its license(s) and applicable waivers and variances. • Advertisement accurately reflects the services provided by the agency.	**Focus Survey** _X_Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
8. The provider is in compliance with MDH waivers and variances **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** _X_ Survey not Expanded ____ Met ____ Correction Order(s) issued ____ 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 4668.0030 Subp. 2

<u>INDICATOR OF COMPLIANCE</u>: # 2

Based on record review and interview, the licensee failed to provide the current Minnesota Home Care Bill of Rights to three of three clients' (A1, B1 and C1) records reviewed. The findings include:

Clients A1, B1 and C1 began receiving services on January 17, 2006, August 5, 2008, and April 17, 2003 respectively. The clients' records contained documentation that they had received a copy of the MN Home Care Bill of Rights, although it was not the most current 2002 version of the home care rights. When interviewed October 21, 2008, employee AC confirmed that the version of the bill of rights that was given to clients A1, B1 and C1 was not the most current version of rights.

2. MN Rule 4668.0030 Subp. 4

<u>INDICATOR OF COMPLIANCE</u>: # 2

Based on record review and interview, the licensee failed to ensure that in addition to the text of the Minnesota Home Care Bill of Rights, clients were given the required information regarding complaints for three of three clients' (A1, B1 and C1) records reviewed. The findings include:

Clients A1, B1 and C1 began receiving services on January 17, 2006, August 5, 2008, and April 17, 2003 respectively. The clients had been given a copy of the bill of rights that did not contain the correct address and telephone number of the Office of Health Facility Complaints and Office of the Ombudsman. In addition, the copy of the bill of rights did not contain the licensee's name, address, telephone number, and name or title of the person to whom problems or complaints may be directed.

When interviewed on October 21, 2008, employee AC confirmed that on the copy of the bill of rights given to the clients, the addresses and telephone numbers of the Office of Health Facility Complaints and Ombudsman were incorrect, and that the licensee's name, address and phone number were not included on this document.

3. MN Rule 4668.0040 Subp. 2

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to provide clients with a complete written notice related to the procedure for making a complaint. The findings include:

The licensee's written "Resident Grievance Procedure" that was provided to clients did not contain information related to the client's right to complain to the Office of Health Facility Complaints at the Minnesota Department of Health, nor did it contain a statement that the provider would not retaliate because of a complaint. When interviewed October 21, 2008, employee AC confirmed that the required information was not included in the "Resident Grievance Procedure."

4. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that tuberculosis screening was completed for three of seven employees' (AD, AG and CA) records reviewed. The findings include:

Employee AD was hired to provide direct care to clients on November 4, 2004. There was no record of tuberculosis screening for employee AD. When interviewed on October 23, 2008, employee AC confirmed that there was no record of tuberculosis screening for employee AD, and stated she was unsure if he had had any tuberculosis screening.

Employee AG was hired to provide direct care to clients on March 16, 2007. Her record contained documentation of a negative Mantoux from August 17, 2006. There was no other documentation of Mantoux testing. When interviewed on October 23, 2008, employee AG confirmed she had not had any further tuberculosis screening since the Mantoux test in August of 2006.

Employee CA was hired to provide direct care to clients on December 17, 2007. There was no record of tuberculosis screening for employee CA. When interviewed on October 24, 2008, employee AC confirmed that employee CA had not had any tuberculosis screening since she was hired.

5. MN Rule 4668.0065 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure the required infection control in-service training was provided for two of six employees (AD and AE) who had direct contact with clients and were employed with the licensee greater than twelve months. The findings include:

Employees AD and AE were hired by the licensee as contractors to provide professional nursing November 4, 2004, and May 7, 2007 respectively. There was no evidence in their records that they had received infection control training for each twelve months of employment. When interviewed October 23, 2008, employee AC confirmed there was no record of infection control training for employees AD and AE in their files, and stated she did not know if they had had infection control training in their professional careers in the last year.

6. MN Rule 4668.0805 Subp. 2

INDICATOR OF COMPLIANCE: # 3

Based on record review and interview, the licensee failed to ensure that the orientation to the home care requirements was complete for seven of seven employees' (AD, AE, AF, AG, BB, BC and CA) records reviewed. The findings include:

Employees AD, AE, AF, AG, BB, BC and CA began providing direct care to clients on November 4, 2004, May 7, 2007, March 11, 2004, March 16, 2007, April 4, 2007, June 22, 2007, and December 17, 2007 respectively. The employees received orientation, but it did not include an overview of the home care rules and statutes. When interviewed on October 23, 2007, employee AC confirmed that an overview of the home care rules and statutes was not included in the employees' orientation.

