MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6178

September 20, 2010

Shelley Cloose, Administrator
Autumn Hills of Bemidji Inc
2528 Park Avenue Northwest
Bemidji, MN 56601

Re: Results of State Licensing Survey

Dear Ms. Cloose:

The above agency was surveyed on July 28 and 29, 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: Beltrami 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 6178

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:	SHELLEY CLOOSE	DATE: September 20, 2010
PROVIDER:	AUTUMN HILLS OF BEMIDJI INC	COUNTY: BELTRAMI
ADDRESS:	2528 PARK AVENUE NORTHWEST BEMIDJI, MN 56601	HFID: 23983

On July 28 and 29, 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 4668.0065 Subp. 3

Based on record review and interview, the licensee failed to ensure annual infection control in-service training was completed for two of two unlicensed staff (B and C) reviewed. The findings include:

Employee B (unlicensed staff) was hired on July 15, 2010. Employee B's record indicated she received infection control training on July 20, 2009. A review of the agency's infection control training indicated staff was trained on hand washing, gloves, cleaning up blood spills, washing and drying laundry and house hold chores.

During an interview on July 28, 2010, the training was reviewed with employee A (registered nurse/administrator). Employee A stated the training did not cover gowns and masks, disposal of contaminated materials and equipment, disinfecting reusable equipment and disinfecting environmental surfaces.

Employee C (unlicensed staff) was hired on July 7, 2005. Employee C's record indicated she last received infection control training on August 7, 2005. When interviewed July 28, 2010, employee C confirmed she had not received annual infection control training. When interviewed July 28, 2010, employee A also confirmed employee C had not received annual infection control training.

TO COMPLY: For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;

B. the need for and use of protective gloves, gowns, and masks;

C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;

D. disinfecting reusable equipment; and

E. disinfecting environmental surfaces.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0810 Subp. 6

Based on record review and interview, the licensee failed to maintain a complete record for one of one client (#1) record reviewed. The findings include:

Client #1 began receiving services on January 8, 2010. The client's diagnoses included Diabetes. A review of agency incident reports (that are not a part of the client's record) revealed the following information related to client #1: on January 17, 2010, at 12:15 p.m., the client fell hitting her left ear and neck on her walker and was sent to the emergency room; on February 15, 2010, at 9:40 p.m., the client fell when getting out of bed to go to the bathroom; on February 17, 2010, at 9:40 p.m. the client fell; on April 3, 2010, at 1:30 a.m. the client fell; on June 18, 2010, at 12:15 a.m. the client called staff to her room stating she was weak and staff could not understand the client when she talked. The client's blood sugar was 45 and the ambulance was called; and on June 18, 2010, at 7:40 a.m. documentation indicated the client had a blood sugar of 29 and the ambulance was called. Client #1's record did not contain any documentation pertaining to the preceding incidents.

Client #1's medication administration record indicated the client was in the hospital on June 2 and 3, 2010. There was no documentation in the client's record pertaining to why she was hospitalized or the condition of the client upon her return to the licensee.

When interviewed July 28, 2010, employee A (registered nurse/administrator) verified the incidents described on the agency's incident reports were not documented in the client's record.

TO COMPLY: The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services;

(6) names, addresses, and telephone numbers of any responsible persons;

(7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

(9) the client's advance directive, if any;

B. an evaluation and service plan as required under part 4668.0815;

C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;

D. medication and treatment orders, if any;

E. the client's current tuberculosis infection status, if known;

F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;

G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;

I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0855 Subp. 9

Based on record review and interview, the licensee failed to have complete medication records for two of two clients' (#1 and #2) records reviewed and failed to administer medications as prescribed for one of two clients' (#1) records reviewed. The findings include:

Client #1 had a prescriber's order, dated June 18, 2010, for Tramadol HCL 50 milligrams (mg.) tablets take one or two tablets by mouth every 6 hours as need for pain. The client's June 2010 medication and treatment record (MAR) indicated the client received the Tramadol on June 23, 24, 27 and 28, 2010; however the time the medication was given and the number of tablets that were administered was not documented on the MAR.

