*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7009 1410 0000 2303 6345

January 6, 2011

Kam Aggarwal, Administrator
Peaceful Mind Homes LLC
3808 Blackhawk Ridge Place
Eagan, MN 55122

RE: Results of State Licensing Survey

Dear Ms. Aggarwal:

The above agency was surveyed November 8, 9, and 10, 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, Supervisor
Home Care & Assisted Living Program

Enclosures

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

01/07 CMR3199

Division of Compliance Monitoring Home Care & Assisted Living Program
85 East 7th Place Suite, 220 • PO Box 64900 • St. Paul, MN 55164-0900 • 651-201-5273
General Information: 651-201-5000 or 888-345-0823 • TTY: 651-201-5797 • Minnesota Relay Service: 800-627-3529
http://www.health.state.mn.us
*An equal opportunity employer*

**CERTIFIED MAIL #:** 7009 1410 0000 2303 6345

**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: | Kam Aggarwal | DATE: January 6, 2011 |
| PROVIDER: | Peaceful Mind Homes LLC | COUNTY: Dakota County |
| ADDRESS: | 3808 Blackhawk Ridge Place<br>Eagan, MN | HFID: 25900 |

On November 8, 9 and 10, 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 4668.0160 Subp. 6**

Based on record review and interview, the licensee failed to provide complete records for one of two clients' (A1) records reviewed. The findings include:

Client A1 had a physician's order, dated October 26, 2010, for "Corcidin" (2 tabs) 325 milligrams, 1 tablet b.i.d (twice daily). There was no documentation of administration of "Corcidin" twice daily.

When interviewed November 9, 2010, employee AD (registered nurse/RN) stated she had contacted the physician regarding the order and the order was for p.r.n. (as needed) and not b.i.d. Employee AD indicated she had not documented a telephone order for the change in the medication order.

**TO COMPLY:** The client 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; and

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

B. a service agreement as required by part 4668.0140;

C. medication and treatment orders, if any;

D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;

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

F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.

Class C licensees need only include the information required by items A, B, and E. Class E licensees need only include the information required by items A, B, D, and E.

**TIME PERIOD FOR CORRECTION**: Fourteen (14) days

**2. MN Statute §144A.44 Subd. 1(2)**

Based on observation, record review and interview, the licensee failed to ensure that home care services were provided according to acceptable medical or nursing standards for infection control, medication administration and personal cares for four of eight clients' (A1, A5, A8 and B1) records reviewed. The findings include:

1) Clients A1 and A5 were not provided with appropriate infection control measures during their blood sugar monitoring procedure. Client A1 and A5 were admitted and began receiving home care services July 19, 2010, and May 1, 2009, respectively. During observation of blood sugar monitoring on November 9, 2010, at 8:50 a.m. for client A5, employee AA (unlicensed staff) did not insert a new lancet into the blood sugar monitoring device prior to performing the blood sugar test.

During observation of blood sugar monitoring on November 9, 2010, at 12 noon, for client A1, employee AB (unlicensed staff) did not insert a new lancet into the blood sugar monitoring device prior to performing the blood sugar test.

Nursing and progress notes, dated August 2 and 20, 2010, and November 3, 2010, indicated the lancets were changed by registered nurses.

The operating manual for the "OneTouch UltraSoft Adjustable Blood Sampler" machine read "always use a new, sterile lancet. Lancets are for single use only." The licensee's blood glucose monitor policy and procedure manual, dated May 24, 2010, read "insert new lancet into the injector."

When interviewed November 9, 2010, employees AA and AB stated that the registered nurse (RN) changed the lancets on the blood sugar monitoring device. When interviewed November 9, 2010, employee AD (RN) stated the nurses put the lancets in the blood sugar monitoring device every week. When interviewed November 10, 2010, employee AF (owner) indicated they had attended an educational class and were told that the that lancets only needed to be changed one time per week and that only a nurse could change the lancets.

2) Clients A8, A1 and B1 were not provided medication administration according to acceptable standards of practice. Client A8 was admitted and began receiving medication administration November 7, 2010. During observation of administration of Advair diskus 250/50 inhaler and Fluticaso 0.05% (nasal spray) employee AA did not instruct client A8 to rinse his mouth after the use of Advair, nor did employee AA have client A8 blow his nose or have him close his opposite nostril during the procedure for nasal spray.

The client's November 2010 medication administration record (MAR) stated to rinse mouth after use of the Advair inhaler.

The licensee's nasal spray administration policy and procedure stated to assist the elder in blowing nose gently to remove mucus close one nostril by gently pressing against the side of the elders nose with your finger. The *Nursing 2011 Drug Handbook* states to instruct the patient to rinse mouth after use of the Advair inhaler to prevent oral candidiasis.

When interviewed November 8, 2010, employee AA indicated it was the first time she had administered client A8's medications and she didn't know that the client needed to rinse his mouth after the Advair. Employee AA indicated she thought client A8 had closed his nostril during the administration of the nasal spray. When interviewed November 9, 2010, employee AD (registered nurse) verified that the MAR, dated November 2010, stated to have the client rinse his mouth after use of the Advair inhaler.

Clients A1 and B1 were admitted and began receiving care health services July 19, 2010, and October 10, 2010, respectively. Clients A1 and B1 received Novolog insulin 17 units twice daily and Lantus insulin 10 units everyday, respectively. Client A1's and B1's November 2010 MAR did not indicate the injection sites where the insulin was administered.

The licensee's policy and procedure for insulin administration stated to document the injection site.

When interviewed November 9, 2010, employee AD verified the licensee did not document the injection site for insulin administration.

3) Client A5 was not provided personal cares according to acceptable standards. During observation of medication administration on November 8, 2010, at 4:30 p.m., employee AC (unlicensed staff) was observed preparing client A5's medication for administration. During the observation client A5 was observed to blow her nose on the inside of her turtle neck sweater two times. The surveyor informed employee AC of the observation. Employee AC replied that he had not seen client A5 blow her nose into her turtle neck sweater.

After the medication administration task employee AC walked client A5 to the living room lounge chair, elevated the client's feet and covered the client with a blanket. Employee AC did not offer to change client A5's sweater, give her a tissue or cleanse her hands. Client A5 was observed in the chair at 5:00 p.m. on November 8, 2010, wearing the same sweater.

During an interview on November 10, 2010, employee AF (owner) was informed by the surveyor of the observation regarding client A5's lack of care on November 8, 2010. Employee AF was concerned which employee failed to provide the care.

**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

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