7. MN Rule 4668.0815 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that a service plan was established for three of three clients' (A1, B1 and C1) records reviewed. The findings include:

Clients A1, B1 and C1 began receiving services on January 17, 2006, August 5, 2008, and April 17, 2003 respectively. There were no written service plans for these clients that included a description of the services to be provided and their frequency, identification of the person or categories of persons who were to provide the services, the frequency of supervision, the fees for each service, and a contingency action plan. The licensee utilized an "Individual Resident Placement Agreement," but this document did not include the required components. When interviewed October 21, 2008, employee AC stated there were no service plans for clients A1, B1, and C1, and confirmed that the "Individual Resident Placement Agreement" did not include the components required in the service plan.

8. MN Rule 4668.0825 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for two of two clients' (A1 and C1) records reviewed who received delegated nursing tasks. The findings include:

Client C1's record indicated he received assistance from unlicensed staff with the delegated nursing tasks of checking his blood sugar, and oxygen administration. On October 23, 2008, employee CA was observed to assist client C1 with his cares. When interviewed on October 23, 2008, employee CA confirmed she checked client C1's blood sugar twice on her shift, and assisted him with his oxygen use as needed. There was no evidence that employee CA had demonstrated competency to a RN prior to performing these procedures. When questioned regarding her training/competency for these delegated tasks, employee CA stated that employee BB, an unlicensed staff person, trained her how to do these tasks. When questioned if the RN trained/competency tested her on how to do these tasks, she stated no. When interviewed October 23, 2008, employee BB confirmed that she trained employee CA on the tasks of checking a client's blood sugar, and oxygen administration. Employee BB stated she was a trained medication aide prior to working for the licensee, and that she had prior experience doing those tasks.

Client A1's record indicated that unlicensed staff performed the delegated nursing task of checking her blood sugar twice a day. On October 22, 2008 employee AG was observed to assist client A1 with her cares. When interviewed on October 22, 2008, employee AG confirmed that she checked client A1's blood sugar in the morning. There was no evidence in employee AG's file that she had demonstrated competency to a RN her ability to perform a blood sugar check. When questioned on October 22, 2008, employee AG stated that the RN did not train her on how to do a blood sugar check, but rather an unlicensed staff person who was assigned to train her showed her how to do the task.

9. MN Rule 4668.0835 Subp. 2

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed employees who performed Class F home care services had successfully completed training or demonstrated competency by the registered nurse in the required topics, for five of five unlicensed employees' (AF, AG, BB, BC and CA) records reviewed. The findings include:

Unlicensed employees, AF, AG, BB, BC and CA were hired to provide direct care services to clients on March 11, 2004, March 16, 2007, April 4, 2007, June 22, 2007, and December 17, 2007, respectively. Employees AF, AG, BB, BC and CAs' core training lacked evidence that the following topics were included in their training/competency: communication skills; observing, reporting, and documenting client status and care; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and physical, emotional and developmental needs of clients and ways to work with clients who have problems in these areas. In addition, there was no evidence of training/competency of the home care services that the unlicensed staff were providing to clients, such as assistance with bathing, dressing, grooming, transferring and toileting. When

interviewed on October 23, 2008 employee AC confirmed the above-mentioned training was lacking, and stated that she was unaware of this requirement.

10. 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' (A1, B1 and C1) records reviewed. The findings include

Clients A1, B1 and C1 began receiving services on January 17, 2006, August 5, 2008, and April 17, 2003 respectively, which included medication administration by unlicensed staff. There were no supervisory visits by the RN within fourteen days after initiation of services and every sixty-two days thereafter noted in the clients' records. When interviewed October 21, 2008, employee AC confirmed there were no RN supervisory visits of the unlicensed staff in the clients' records and stated that supervisory visits had not been done. Employee AC stated she was not aware of this requirement.

11. MN Rule 4668.0855 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on interview, the licensee failed to have medications set-up by a nurse, physician, or pharmacist for three of three clients' (A1, B1 and C1) reviewed. The findings include:

When interviewed October 23, 2008, employee AC stated that the practice for the agency was that the House Managers, who were unlicensed personnel, set-up clients A1, B1 and C1s' medications in weekly medi-set containers. She stated that they were trained medication aides, and that she thought this was an acceptable practice. A review of personnel files for employees AF and BB, who were House Managers, confirmed that they were unlicensed staff.

