MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6819

October 7, 2010

Rhonda Schillinger, Administrator
Inver Grove Heights White Pine
720 Main Street #205
Mendota Heights, MN 55118

Re: Results of State Licensing Survey

Dear Ms. Schillinger:

The above agency was surveyed on August 31 and September 1, 3, 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: Dakota County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Board of Nursing

01/07 CMR3199

CERTIFIED MAIL #: 7009 1410 0000 2303 6819

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 220, P.O. Box 64900St. Paul, Minnesota 55164-0900
Home Care & Assisted Living Program

Patricia Nelson, Supervisor- (651) 201-4309

TO:	RHONDA K SCHILLINGER	DATE: October 7, 2010
PROVIDER:	INVER GROVE HEIGHTS WHITE PINE	COUNTY: DAKOTA
ADDRESS:	720 MAIN STREET SUITE 205 MENDOTA HEIGHTS, MN 55118	HFID: 26132

On August 31, 2010, and September 1, 3 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.

A complaint investigation was also completed at the time of the survey. An investigation of complaint #HL26132001 was completed. The complaint was unsubstantiated.

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. 1

Based on interview and record review, the licensee failed to ensure that tuberculosis testing was completed prior to health care workers (HCWs) providing services to clients for three of three employees' (B, C and D) records reviewed. The agency failed to follow any TB screening including the conditions of Informational Bulletin 09-04: Subpart 1. Pursuant to Minnesota Rule 4668.0016, and as defined in Minnesota Department of Health Information Bulletin 09-04 Tuberculosis Prevention and Control: Home Care. Minnesota Rule 4668.0065 Subpart 1, Tuberculosis Screening is waived. The findings include:

Employee B was hired as the registered nurse to provide direct care to clients on October 22, 2009. There was no evidence of tuberculosis testing in employee B's records. When interviewed September 3, 2010, employee A (housing director) confirmed employee B did not have any tuberculosis testing since she was hired.

Employee C was hired as an unlicensed staff person to provide direct care to clients on August 11, 2010. There was no evidence of tuberculosis testing in employee C's records. When interviewed September 3, 2010, employee B (registered nurse) stated she thought employee C had a Mantoux test done, but stated it must not have been done.

Employee D was hired as an unlicensed staff person to provide direct care to clients on May 8, 2009. There was no evidence of tuberculosis testing in employee D's records. When interviewed September 3, 2010, employee D stated she had not had a Mantoux test done since working for the licensee.

When interviewed September 3, 2010, regarding the licensee's policy on two-step Mantoux and screening employees for signs and symptoms of tuberculosis, employee B stated they did not have a policy to do a two step Mantoux, nor did they screen employees for signs and symptoms of tuberculosis. Employee B stated she was not aware of the Minnesota Department of Health Information Bulletin 09-04 related to Tuberculosis screening/testing.

TO COMPLY: - All paid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold- In Tube, T-Spot ® .TB).

- All paid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility's risk level: (1) low risk – not needed; (2) medium risk – yearly; (3) potential ongoing transmission – consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414.

- HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb

- All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW's employee file.

-All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

2. MN Rule 4668.0810 Subp. 6

Based on interview and record review, the licensee failed to ensure that significant changes in the client's status were documented in the client's record for two of two clients' (#2 and #6) records reviewed who had changes in their status. The findings include:

Client #2 began receiving services from the licensee February 28, 2010, which included medication set-up and assistance with oxygen tank refills. When interviewed September 1, 2010, client #2 described an incident that occurred within the last three to four months where she began to bleed spontaneously from her dialysis access site and needed to go to the emergency room. Client #2's record was reviewed and there was no documentation of an incident where she began to bleed from her dialysis access site. When interviewed September 1, 2010, employee B (registered nurse) confirmed that client #2 began to bleed spontaneously from her dialysis access site sometime between June and August of 2010. Employee B stated she recalled that the client's son was called and came in to stay with the client until the bleeding stopped. Employee B stated she did not think the client went to the emergency room, but was unsure. Employee B confirmed there was no documentation of this incident in the client's record.

