MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6185

September 20, 2010

Nnenna Dinney, Administrator
Totalcare Assisted Living Serv
2730 Winnetka Avenue North
New Hope, MN 55428

Re: Results of State Licensing Survey

Dear Ms. Dinney:

The above agency was surveyed on July 27 and 28, 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: Hennepin 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 6185

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 and Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	NNENNA DINNEY	DATE: September 20, 2010
PROVIDER:	TOTALCARE ASSISTED LIVING SERV	COUNTY: HENNEPIN
ADDRESS:	2730 WINNETKA AVENUE NORTH NEW HOPE, MN 55428	HFID: 24859

On July 27 and 28, 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 4668.0805 Subp. 1

Based on record review and interview, the licensee failed to ensure that each employee received orientation to home care requirements before providing home care services to clients for three of three employee**s'** (A, B and C) records reviewed. The findings include:

Employees A, B and C were hired and began providing home care services June 12, 2010, July 3, 2009 and March 3, 2009, respectively. Employee A's, B's and C's records did not contain evidence of orientation to home care requirements.

When interviewed July 28, 2010, at 12:50 p.m., employee D (administrator) stated that the orientation to home care had not been completed for any of the staff.

TO COMPLY: An individual applicant for a class F home care provider license and a person who provides direct care, supervision of direct care, or management of services for a licensee must complete an orientation to home care requirements before providing home care services to clients. The orientation may be incorporated into the training of unlicensed personnel required under part 4668.0835, subpart 2. The orientation need only be completed once.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0815 Subp. 4

Based on record review and interview, the licensee failed to ensure that service plans were complete for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted and began receiving home care services including medication administration and central storage of medication March 1, 2010. The client's service plan did not include medication administration and central storage of medication nor did it include the fees for services or a contingency plan.

When interviewed July 28, 2010, at 2:00 p.m., employee D (administrator) indicated that all of the client's service plans were the same and the service plans would all have to be redone. When interviewed July 28, 2010, employee A (registered nurse) indicated she had only been employed since June 2010 and had not worked on any of the service plans.

TO COMPLY: The service plan required under subpart 1 must include:

A. a description of the assisted living home care service or services to be provided and the frequency of each service, according to the individualized evaluation required under subpart 1;

B. the identification of the persons or categories of persons who are to provide the services;

C. the schedule or frequency of sessions of supervision or monitoring required by law, rule, or the client's condition for the services or the persons providing those services, if any;

D. the fees for each service; and

E. a plan for contingency action that includes:

(1) the action to be taken by the class F home care provider licensee, client, and responsible person if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the class F home care provider licensee whenever staff are providing services;

(3) the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the class F home care provider licensee to contact a responsible person of the client, if any; and

(5) the circumstances in which emergency medical services are not to be summoned, consistent with Minnesota Statutes, chapters 145B and 145C, and declarations made by the client under those chapters.

TIME PERIOD FOR CORRECTION: Thirty (30) days

3. MN Rule 4668.0825 Subp. 4

Based on record review and interview, the licensee failed to ensure that unlicensed staff 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 one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted and began receiving home care services March 1, 2010. The client used a CPAP (continuous positive airway pressure) machine and a Bi-level humidifier.

The July 2010 medication administration record (MAR) contained a typed written instruction sheet for cleaning of the CPAP and Bi-Level humidifier (the instructions had been signed by a licensed practical nurse from another agency). There was no documentation that the cleaning was being done.

When interviewed July 28, 2010, client #1 indicated she had been using the CPAP machine every night since the new mask had arrived in July 2010, but last night (July 27, 2010) she had to train employee C (unlicensed staff) on how to clean the machine.

When interviewed July 28, 2010, at 2:00 p.m., employee A (registered nurse) indicated she had not done any training for unlicensed employees since she was hired in June 2010. When interviewed July 28, 2010, at 3:00 p.m., employee D (administrator) indicated the unlicensed staff had not been trained to clean the CPAP or the humidifier.