12. MN Rule 4668.0855 Subp. 4

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure the registered nurse (RN) instructed unlicensed personnel on the procedures for assistance with self-administration of medications or medication administration for one of one unlicensed staff person's (CA) record reviewed who was hired within the last year. The findings include:

Employee CA was hired to provide direct care to clients December 17, 2007, which included medication administration. On October 23, 2008, employee CA was observed to administer medications to client C1. There was no evidence in employee CA's file that she had been trained and evaluated by the RN in the procedures for medication administration which were delegated tasks employee CA was performing. When interviewed October 23, 2008, employee CA stated that the house manager, employee BB, an unlicensed staff person, had trained her in how to do medication administration. Employee CA confirmed the RN had not instructed and evaluated her in medication administration.

13. MN Rule 4668.0855 Subp. 6

INDICATOR OF COMPLIANCE: # 6

Based on observation and interview, the licensee failed to ensure that unlicensed staff did not draw up insulin for one of one client's (C1) record reviewed who received insulin via an insulin pen. The findings include:

Client C1's physician's orders indicated he received Novolog Insulin via a Flexpen; six units before breakfast, six units before lunch, and eight units before supper. On October 23, 2008, employee AB was observed to administer client C1's noon insulin using a Novolog Flexpen. Employee AB was observed to dial the dosage on the insulin pen to six units prior to injecting the insulin. When interviewed October 23, 2008, employee AB confirmed that she was an unlicensed staff person, not a nurse. When interviewed on October 23, 2008, employee AC stated that it had been the practice of the agency to have unlicensed staff administer insulin using the Novolog Flexpens after they received training from the registered nurse. Employee AC stated she was not aware unlicensed staff could not dial the dosage of insulin on these pens.

14. MN Rule 4668.0855 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure a registered nurse (RN) instructed unlicensed staff before delegating the task of nebulizer treatments for one of one client's (C1) record reviewed who received nebulizer treatments. The findings include:

Client C1's record indicated that he received nebulizer treatments twice a day as needed. When interviewed on October 23, 2008, employee CA stated that she had administered client C1's nebulizer treatment several times, as the client needed it. There was no evidence in employee C1's file that the RN had instructed the employee in the proper methods to perform the nebulizer treatment nor was there evidence that employee CA demonstrated to the RN her ability to competently perform the procedure. When questioned on October 23, 2008, as to who trained her on how to perform the nebulizer treatment, employee CA stated that the House Manger, employee BB showed her how to do the nebulizer treatment. Employee BB was an unlicensed staff person.

15. MN Rule 4668.0855 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that medication administration was completed as prescribed for two of three clients' (A1 and B1) records reviewed. The findings include:

Client A1 had a physician's order, dated August 6, 2008, from a clinic visit which indicated Novolin Insulin 70/30 11 units subcutaneous before breakfast. The client's October 2008 medication administration record (MAR) indicated that the client had been receiving Novolin 70/30 12 units subcutaneous before breakfast. In addition, Client A1 had a physician's order to do blood sugar tests four times a day, at 8:00 a.m., noon, 5:00 p.m., and 8:00 p.m. The client's October, 2008 MAR indicated that the client's blood sugar had been checked only two times a day, at 8:00 a.m. and 5:00 p.m.

When interviewed on October 23, 2008, employee AC confirmed there was a discrepancy between the insulin dosages and the blood sugar check frequency, and stated that she did not know why they were not completed as ordered.

When interviewed on October 22, 2008, employee AF confirmed that she set up client A1's medications in weekly medi-set containers on a weekly basis. The reviewer and employee AF checked client A1's medi-set container to determine that the medications that were set-up in each time slot for the week, were what the physician had ordered. Client A1 had a physician's order, dated May 28, 2008, which stated Mirtazapine 22.5 milligrams (1 and ½ tablets) orally at HS (hours of sleep) every day. Client A1's "HS" slot for the remainder of the days in the medi-set container (Wednesday through Sunday), contained one 15 milligram tablet of Mirtazapine. The HS slots Wednesday through Sunday were missing the ½ tablet of Mirtazapine. When interviewed October 22, 2008, employee AF stated she must have "missed it."

Client B1's physician's orders, dated August 20, 2008, indicated, Flagyl 500 milligrams three times a day for ten days. The client's August and September MAR indicated the client received Flagyl for 12 days, instead of ten days as ordered. When interviewed October23, 2008, employee BA confirmed that the Flagyl had been given for more days then ordered, and stated she did not know why.

