MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7229

July 15, 2010

Julie Peterson, Administrator
Villa Court
1220 Villa Court Drive
Cromwell, MN 55726

Re: Results of State Licensing Survey

Dear Ms. Peterson:

The above agency was surveyed on June 1, 2 and 7, 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: Carlton 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 7229

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 220, P.O. Box 64938, St. Paul, Minnesota 55164-0900
Home Care & Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	JULIE PETERSON	DATE July 15, 2010
PROVIDER:	VILLA COURT	COUNTY: CARLTON
ADDRESS:	1220 VILLA COURT DRIVE CROMWELL, MN 55726	HFID: 26451

On June 1, 2 and 7, 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.

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 4668.0815 Subp. 2

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and revised each client's evaluation and service plan at least annually or more frequently when there was change in the client's condition that required a change in service for two of two clients' (#1 and #2) records reviewed. The findings include:

Client #1's service plan, dated January 11, 2010, indicated the client was to be walked every day. The client's RN evaluation, dated April 3, 2010, also indicated the client ambulated with assistance. A review of the client's resident service delivery record, dated March 29, 2010, to June 1, 2010, lacked evidence that the client had been walked daily. When interviewed June 2, 2010, employee B (unlicensed personnel) stated the client does not walk very often because she does not want to.

When interviewed June 2, 2010, employee D (RN) stated the client needed to be reevaluated in the area of ambulation and the service plan needed to be updated to reflect the services the client was currently receiving.

Client #2's RN evaluation, dated April 1, 2010, indicated the client needed assistance with transfers, ambulation, and at times needed the use of the EZ stand (a device which enables an individual to attain a standing position) to aide in transfers. The client's service plan, dated January 11, 2010, indicated the client needed assistance with transfers and assistance with ambulation daily. The service plan did not address the need for the EZ stand. The client's resident service delivery record, dated March 1, 2010, to June 1, 2010, lacked evidence that the client had been walked at all. When interviewed June 2, 2010, employee B (unlicensed personnel) stated the client had not walked for a long time and at times they need to use the EZ stand when transferring the client because he will not stand up. When interviewed June 2, 2010, employee D (RN) stated the client's service plan needed to be updated to reflect the services the client is currently receiving.

TO COMPLY: A registered nurse must review and revise a client's evaluation and service plan at least annually or more frequently when there is a change in the client's condition that requires a change in services.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0825 Subp. 4

Based on observation, record review and interview, the licensee failed to ensure that the registered nurse (RN) specified in writing the instructions for unlicensed personnel to follow when performing delegated nursing tasks for three of three clients' (#1, #2 and #3) records reviewed. The findings include:

Employee B (unlicensed personnel) was observed on June 1, 2010, at 3:15 p.m. performing a dressing change to client #1's buttock. The client's record lacked evidence of written instructions by the RN for how unlicensed personnel were to perform the dressing change.

Employee C (unlicensed personnel) was observed on June 2, 2010, at 7:30 a.m. providing client # 5 blood sugar checks and pulse oximeter (a device which measures the oxygen saturation level of the blood and pulse rate). The client's record lacked evidence of written instructions by the RN for how unlicensed personnel were to perform the blood sugar checks and pulse oximeter checks.

Client #2 was observed on June 1 and 2, 2010, in his wheelchair with a tabs alarm applied to his clothing. The client's record lacked evidence of written instructions by the RN for how the tabs alarm was to be applied. The client's record contained progress notes, dated February 11, 2010, March 5 and 26, 2010, April 24, 2010, and May 22, and 28, 2010, which indicated an EZ stand (a device which enables an individual to attain a standing position) was used to transfer the client. The RN evaluation, dated April 1, 2010, also indicated an EZ stand was used when transferring the client. When interviewed June 2, 2010, employee B stated they needed to use the EZ stand to transfer the client. The client's record lacked evidence of written instructions by the RN for how unlicensed personnel are to apply the tabs alarm or use the EZ stand.

When interviewed June 2, 2101, employee D (registered nurse) stated there were no written instructions for the blood sugar checks, pulse oximeter, tabs alarm, EZ stand and client #1's dressing changes.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0855 Subp. 7

Based on interview and record review, the licensee failed to ensure that the registered nurse (RN) documented in the client's record, the specific instructions for performing the procedures for each client, receiving pro re nata (PRN, as needed) medications for one of two clients' (#2) records reviewed. The findings include:

Client #2 had a prescriber's order, dated June 30, 2007, for Bisacodyl 5 milligram (mg.) tablet one or two by mouth PRN for constipation. Client #2's medication administration record (MAR) indicated on May 13, 2010, employee E (unlicensed personnel) administered two tablets of Bisacodyl to the client. The client's record did not contain specific instructions for when one or two tablets of the medication were to be given.

Client #2 had a prescriber's order, dated September 28, 2010, for Lorazepam 0.5 mg tablet, take one or two tablets by mouth as needed for anxiety and agitation. The client's MAR indicated employee F(unlicensed personnel) administered two tablets of Ativan to the client on April, 2, 3, 4, 5, 7, 8, 9, 10, 14, 15, 16, 17, 18 and 19, 2010. The client's record did not contain specific instructions for when one or two tablets of the medication were to be given.