Client #6 began receiving services from the licensee June 12, 2010, which included medication set-ups, medication administration and assistance with bathing. Documentation on Incident/Accident Reports dated July 27, 2010, in the a.m., July 27, 2010, at 5:00 p.m., and August 6, 2010, at 8:45 p.m., indicated the client fell on three separate occasions. The incidents on July 27, 2010, in the a.m. and August 6, 2010, indicated the client sustained an abrasion and/or skin tear. There was no documentation in the client's record regarding these falls, injuries or any follow-up. When interviewed September 3, 2010, employee A (housing director) stated Incident/Accident Reports were not considered part of a client's record. When interviewed September 3, 2010, employee B (registered nurse) confirmed client #6's two falls on July 27, 2010 and the fall on August 6, 2010 in addition to any follow-up 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 4668.0815 Subp. 1

Based on observation, interview and record review, the licensee failed to ensure that the registered nurse (RN) completed an individualized evaluation of the client's needs and developed a service plan in accordance with accepted standards of practice that included the care and emergency services related to the client's dialysis access site for one of one client (#2**)** reviewed who received dialysis from an outside kidney dialysis unit. The findings include:

The home care provider did not develop a plan for client #2 that identified potential emergency conditions and monitoring of her dialysis access site.

Client #2 began receiving services from the home care provider on February 28, 2010. Client #2 was identified as having end stage renal failure and received hemodialysis from an outside kidney dialysis unit three times a week.

Client #2 was observed on September 1, 2010, at 11:20 a.m. to have an arteriovenous fistula access site that was located on her right upper arm for dialysis treatment.

Client #2's RN evaluation and service plan, dated February 28, 2010, did not include anything about the client receiving dialysis or that the client had an access site. The only mention of dialysis in the client's record was on a "Pre-Screening Questionnaire," dated February 25, 2010, completed by the RN. The questionnaire indicated the client was to be woken up at 4:30 a.m. on dialysis days. The RN did not

evaluate and develop a plan for the arteriovenous fistula access site that included interventions to assist in preventing infection of the access site, nor was there a plan that identified emergency interventions if the client should bleed spontaneously from the access site. The "Resident Care Plan," a document the unlicensed staff used to provide care and services to client #2 did not include any special precautions for staff to follow or be aware of when caring for the client related to her dialysis access site.

When interviewed September 1, 2010, employee D (unlicensed staff) stated the only special precaution she was aware of with client #2 was that she should not take her blood pressure in the arm she has her dialysis access site. Employee D stated the client returns from dialysis with a bandage on her arm. When questioned as to if and when she should remove the bandage, employee D stated she was not sure, but probably should take it off right away.

When interviewed September 1, 2010, employee G (unlicensed staff) stated the only special precaution she was aware of with client #2 was that her blood pressure should not be taken on the arm she has her dialysis access site. Employee G stated that if the client began bleeding from her dialysis access site, she would call the nurse.

When interviewed July 9, 2010, employee B (RN) confirmed client #2's evaluation and service plan did not address the client's dialysis access site and the emergency care and treatment of the site or measures to be taken to prevent infection to the access site. Employee B also confirmed that the "Resident Care Plan" did not include any special precautions for the unlicensed staff to follow when caring for client #2.

TO COMPLY: No later than two weeks after the initiation of assisted living home care services to a client, a registered nurse must complete an individualized evaluation of the client's needs and must establish, with the client or the client's responsible person, a suitable and up-to-date service plan for providing assisted living home care services in accordance with accepted standards of practice for professional nursing. The service plan must be in writing and include a signature or other authentication by the class F home care provider licensee and by the client or the client's responsible person documenting agreement on the services to be provided.

TIME PERIOD FOR CORRECTION: Seven (7) days

4. MN Rule 4668.0815 Subp. 2

Based on interview and record review, the licensee failed to ensure the registered nurse (RN) reevaluated the client when there was a change in the client's condition for one of one client's (#6) record reviewed who had a change in condition. The findings include:

Client #6, who was identified at high risk for falls, was not re-evaluated by the RN after several falls nor were interventions put in place to assist in preventing further falls.

Client #6 began receiving services from the licensee June 12, 2010, which included medication set-ups, medication administration and assistance with bathing. A Fall Risk Assessment, dated June 9, 2010, indicated the client scored 14 points. The assessment indicated that a score greater than 10 points indicated "high fall risk." The client was identified as receiving the medication Warfarin **(**a blood thinner) 4 milligrams on Mondays, Wednesdays and Fridays and 3 milligrams on Sunday, Tuesday, Thursdays and Saturdays. The client's International Normalized Ratio (INR) (a measure used to determine the clotting tendency of the blood) blood level was drawn July 14, 2010, July 21, 2010, and

August 4, 2010, with results of 1.96, 2.01 and 2.91 respectively. The INR laboratory reports indicated these levels were considered "High," with expected values of 0.90-1.10. Although being on a blood thinner put the client at greater risk if he fell, the licensee's Fall Risk Assessment did not identify this as a medication that put the client at risk. A "Mini-Mental State Examination, dated July 9, 2010, indicated the client scored 28 out of 30 possible points. The assessment indicated the client only had difficulty in the area of recalling objects.