16. 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 one of three clients' (B1) records reviewed. The findings include:

Client C1 began receiving services from the licensee August 5, 2008. The client received medication administration. The client's August medication administration record indicated that he received seven medications including Prozac, Seroquel and Trazodone. The client's record lacked prescriber's orders for the medications that were administered to the client. When interviewed October 23, 2008, employee AC confirmed that the agency was providing medication administration to the client and that the record did not contain the client's admission orders. Employee AC stated that the client's family had the client's medication orders, but was unable to locate them during the survey.

Client C1 had prescriber's orders from a hospitalization dated August 20, 2008, that included Seroquel 100 milligrams one orally twice a day. The client's medication administration record (MAR) for August 2008 indicated that on August 26, 2008, the client's Seroquel was increased from two times a day to three times a day. The client's September 2008 MAR indicated that on September 4, 2008, the client's Seroquel was changed, from 100 milligrams three times a day, to 200 milligrams twice a day. There were no prescriber's orders for these Seroquel changes in the client's record. When interviewed on October 23, 2008, employee BA confirmed there were no prescriber's orders for these changes in the client's record, but stated that she had spoken to the physician, and the physician ordered these changes. Employee BA stated that the physician was to follow-up their conversation by sending a fax to the agency with the Seroquel order changes, because she was an unlicensed staff, and could not take the order changes over the phone. Employee BA stated the agency never received the faxes.

17. MN Rule 4668.0860 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on interview, the licensee failed to ensure that an order received by electronic means was communicated to the supervising registered nurse (RN) within one hour of receipt. The findings include:

When interviewed on October 24, 2008, employee AC described the system the agency followed when a prescriber's order was received by fax or other electronic means. Employee AC stated that periodically prescriber's send faxes or e-mails concerning medication changes for the clients. Employee AC stated the House Manager, who was an unlicensed staff person, faxed the order to the pharmacy. Once the medication was received from the pharmacy, the order was transcribed by the House Manager into the medication administration record, and the medication was started. When questioned as to when the RN would be notified of the new order, employee AC stated that the RN checks the orders of each client on a weekly basis. Employee AC confirmed the RN was not notified within one hour of receipt of receiving the prescriber's order unless he/she happened to be at the facility at the time an order was received by fax or other electronic means.

18. MN Rule 4668.0865 Subp. 7

INDICATOR OF COMPLIANCE: # 6

Based on observation and interview, the licensee failed to ensure that insulin used for one client was not saved for the use of another client at one of three Housing with Services sites (C) visited. The findings include:

On October 23, 2008, central storage of refrigerated medications at site C was reviewed. Boxes of Novolog Insulin Flexpens belonging to clients who had never lived at this site were stored with insulin belonging to clients who currently lived at site C. A box of four Novolog Insulin Flexpens with a prescription label on it for client A1 was noted in the refrigerator. Client A1 lived at site A, and no longer received her insulin via a Flexpen. A box of four Novolog Insulin Flexpens with a prescription label on it for client A3 was also noted in the refrigerator. Client A3 had lived at site A, and expired October 13, 2008. Client C1 who lived at site C received the same type of insulin through a Flexpen as the Flexpen Insulin prescriptions for client A1 and A3.

When interviewed October 23, 2008 employee CA and AB confirmed clients A1 and A3 never lived at site C, and stated they had no idea how or why these insulin flexpens were in site C's refrigerator. When interviewed on October 31, 2008, the registered nurse stated that both client's A1 and A3 were taken off the Novolog Flexpen Insulin and they should have been destroyed. The RN stated he did not know how client's A1 and A3's discontinued insulin got in site C's refrigerator. The RN stated that he did not take care of the insulin via a Flexpen, only the insulin that was to be drawn up by syringe. The RN stated that the unlicensed staff took care of and administered the insulin via a Flexpen.

19. MN Rule 4668.0865 Subp. 8

INDICATOR OF COMPLIANCE: # 6

Based on observation and interview, the licensee failed to store drugs in locked compartments at two of three Housing with Services sites (A and C) visited. The findings include:

Housing with Services sites A and C provide central storage of medications. On October 22, 2008, the central storage of medications was observed at site A. Prefilled insulin syringes and a vial of insulin belonging to client A1 were observed to be stored on the shelf of an unlocked common use refrigerator in the kitchen. When interviewed October 22, 2008, employee AC confirmed that the medications requiring refrigeration were not locked.