When interviewed June 2, 2010, employee D (registered nurse) stated there were no written instructions to indicate whether the unlicensed staff was to administer one or two tablets of Bisacodyl or Ativan. Employee D also stated the unlicensed personnel write on the report sheet when the PRN medications are administered and the registered nurse reviews the report sheet the next day.

TO COMPLY: A person who satisfies the training requirements of subpart 4 may perform assistance with self-administration of medication or medication administration if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's records; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

4. MN Rule 4668.0855 Subp. 9

Based on record review and interview, the licensee failed to ensure medications were administered as ordered for one of two clients (#1) reviewed. The findings include:

Client #1 had a prescriber's order, dated February 16, 2010, for Ensure (nutritional supplement) three times a day. Client #1's April and May 2010 medication administration record (MAR) indicated the client received the Ensure two times a day instead of the three times a day as ordered.

Client #1 had a prescriber's order, dated May 11, 2010, for Lortab 5/500 (analgesic) one or two tabs every four to six hours PRN. The client's May 2010 MAR indicated the client received Lortab one tablet on May 24, 2010, at 6:30 p.m. and on May 24, 2010, at 10:00 p.m. (only three and a half hours between doses).

When interviewed June 2, 2010, employee D (registered nurse) stated both the Ensure and Lortab were not given as ordered.

TO COMPLY: The name, date, time, quantity of dosage, and the method of administration of all prescribed legend and over-the-counter medications, and the signature and title of the authorized person who provided assistance with self-administration of medication or medication administration must be recorded in the client's record following the assistance with self-administration of medication or medication administration. If assistance with self-administration of medication or medication administration was not completed as prescribed, documentation must include the reason why it was not completed and any follow up procedures that were provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

5. MN Statute §144A.44 Subd. 1(2)

Based on observation, record review, and interview, the licensee failed to ensure clients received care and services according to acceptable nursing standards of practice for infection control and medication administration for six of six clients (#1, #2, #3, #4, #5 and 6) reviewed. The findings include:

Client #1 had a prescriber's order, dated February 16, 2010, for Dabs Solution on gauze dressing twice a day to ulcers. Employee B (unlicensed personnel) was observed on June 1, 2010, at 3:20 p.m. performing the dressing change to the client's ulcers. Employee B was observed to carry the Dab solution into the client's room. She then washed her hands, but did not use paper towel to turn the water facet off. Employee B then placed her fingers into the bottle of gauze and pulled out a piece of gauze with her bare fingers, placed the gauze into the Dabs solution, applied gloves and completed the treatment. Employee B then removed the gloves and washed her hands again not using paper towel to turn off the facet. When interviewed June 1, 2010, employee B stated she did not use paper towel to turn off the water facet. She also stated that she should have put on gloves to pull the gauze out of the bottle but she did not because it is difficult to pull out the gauze with gloved hands. The client's record did not contain written instructions for how the unlicensed personnel were to perform the treatment. When interviewed June 1, 2010, employee D (registered nurse) stated the unlicensed personnel are to use gloved hands to pull the gauze out of the bottle and they are to use paper towel to turn off the water facet. Employee D went on to state that there were no written instructions for how staff were to do the dressing change. Employee B's personnel record indicated she had received training in hand washing.

Client #1's medication administration record (MAR) indicated the client was to be weighed weekly. The client's weight on April 6, 2010, was 111.9 pounds and May 12, 2010, the client weighed 105 pounds. The progress notes in the client's record on May 4, 2010, indicated the client usually eats a good breakfast and drinks her Ensure (nutritional supplement), but her appetite is not good at lunchtime and she is losing weight. Notes on May 10, 2010, indicated the client's appetite is poor and she is not hungry, the Ensure is given at 3:00 p.m. so it will not interfere with supper, and she mixes her food together so she will not have to eat it. The client had a prescriber's order, dated February 16, 2010, for Ensure three times a day. The client's April and May 2010 MARs indicated the client had only received the Ensure twice a day. The client's record lacked further evaluation of the weight loss. When interviewed June 2, 2010, employee D (registered nurse) stated she was concerned about the client's weight loss and that further evaluation of the client's weight loss needed to be completed.

Employee C (unlicensed personnel) was observed June 2, 2010, during the morning medication pass. Employee C was observed to wash her hands several times, but did not use paper towel to turn off the water facet off. When interviewed June 2, 2010, employee C stated she did not use paper towel to turn the water facet off.

The licensee's hand washing policy indicated staff is to use a clean piece of paper towel to turn of the water facet after washing hands.

During the morning medication pass on June 2, 2010, employee C was observed to enter the dining room with a tray of medication cups labeled with the clients' names. Employee C proceeded to place cups of medications in front of clients # 3, #4, and #5 and walk away from the table. Employee C then gave medications to the other clients in the dining room and then left the dining room. When employee C returned to the dining room she did not check to see if clients #3, #4, and #5 had swallowed their medications. Client #3's, #4's and #5's service plans dated May 12, 2009, September 18, 2009, and April 1, 2009, respectively indicated the clients were to receive medication administration. When interviewed June 2, 2010, employee D (registered nurse) stated unlicensed personnel are to watch the clients swallow their medications.

The licensee's medication administration policy indicates staff is to set up and give medications to one resident at a time.

TO COMPLY: A person who receives home care services has these rights:
(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

TIME PERIOD FOR CORRECTION: Thirty (30) days

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