Client #1 had a prescriber's order, dated June 18, 2010, which stated Glyburide 5 mg. by mouth three times a day. Client #1's June and July 2010 MAR indicated the client received Glyburide 5 mg. two tablets at 8:00 a.m., one tablet at 12:00 noon, and one tablet at 5:00 p.m.

When interviewed July 28, 2010, employee A (registered nurse/ manager) confirmed the number of tablets of Tramadol was not documented and the Glyburide was not administered as ordered.

Client #2 had the following prescriber's orders: July 7, 2010, Coumadin 7.5 mg. on Monday, Wednesday, Friday and Sunday and 5 mg. on Tuesday, Thursday and Saturday; July 14, 2010, give Coumadin 10 mg. today and 7.5 mg. the other days; and July 21, 2010, give Coumadin 5 mg. today and 7.5 mg all other days. The client's July 2010 MAR indicated he Coumadin was administered daily, but did not indicate the dose of Coumadin that was administered.

When interviewed July 28, 2010, employee A (registered nurse/administrator) stated she set the Coumadin up weekly in individual medi set boxes. Employee A went on to state she did not document the set up of the Coumadin. Employee A also confirmed the clients MAR did not reflect the dose of Coumadin that was administered each day.

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

4. MN Statute §144A.44 Subd. 1(2)

Based on observation, record review and interview, the licensee failed to provide services according to acceptable medical and nursing standards for four of four clients (#1, #2, #3 and #4) reviewed.

Client #1 began receiving services on January 8, 2010. The client's diagnoses included Diabetes. A review of agency incident reports (that are not a part of the client's record) revealed the following information related to client #1: on January 17, 2010, at 12:15 p.m., the client fell hitting her left ear and neck on her walker and was sent to the emergency room; on February 15, 2010, at 9:40 p.m., the client fell when getting out of bed to go to the bathroom; on February 17, 2010, at 9:40 p.m. the client fell; on April 3, 2010, at 1:30 a.m. the client fell; on June 18, 2010, at 12:15 a.m. the client called staff to her room stating she was weak and staff could not understand the client when she talked. The client's blood sugar was 45 and the ambulance was called; and on June 18, 2010, at 7:40 a.m. documentation indicated the client had a blood sugar of 29 and the ambulance was called. Client #1's record did not contain any documentation pertaining to the preceding incidents.

Client #1's medication administration record (MAR) indicated the client was in the hospital on June 2 and 3, 2010. There was no other documentation in the client's record pertaining to why she was hospitalized or the condition of the client upon her return to the licensee.

Client #1's record contained a fall risk assessment, dated January 12, 2010, which indicated she was at high risk for falls. The client's record lacked documentation of further evaluation related to the falls.

When interviewed July 28, 2010, employee A (registered nurse/administrator) stated the incidents were not documented in the client's record and that she had not completed any further assessments pertaining to the changes in the client's condition. Employee A was not able to state why the client was hospitalized on June 2, 2010. When interviewed July 28, 2010, employee C (unlicensed staff/manager) stated client #1 was hospitalized for pneumonia and confirmed there was no documentation to reflect the client's condition at the time the client was hospitalized or when she returned from the hospital.

During observation of medication administration on July 28, 2010, at 8:30 a.m. employee B (unlicensed personnel) was observed preparing client #2's medications by placing the medications in a paper medication cup. As she placed each medication in the medication cup she initialed the medications on the client's MAR. The client also requested one tablet of Tramadol 50 milligrams (mg.) Xanax 0.5 mg. and Promethazine 25 mg. to be given at this time. These medications were placed in the separate medication cups. Employee B documented that these medication were administered to the client at 8:33 a.m. Employee B then went and gave the two cups with the medications to client #2 by placing then on the dining room table by the client and then she walked away from the client. It was not until after the client had completed eating her breakfast at 8:52 a.m. that the client took the medication in the two medication cups. Employee B had walked in and out of the dinning room several times during this period of time. Client #2's record contained a medication administration assessment, dated October 17, 2010, which indicated the client required medication administration by the staff.