On October 23, 2008, the central storage of medications was observed at site B. Bags of prefilled syringes and a package of Novolog Flexpen Insulin that belonged to client C1 were stored on a shelf in an unlocked common use refrigerator. Boxes of Novolog Flexpen Insulin that belonged to client A1 and A3 were also stored on the shelf in this unlocked refrigerator. A box of 22 Nicotrol inhalation cartridges, 7 vials of Betaseron Interferon for client C2, 9 packages of Duoneb Inhalation vials, and 30 capsules of Spireva inhalation were noted to be stored in an unlocked cupboard in the kitchen. When interviewed on October 23, 2008, employee CA confirmed the clients' insulin and prescription medications were not stored in locked compartments.

20. MN Rule 4668.0865 Subp. 9

INDICATOR OF COMPLIANCE: # 6

Based on observation and interview, the licensee failed to store controlled drugs in a separately locked compartment, permanently affixed to the physical plant at two of three Housing with Services sites (B and C) visited. The findings include:

Housing with Services Sites B and C provide central storage of medications. On October 22, 2008, the central storage of medications at Site B was observed. The clients' routine medications were stored in a locked cupboard in separate bins labeled with each client's name. A bottle of Morphine Sulfate concentrate with no prescription label on it was noted in client B1's medication bin along with his other prescription medications. Morphine Sulfate is a controlled drug. When interviewed on October 22, 2008, employee BB stated that she did not know who the Morphine belonged to, and confirmed that it should have been stored in their separately locked compartment for controlled medications.

On October 23, 2008, the central storage of medications at Site C was observed. The clients' routine medications were stored in a locked cupboard in separate bins labeled with each client's name. Client C3's bin of medications contained two small medi-set containers. One medi-set container was labeled "PRN (as necessary) Vicodin." The medi-set container contained four tablets of Vicodin, a controlled medication. Another med-set container was labeled, "PRN Oxycodone." The medi-set container contained three tablets of Oxycodone, a controlled medication. When interviewed October 23, 2008, employee AB confirmed that these medications were controlled medications and should be locked with the other controlled medications.

21. MN Statute §144A.44 Subd. 1(14)

INDICATOR OF COMPLIANCE: # 2

Based on observations, and interview, the licensee failed to ensure that each client was treated with courtesy and respect for one of one client (A2) observed at Housing with Services site A. The findings include:

During the visit at Housing with Services Site A, it was noted that a six inch camera monitor was displayed in the living area of the house which was frequented by clients and visitors. Client A2 was observed on this monitor. Observations of the monitor the morning of October 22, 2008 revealed client A2 sitting on her bed in her night gown. On October 22, 2008 at approximately 11:00 a.m. the camera monitor was observed to be moved to the kitchen counter. Other clients were seated at the dining table and had full view of this monitor. Client A2 was observed to stand up, lift her night gown up in the back, exposing her buttocks in full view on the monitor. When interviewed on October 22, 2008 employee AG stated that there was a camera in client's A2's room per family request. She stated that the camera was pointed at the client's bed and commode that the client used at bedside. On October 22, 2008, the reviewer spoke to employee AC regarding the concern that this practice was a violation of the client's right to privacy. Employee AC corrected this practice during the survey by immediately removing the camera and monitor from the client's room.

22. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on observations, record review and interview, the licensee failed to ensure that a client who was at risk of abuse by another individual had an abuse prevention plan developed with specific measures identified to assist in minimizing the risk of abuse to the client for one of four clients (A2) who resided at Housing with Services site A. The findings include:

Client A2 had a diagnosis of mild dementia and had mental health issues which she was receiving treatment for. On October 21, 2008, from approximately 2:30 p.m. to 3:15 p.m., a conversation was overheard by the reviewer between client A2 and a visitor. The client was in her upstairs bedroom, and the reviewer overheard the conversation from the level below, in the dining area. The visitor was overheard repeatedly speaking in a loud voice, stating to the client; "Shut-up; You are miserable; If you had brains you would be dead; Just shut-up, I am tired of hearing your mouth." Employees AB, AC and AF were in the area where the reviewer was seated and overheard this conversation as well as the reviewer. When interviewed October 21, 2008, employee AC acknowledged that this situation "goes on pretty much every time" the client had this visitor. When questioned by the reviewer as to whether this visitor ever had been physically abusive to the client, employee AC acknowledged that in July of 2007 the visitor "yanked' the client's arms roughly to get her out of the car. Employee AC stated she reported this incident to an outside agency. The client's individual abuse prevention plan was reviewed and did not identify the client's risk of abuse from this visitor, nor did it address specific measures to assist in minimizing the risk of abuse to client A2. Employee AC acknowledged that the client's individual abuse prevention plan did not address the client's susceptibility to abuse by this visitor.

A draft copy of this completed form was reviewed with Michelle Youngberg, Director of Operations at an exit conference on November 12, 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).