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: Fourteen (14) days

4. MN Rule 4668.0840 Subp. 3

Based on record review and interview, the licensee failed to ensure training and competency testing was completed prior to performing assisted living home care services for two of two unlicensed employees' (B and C) records reviewed. The findings include:

Employees B and C were hired as unlicensed staff July 3, 2009, and March 3, 2009, respectively. Employee B's records indicated she received training in universal precautions and emergency procedures September 16, 2009. Employee C's records indicated she read information on blood borne pathogens and emergency procedures on September 1, 2009. There was no documentation that employees B and C received all of the required components of the core training.

When interviewed July 28, 2010, employee D (administrator) indicated that home care services began in August 2009 when clients started moving in. He stated that employees B and C had not completed the core training. Employee D indicated that employee B might have read some information or been at a staff meeting in September 2009 when some of the training occurred.

TO COMPLY: A. An unlicensed person performing assisted living home care services must successfully complete training or demonstrate competency in the topics described in subitems (1) to (12). The required topics are:

(1) an overview of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

(2) recognizing and handling emergencies and using emergency services;

(3) reporting maltreatment of vulnerable minors or adults under Minnesota Statutes, sections 626.556 and 626.557;

(4) the home care bill of rights, Minnesota Statutes, section 144A.44;

(5) handling clients' complaints and reporting complaints to the Office of Health Facility Complaints;

(6) the services of the ombudsman for older Minnesotans;

(7) communication skills;

(8) observing, reporting, and documenting client status and the care or services provided;

(9) basic infection control;

(10) maintaining a clean, safe, and healthy environment;

(11) basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and

(12) physical, emotional, and developmental needs of clients, and ways to work with clients who have problems in these areas, including respect for the client, the client's property, and the client's family.

B. The core training of unlicensed personnel must be taught by a registered nurse with experience or training in home care, except that item A, subitems (1) to (7), may be taught by another instructor under the direction of the registered nurse.

C. The core training curriculum must meet the requirements of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47.

TIME PERIOD FOR CORRECTION: Thirty (30) days

5. MN Rule 4668.0845 Subp. 2

Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise unlicensed personnel who performed services that require supervision for one of one client's (#1) record reviewed. The findings include:

Client #1 was admitted and began receiving home care services including medication administration March 1, 2010. There was no RN supervisory visit within fourteen days after initiation of home care services nor were there supervisory visits made at least every sixty two days thereafter.

When interviewed July 28, 2010, at 2:00 p.m., employee A (RN) indicated she had not done any supervisory visits since her employment began in June 2010. When interviewed July 28, 2010, at 2:00 p.m., employee D (administrator) indicated the previous RN had not done supervisory visits on any of the clients.

TO COMPLY: A. After the orientation required under part 4668.0835, subpart 5, a registered nurse must supervise, or a licensed practical nurse under the direction of a registered nurse must monitor, unlicensed persons who performed assisted living home care services that require supervision by a registered nurse at the housing with services establishment, to verify that the work is being performed adequately, identify problems, and assess the appropriateness of the care to the client's needs. Supervision or monitoring must be provided no less often than the following schedule:

(1) within 14 days after initiation of assisted living home care services that require supervision by a registered nurse; and

(2) at least every 62 days thereafter, or more frequently if indicated by a nursing assessment and the client's individualized service plan.

B. If the unlicensed person is monitored by a licensed practical nurse, the client must be supervised by a registered nurse at the housing with services establishment at least every other visit and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

TIME PERIOD FOR CORRECTION: Thirty (30) days

6. MN Rule 4668.0855 Subp. 4

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) instructed unlicensed personnel on the procedures for administration of medications for two of two unlicensed employees' (B and C) records reviewed. The findings include:

Employees B and C were hired as resident assistants July 3, 2009, and March 3, 2009, respectively. Employee B's record contained a certificate, dated July 20, 2010, for medication administration and employee C's record lacked documentation of training in medication administration by the RN.