Employee B went on to administer medications to client #3 and #4. Both clients had medication administration assessments, dated July 3, 2010, and January 2010, respectively that indicated they required medication administration by staff. Employee B placed their medications in medication cups, initialed the medications had been given, and gave the medication cups containing the medications to the clients and waked away. Employee B did not observe the clients swallow the medications.

A review of the agency's medication administration policy revealed that staff is to observe the clients swallow their medications and document the administration of the medication on the client's MAR after the medications are administered to the client.

Employee B's record indicated she received medication administration training on July 20, 2009. When interviewed July 28, 2010, employee B confirmed she had initialed the medication as being given on the MAR prior to giving the medications to the client and that she did not observe the clients swallow their medication.

When interviewed July 28, 2010, employee a (registered nurse/manager) stated staff are to document the medications after giving them and are to observe the client swallow their medications.

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: Seven (7) days

5. MN Statute §626.557 Subd. 14(b)

Based on record review and interview, the licensee failed to develop an individual abuse prevention plan for one of one client's (#1) record reviewed. The findings include:

Client #1's record contained a vulnerable adult assessment dated July 8, 2010. The assessment did not include the client's susceptibility to abuse by other individuals or the client's risk of abusing other vulnerable adults. When interviewed July 28, 2010, employee A (registered/manager) stated the vulnerable adult assessment did not contain an assessment of the client's susceptibility to abuse by other individuals or the client's risk of abusing other vulnerable adults.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

TIME PERIOD FOR CORRECTION: Thirty (30) days

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

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 1019

October 3, 2006

Shelley Cloose, Administrator
Autumn Hills of Bemidji Inc
2528 Park Avenue Northwest
Bemidji, MN 56601

Re: Results of State Licensing Survey

Dear Ms. Cloose:

The above agency was surveyed on September 7 and 11, 2006, 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 Johnston, Program Manager
Case Mix Review Program

Enclosures

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

CMR 3199 6/06

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6178

September 20, 2010

Shelley Cloose, Administrator
Autumn Hills of Bemidji Inc
2528 Park Avenue Northwest
Bemidji, MN 56601

Re: Results of State Licensing Survey

Dear Ms. Cloose:

The above agency was surveyed on July 28 and 29, 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.

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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: Beltrami 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 6178

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:	SHELLEY CLOOSE	DATE: September 20, 2010
PROVIDER:	AUTUMN HILLS OF BEMIDJI INC	COUNTY: BELTRAMI
ADDRESS:	2528 PARK AVENUE NORTHWEST BEMIDJI, MN 56601	HFID: 23983

On July 28 and 29, 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 4668.0065 Subp. 3

Based on record review and interview, the licensee failed to ensure annual infection control in-service training was completed for two of two unlicensed staff (B and C) reviewed. The findings include:

Employee B (unlicensed staff) was hired on July 15, 2010. Employee B's record indicated she received infection control training on July 20, 2009. A review of the agency's infection control training indicated staff was trained on hand washing, gloves, cleaning up blood spills, washing and drying laundry and house hold chores.

During an interview on July 28, 2010, the training was reviewed with employee A (registered nurse/administrator). Employee A stated the training did not cover gowns and masks, disposal of contaminated materials and equipment, disinfecting reusable equipment and disinfecting environmental surfaces.

Employee C (unlicensed staff) was hired on July 7, 2005. Employee C's record indicated she last received infection control training on August 7, 2005. When interviewed July 28, 2010, employee C confirmed she had not received annual infection control training. When interviewed July 28, 2010, employee A also confirmed employee C had not received annual infection control training.