Documentation in the client's record, dated July 25, 2010, indicated the client had fallen off a dining room chair and sustained an abrasion behind his right ear. Documentation on an Incident/Accident Report, dated July 27, 2010, in the a.m. indicated the client was found on the bedroom floor on his back and sustained a small abrasion on his arm. Documentation on an Incident/Accident Report, dated July 27, 2010, at 5:00 p.m. indicated the client was pushing a wheelchair and fell backwards and "layed there for close to an hour." Documentation on the report indicated the client's level of consciousness was "confused" after this fall. Documentation on an Incident/Accident Report, dated August 6, 2010, at 8:45 p.m. indicated the client's feet slid out from under him and he fell onto his back and sustained a small skin tear on his left forearm. There was no evidence of an assessment of the client by the RN after the client's falls, interventions put in place to assist the client in preventing further falls, or any follow-up of the client's status after the falls.

Documentation in the client's record, dated August 9, 2010, indicated client #6's friend approached employee B (RN) because the friend was concerned about the client. Documentation indicated the client was having a difficult time walking and was not acting like himself. The note stated the RN assessed the client and the client was alert but confused. The RN called the client's doctor and the doctor ordered the client to be sent to the emergency room for evaluation. A note, dated August 10, 2010, at 8:00 a.m. indicated the client was admitted to the hospital's intensive care unit with a "slow brain bleed." Documentation revealed the client died at the hospital August 20, 2010.

When interviewed September 3, 2010, employee B confirmed there was no reassessment of the client documented until August 9, 2010. Employee B stated sometime after the July 25, 2010, fall and before the July 27, 2010, fall client #6 was given a wheelchair to use. Employee B stated she would not have assessed the client after the July 25, 2010, fall until the following day July 26, 2010, because July 25, 2010, was a weekend. Employee B stated she could not recall assessing the client after the two falls on July 27, 2010, and stated she was not aware that on the fall of July 27, 2010, at 5:00 p.m., that the client's level of consciousness was "confused." Employee B stated she did not assess the client after the August 6, 2010, fall until the morning of August 9, 2010, when the client's friend alerted her to concerns about the client. When questioned, employee B stated staff do not document or routinely ask the client after a fall if they hit their head. Employee B stated the licensee did not have a protocol for doing neurological checks after a fall when the client has hit their head. Employee B stated that in May of 2010 she had implemented a protocol for staff to do vital signs after a fall every shift for the first 24 hours. Employee B stated problems were noted with staff following the protocol and the protocol was no longer being followed.

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: Seven (7) days

5. MN Rule 4668.0855 Subp. 6

Based on observation and interview, the licensee failed to ensure that unlicensed staff administered insulin injections that were drawn up only by a nurse, pharmacist or physician for three of three clients (#3, #4 and #5) observed receiving insulin via an insulin pen. The findings include:

Unlicensed staff directed clients on how many units to dial on pre-filled insulin pens and then the unlicensed staff injected the insulin that had been dialed on the insulin pen by the client.

On August 31, 2010, at 4:00 p.m., employee C (unlicensed staff) was observed to hand client #5 a NovoLog Flex insulin pen and instructed the client to dial 25 units on the insulin pen. The client was observed to dial the pen and hand the pen back to employee C. Employee C checked that the insulin dose was correctly dialed and injected the insulin into the client's abdomen.

On August 31, 2010, at 4:15 p.m., employee H (unlicensed staff) was observed to hand client #3 a NovoLog Flex insulin pen and instructed the client to dial 14 units on the insulin pen. The client was observed to dial the pen and hand the pen back to employee H. Employee H checked that the insulin dose was correctly dialed and injected the insulin into the client's abdomen. On September 1, 2010, employee G (unlicensed staff) was observed to hand client #3 a Lantus SoloSTAR insulin pen and instructed the client to dial 65 units on the insulin pen. The client was observed to the dial the pen and hand the pen back to employee G. Employee G checked that the dose was correctly dialed on the insulin pen and injected the insulin into the client's abdomen.