Client #1's July 2010 medication administration record (MAR) contained documentation that indicated employee B administered medications to the client in June and July 2010 and employee C administered medications to the client in July 2010.

When interviewed July 28, 2010, employee A (RN) indicated she had not done any training since she was hired in June 2010. When interviewed July 28, 2010, employee D (administrator) and employee A indicated employees B and C had been administering medications since they were hired in 2009. Employee D stated employee C was scheduled to take the medication administration class on August 7, 2010.

TO COMPLY: Before the registered nurse delegates the task of assistance with self-administration of medication or the task of medication administration, a registered nurse must instruct the unlicensed person on the following:

(1) the complete procedure for checking a client's medication record;

(2) preparation of the medication for administration;

(3) administration of the medication to the client;

(4) assistance with self-administration of medication;

(5) documentation, after assistance with self-administration of medication or medication administration, of the date, time, dosage, and method of administration of all medications, or the reason for not assisting with self-administration of medication or medication administration as ordered, and the signature of the nurse or authorized person who assisted or administered and observed the same; and

(6) the type of information regarding assistance with self-administration of medication and medication administration reportable to a nurse.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

7. MN Rule 4668.0855 Subp. 9

Based on observation, record review and interview, the licensee failed to ensure medication administration records (MAR) were accurate and complete for one of two clients' (#2) records reviewed. The findings include:

Client #2 had an order, dated July 8, 2010, for Dorzolamide HCL, one drop to each eye twice daily. During observation of medication administration on July 28, 2010, the label on the eye drop container was noted to read Dorzolamide HCL. The July 2010 MAR stated Cosopt (Dorzolalmide Timolol) Ophthalmic 2-0.5% one drop in both eyes b.i.d. (twice daily). Employee B administered Alphagan and Travan eye drops, and then was going to administer the Cosopt, but this surveyor asked employee B to check the label on the eye drop container against the MAR. Employee B then stated she would check with employee D (administrator/unlicensed staff) regarding the discrepancy.

When interviewed July 28, 2010, employee A (registered nurse) indicated the Cosopt was from the admission orders, but the Dorzolamide HCL was being administered after the order of July 8, 2010, and the pharmacy had not changed the MAR to the correct eye drop. She confirmed that staff was not checking the MAR close enough to determine they were not administering the medication that was listed on the MAR.

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

8. 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 one of one client's (#2) record reviewed. The findings include:

Prior to administration of eye drops to client #2 on July 28, 2010, at 8:15 a.m., employee B (unlicensed staff) asked this surveyor the amount of time between administrations of different kinds of eye drops. This surveyor referred her to the licensee's policy and procedure for eye drop administration. Employee B did not review the policy or call the registered nurse or the owner (who is a pharmacist) before administering the eye drops to client #1.

Employee B administered Alphagan .15% eye drops to both of client #2's eyes and then instructed the client to close his eyes for five seconds and then administered Travan .004% eye drop (glaucoma). The licensee's medication procedure for administering eye drops stated: if using more than one drop wait about five minutes before putting in the next drop.

When interviewed July 28, 2010, employee D (administrator) and employee A (registered nurse) indicated they had just discussed the time frame between eye drops on the evening of July 27, 2010, and confirmed the procedure indicated five minutes if using more than one eye drop.

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

9. MN Statute §626.557 Subd. 14(b)

Based on record review and interview, the licensee failed to complete a vulnerable adult assessment and develop an individualized abuse prevention plan for two of two clients (#1 and #2) records reviewed. The findings include:

Clients #1 and #2 were admitted and began receiving home care services March 1, 2010, and July 7, 2010, respectively. Their diagnoses included chronic mental illness. There was no individualized assessment of the clients' susceptibility to abuse by other individuals, the clients' risk of abusing other vulnerable adults, and specific measures to be taken to minimize the risk of abuse to the clients and other vulnerable adults.

When interviewed July 27, 2010, at 2:00 p.m., employee D (administrator) confirmed that a vulnerable adult assessment and plan had not been done for any of the clients.

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