TO COMPLY: For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;

B. the need for and use of protective gloves, gowns, and masks;

C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;

D. disinfecting reusable equipment; and

E. disinfecting environmental surfaces.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0810 Subp. 6

Based on record review and interview, the licensee failed to maintain a complete record for one of one client (#1) record reviewed. The findings include:

Client #1 began receiving services on January 8, 2010. The client's diagnoses included Diabetes. A review of agency incident reports (that are not a part of the client's record) revealed the following information related to client #1: on January 17, 2010, at 12:15 p.m., the client fell hitting her left ear and neck on her walker and was sent to the emergency room; on February 15, 2010, at 9:40 p.m., the client fell when getting out of bed to go to the bathroom; on February 17, 2010, at 9:40 p.m. the client fell; on April 3, 2010, at 1:30 a.m. the client fell; on June 18, 2010, at 12:15 a.m. the client called staff to her room stating she was weak and staff could not understand the client when she talked. The client's blood sugar was 45 and the ambulance was called; and on June 18, 2010, at 7:40 a.m. documentation indicated the client had a blood sugar of 29 and the ambulance was called. Client #1's record did not contain any documentation pertaining to the preceding incidents.

Client #1's medication administration record indicated the client was in the hospital on June 2 and 3, 2010. There was no documentation in the client's record pertaining to why she was hospitalized or the condition of the client upon her return to the licensee.

When interviewed July 28, 2010, employee A (registered nurse/administrator) verified the incidents described on the agency's incident reports were not documented in the client's record.

TO COMPLY: The client record must be accurate, up to date, and available to all persons responsible for assessing, planning, and providing assisted living home care services. The record must contain:

A. the following information about the client:

(1) name;

(2) address;

(3) telephone number;

(4) date of birth;

(5) dates of the beginning and end of services;

(6) names, addresses, and telephone numbers of any responsible persons;

(7) primary diagnosis and any other relevant current diagnoses;

(8) allergies, if any; and

(9) the client's advance directive, if any;

B. an evaluation and service plan as required under part 4668.0815;

C. a nursing assessment for nursing services, delegated nursing services, or central storage of medications, if any;

D. medication and treatment orders, if any;

E. the client's current tuberculosis infection status, if known;

F. documentation of each instance of assistance with self-administration of medication and of medication administration, if any;

G. documentation on the day of occurrence of any significant change in the client's status or any significant incident, including a fall or a refusal to take medications, and any actions by staff in response to the change or incident;

H. documentation at least weekly of the client's status and the home care services provided, if not addressed under item F or G;

I. the names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;

J. a summary following the discontinuation of services, which includes the reason for the initiation and discontinuation of services and the client's condition at the discontinuation of services; and

K. any other information necessary to provide care for each individual client.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0855 Subp. 9

Based on record review and interview, the licensee failed to have complete medication records for two of two clients' (#1 and #2) records reviewed and failed to administer medications as prescribed for one of two clients' (#1) records reviewed. The findings include:

Client #1 had a prescriber's order, dated June 18, 2010, for Tramadol HCL 50 milligrams (mg.) tablets take one or two tablets by mouth every 6 hours as need for pain. The client's June 2010 medication and treatment record (MAR) indicated the client received the Tramadol on June 23, 24, 27 and 28, 2010; however the time the medication was given and the number of tablets that were administered was not documented on the MAR.

Client #1 had a prescriber's order, dated June 18, 2010, which stated Glyburide 5 mg. by mouth three times a day. Client #1's June and July 2010 MAR indicated the client received Glyburide 5 mg. two tablets at 8:00 a.m., one tablet at 12:00 noon, and one tablet at 5:00 p.m.

When interviewed July 28, 2010, employee A (registered nurse/ manager) confirmed the number of tablets of Tramadol was not documented and the Glyburide was not administered as ordered.

Client #2 had the following prescriber's orders: July 7, 2010, Coumadin 7.5 mg. on Monday, Wednesday, Friday and Sunday and 5 mg. on Tuesday, Thursday and Saturday; July 14, 2010, give Coumadin 10 mg. today and 7.5 mg. the other days; and July 21, 2010, give Coumadin 5 mg. today and 7.5 mg all other days. The client's July 2010 MAR indicated he Coumadin was administered daily, but did not indicate the dose of Coumadin that was administered.

When interviewed July 28, 2010, employee A (registered nurse/administrator) stated she set the Coumadin up weekly in individual medi set boxes. Employee A went on to state she did not document the set up of the Coumadin. Employee A also confirmed the clients MAR did not reflect the dose of Coumadin that was administered each day.