On August 31, 2010 at 4:20 p.m., employee H was observed to hand client #4 a NovoLog Flex insulin pen and instructed the client to dial 7 units on the insulin pen. The client was observed to dial the pen, and hand the pen back to employee H. Employee H checked that the dose was correctly dialed on the insulin pen and injected the insulin into the client's upper arm. On September 1, 2010, at 7:25 a.m. employee G was observed to hand client #4 an Insulin Flex-Pen and instructed the client to dial 9 units on the insulin pen. The client was observed to dial the pen and hand the pen back to employee G. Employee G checked that the dose was correctly dialed on the insulin pen and injected the insulin into the client's right thigh.

When interviewed September 1, 2010, employee B (registered nurse) confirmed that the unlicensed staff have been trained to instruct the clients on how many units to dial on an insulin pen and then the unlicensed staff would inject the insulin after the client had dialed the dose. Employee B stated she was not aware that this was not in compliance with the requirements.

TO COMPLY: A person who administers medications under subpart 3 may not draw up injectables. Medication administered by injection under subpart 5 is limited to insulin.

TIME PERIOD FOR CORRECTION: Seven (7) days

6. MN Rule 4668.0855 Subp. 9

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

Client #1 began receiving services from the licensee February 7, 2009, which included medication set-ups and medication administration. Client #1 had a prescriber's order, dated August 25, 2010, for Keflex 500 milligrams orally three times a day for seven days to treat impetigo. The client's August 2010 medication administration record (MAR) indicated the client's Keflex was set-up in a medi-set container twice a day instead of three times a day as ordered. When interviewed September 1, 2010, regarding the discrepancy, employee B (registered nurse) stated the client requested that he take the Keflex twice a day instead of three times a day as ordered. Employee B stated she did not contact the prescriber to let them know the client refused to take the Keflex three times a day. There was no documentation on the client's MAR that the client refused the medication three times a day as ordered.

Client #1 had prescriber's orders, dated May 12, 2010, which read Potassium Chloride 8 milliequivalents three tablets orally every day. The client's August 2010 MAR indicated the client was receiving Potassium Chloride 8 milliequivalents two tablets orally every day. In addition, client #1 had prescriber's orders dated, May 12, 2010, for several eye drops, including Atropine Sulfate, Brimondine Tartrate, Dorzolamide and Prednisolone Acetate. The client's August 2010 MAR did not indicate the eye drops were being administered. When interviewed September 1, 2010, employee B confirmed client #1's Potassium and eye drops were not being administered as ordered by the prescriber on May 12, 2010, and that she would call the prescriber to clarify the client's orders.

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

7. MN Rule 4668.0860 Subp. 2

Based on observation, interview and record review, the licensee failed to ensure there were written prescriber's orders for medications that were administered for one of one client (#7) observed receiving medication from a standing house order list. The findings include:

Client #7 was observed on September 1, 2010, at 3:25 p.m. to request something for diarrhea. Employee I (unlicensed staff) checked the client's record and administered Imodium 2 milligrams to client #7.

After reviewing the client's August 2010 medication administration record and noting that Imodium was not listed on the client's MAR as a medication to administer on a pro ra nata (PRN or whenever necessary) basis, employee I was questioned as to where she got the prescriber's order to administer the Imodium. When interviewed September 1, 2010, employee I stated she used the Imodium order off the Standing House Order sheet. Employee I showed the surveyor a Standing House Order sheet that was undated, listed four medications and one treatment and was signed by a physician. The Standing House Order sheet did not include the client's name for which the medications were authorized to be given to.

When interviewed September 1, 2010, employee B (registered nurse) stated the house physician, who no longer sees clients at the facility had signed the Standing House Order sheet. Employee B stated she had not obtained separate Standing House Orders from each client's physician but was in the process of doing that.

TO COMPLY: There must be a written prescriber's order for a drug for which an class F home care provider licensee provides assistance with self-administration of medication or medication administration, including an over-the-counter drug.

TIME PERIOD FOR CORRECTION: Seven (7) days

8. MN Rule 4668.0860 Subp. 9

Based on interview and record review, the licensee failed to ensure that orders for medications and treatments were renewed by the prescriber at least every twelve months for two of four clients' (#3 and #4) records reviewed. The findings include:

Client #3 began receiving services from the licensee February 14, 2009, which included medication administration. The client's prescriber's orders had not been renewed since she was admitted in February of 2009.