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

4. MN Statute §144A.44 Subd. 1(2)

Based on observation, record review and interview, the licensee failed to provide services according to acceptable medical and nursing standards for four of four clients (#1, #2, #3 and #4) reviewed.

Client #1 began receiving services on January 8, 2010. The client's diagnoses included Diabetes. A review of agency incident reports (that are not a part of the client's record) revealed the following information related to client #1: on January 17, 2010, at 12:15 p.m., the client fell hitting her left ear and neck on her walker and was sent to the emergency room; on February 15, 2010, at 9:40 p.m., the client fell when getting out of bed to go to the bathroom; on February 17, 2010, at 9:40 p.m. the client fell; on April 3, 2010, at 1:30 a.m. the client fell; on June 18, 2010, at 12:15 a.m. the client called staff to her room stating she was weak and staff could not understand the client when she talked. The client's blood sugar was 45 and the ambulance was called; and on June 18, 2010, at 7:40 a.m. documentation indicated the client had a blood sugar of 29 and the ambulance was called. Client #1's record did not contain any documentation pertaining to the preceding incidents.

Client #1's medication administration record (MAR) indicated the client was in the hospital on June 2 and 3, 2010. There was no other documentation in the client's record pertaining to why she was hospitalized or the condition of the client upon her return to the licensee.

Client #1's record contained a fall risk assessment, dated January 12, 2010, which indicated she was at high risk for falls. The client's record lacked documentation of further evaluation related to the falls.

When interviewed July 28, 2010, employee A (registered nurse/administrator) stated the incidents were not documented in the client's record and that she had not completed any further assessments pertaining to the changes in the client's condition. Employee A was not able to state why the client was hospitalized on June 2, 2010. When interviewed July 28, 2010, employee C (unlicensed staff/manager) stated client #1 was hospitalized for pneumonia and confirmed there was no documentation to reflect the client's condition at the time the client was hospitalized or when she returned from the hospital.

During observation of medication administration on July 28, 2010, at 8:30 a.m. employee B (unlicensed personnel) was observed preparing client #2's medications by placing the medications in a paper medication cup. As she placed each medication in the medication cup she initialed the medications on the client's MAR. The client also requested one tablet of Tramadol 50 milligrams (mg.) Xanax 0.5 mg. and Promethazine 25 mg. to be given at this time. These medications were placed in the separate medication cups. Employee B documented that these medication were administered to the client at 8:33 a.m. Employee B then went and gave the two cups with the medications to client #2 by placing then on the dining room table by the client and then she walked away from the client. It was not until after the client had completed eating her breakfast at 8:52 a.m. that the client took the medication in the two medication cups. Employee B had walked in and out of the dinning room several times during this period of time. Client #2's record contained a medication administration assessment, dated October 17, 2010, which indicated the client required medication administration by the staff.

Employee B went on to administer medications to client #3 and #4. Both clients had medication administration assessments, dated July 3, 2010, and January 2010, respectively that indicated they required medication administration by staff. Employee B placed their medications in medication cups, initialed the medications had been given, and gave the medication cups containing the medications to the clients and waked away. Employee B did not observe the clients swallow the medications.

A review of the agency's medication administration policy revealed that staff is to observe the clients swallow their medications and document the administration of the medication on the client's MAR after the medications are administered to the client.

Employee B's record indicated she received medication administration training on July 20, 2009. When interviewed July 28, 2010, employee B confirmed she had initialed the medication as being given on the MAR prior to giving the medications to the client and that she did not observe the clients swallow their medication.

When interviewed July 28, 2010, employee a (registered nurse/manager) stated staff are to document the medications after giving them and are to observe the client swallow their medications.

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: Seven (7) days

5. MN Statute §626.557 Subd. 14(b)

Based on record review and interview, the licensee failed to develop an individual abuse prevention plan for one of one client's (#1) record reviewed. The findings include:

Client #1's record contained a vulnerable adult assessment dated July 8, 2010. The assessment did not include the client's susceptibility to abuse by other individuals or the client's risk of abusing other vulnerable adults. When interviewed July 28, 2010, employee A (registered/manager) stated the vulnerable adult assessment did not contain an assessment of the client's susceptibility to abuse by other individuals or the client's risk of abusing other vulnerable adults.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

TIME PERIOD FOR CORRECTION: Thirty (30) days

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

Assisted Living 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 Assisted Living home care providers (ALHCP). ALHCP 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 Assisted Living 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 ALHCP home care regulations. Any violations of ALHCP licensing requirements are noted at the end of the survey form.

Name of ALHCP: AUTUMN HILLS OF BEMIDJI INC
HFID #: 23983
Date(s) of Survey: September 7 and 11, 2006
Project #: QL23983002

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. • MN Rule 4668.0050 • MN Rule 4668.0800 Subp. 3 • MN Rule 4668.0815 • 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 understands what care will be provided and what it costs.	Annual Licensing Survey _X_ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #____ ____ New Correction Order issued ____ Education Provided
2. The provider promotes the clients' rights. • MN Rule 4668.0030 • MN Rule 4668.0040	• Clients are aware of and have their rights honored. • Clients are informed of and afforded the right to file a complaint.	Annual Licensing Survey _X_ Met ____ Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
• MN Rule 4668.0170 • MN Rule 4668.0870 • MN Statute §144A.44 • MN Statute §144D.04	• Continuity of Care is promoted for clients who are discharged from the provider.	Follow-up Survey #___ ____New Correction Order issued ____Education Provided
3. The health, safety, and well being of clients are protected and promoted. • MN Rule 4668.0035 • MN Rule 4668.0805 • MN Statute §144A.46 • MN Statute §144D.07 • MN Statute §626.557	• Clients are free from abuse or neglect. • Clients are free from restraints imposed for purposes of discipline or convenience. Provider 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.	Annual Licensing Survey _X_Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided
4. The clients' confidentiality is maintained. • 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.	Annual Licensing Survey _X_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. • MN Rule 4668.0820 • MN Rule 4668.0825 • MN Rule 4668.0830 • MN Rule 4668.0835 • MN Rule 4668.0840 • MN Rule 4668.0065 • MN Rule 4668.0070 • MN Statute §144D.065 • MN Statute §144A.45 • MN Statute §144A.461	• 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.	Annual Licensing Survey _X_Met ____Correction Order(s) issued ____Education Provided Follow-up Survey #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
6. Changes in a client's condition are recognized and acted upon. Medications are stored and administered safely. • MN Rule 4668.0800 • MN Rule 4668.0815 • MN Rule 4668.0820 • MN Rule 4668.0855 • MN Rule 4668.0860 • 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 provider 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.	Annual Licensing Survey _X_ Met ____ Correction Order(s) issued _X_ Education Provided Follow-up Survey #___ ____ New Correction Order issued ____ Education Provided
7. The provider has a current license. • MN Rule 4668.0008 • MN Rule 4668.0012 • MN Rule 4668.0016 • MN Rule 4668.0019 • MN Rule 4668.0220 • MN Statute §144A.47 • MN Statute §144D.02 • MN Statute §144D.04 • MN Statute §144D.05 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 ALHCP 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.	Annual Licensing Survey _X_ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #___ ____ New Correction Order issued ____ Education Provided
8. The is in compliance with MDH waivers and variances • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	Annual Licensing Survey _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 violations may be cited depending on what systems a provider has or fails to have in place and/or the severity of a violation. Also, the results of the focused licensing survey may result in an expanded survey where additional interviews, observations, and documentation reviews are conducted.

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

For Indicators of Compliance not met, list the rule or statute number and the findings of deficient practice noted.

A draft copy of this completed form was left with Shelley Cloose, R.N. at an exit conference on September 11, 2006. Any correction orders issued as a result of the on-site visit and the final Licensing Survey Form will arrive by certified mail 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 supervisory review, this form will be posted on the MDH website. General information about ALHCP is also available on the MDH website:
http://www.health.state.mn.us/divs/fpc/profinfo/cms/alhcp/alhcpsurvey.htm

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).