Client #4 began receiving services from the licensee October 14, 2008, which included medication administration. The client's prescriber's orders had not been renewed since she was admitted in October of 2008.

When interviewed September 1, 2010, employee B (registered nurse) confirmed client #3's and #4's medication orders had not been renewed by the prescriber since they started services. Employee B stated the medications had not been renewed by the prescriber since she started in 2009. Employee B also stated there is not a system at the present time to ensure medications are renewed in a timely manner.

TO COMPLY: A medication or treatment order must be renewed at least every 12 months or more frequently as indicated by the nursing assessment required under part 4668.0855, subpart 2.

TIME PERIOD FOR CORRECTION: Thirty (30) days

9. MN Statute §144A.44 Subd. 1(2)

Based on observation, interview and record review, the licensee failed to provide services according to accepted standards of practice related to infection control for four of five clients (#1, #3, #4 and #5) observed receiving assistance with blood glucose monitoring and/or insulin administration. The findings include:

The licensee's procedure for blood glucose testing included "swab/clean resident's finger" prior to pricking the client's finger with a lancet. The licensee's procedure for insulin administration included "clean site with an alcohol wipe" prior to inserting the needle into the client's skin.

On August 31, 2010, at 4:00 p.m., employee C (unlicensed staff) was observed to check client #5's blood glucose and administer his insulin. Employee C did not swab/clean the client's finger prior to pricking the client's finger with a lancet when testing his blood glucose. In addition, employee C did not clean the client's abdomen with an alcohol wipe prior to injecting the insulin into the client's skin.

On August 31, 2010, at 4:15 p.m., employee H (unlicensed staff) was observed to check client #3's blood glucose and administer her insulin. Employee H did not swab/clean the client's finger prior to pricking the client's finger with a lancet when testing her blood glucose. In addition, employee H did not clean the client's abdomen with an alcohol wipe prior to injecting the insulin into the client's skin. On September 1, 2010, at 7:55 a.m., employee G (unlicensed staff) was observed to administer client #3's insulin. Employee G did not clean the client's abdomen with an alcohol wipe prior to injecting the insulin into the client's skin.

On August 31, 2010, at 4:20 p.m., employee H was observed to check client #4's blood glucose and administer her insulin. Employee H did not swab/clean the client's finger prior to pricking the client's finger with a lancet when testing her blood glucose. In addition, employee H did not clean the client's upper arm with an alcohol wipe prior to injecting the insulin into the client's skin.

On September 1, 2010, at 7:40 a.m. employee D (unlicensed staff) was observed to administer client #1's insulin. Employee D did not clean the client's abdomen with an alcohol wipe prior to injecting the insulin into the client's skin.

When interviewed September 3, 2010, employee B (registered nurse) confirmed the unlicensed staff were trained to use an alcohol wipe on the client's skin prior to testing the client's blood glucose and prior to insulin administration. Employee B stated she would re-educate the staff on the procedures.
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

10. MN Statute §144.057 Subd. (1)

Based on observation, interview and record review, the licensee failed to ensure that when a person was disqualified from having direct contact with clients, that the licensee followed the provisions of their disqualification for one of one employee (D) reviewed who was disqualified from providing direct contact to clients. The findings include:

Employee D (unlicensed staff) was hired May 8, 2009, to provide direct care to clients. Employee D was observed on September 1, 2010, between 7:30 a.m. and 2:00 p.m. to provide direct care to clients by administering medications and providing personal cares as requested by the clients. Employee D was observed to work independently and was observed to go into client's rooms by herself to administer medications and assist clients with personal cares throughout the day.

Employee D's personnel file was reviewed and included a letter, dated June 4, 2009, from the Minnesota Department of Human Services that indicated employee D was disqualified from any position allowing

direct contact with, or access to persons receiving services from programs licensed by the Minnesota Department of Health. The letter further stated that if the program chose to allow the employee to provide direct contact services pending a possible reconsideration, the program must "ensure that the individual is under continuous, direct supervision when providing direct contact services with persons receiving services." A subsequent letter in employee D's personnel file, dated October 15, 2009, from the Minnesota Department of Health indicated that the individual's request for reconsideration of the disqualification had been reviewed and as a result of the review the disqualification had not been set aside. The letter continued, "Until further notification from the Minnesota Department of Health, You may permit the individual to continue working in direct contact position subject to continuous supervision, as previously ordered."

When interviewed September 3, 2010, regarding the disqualification, employee B (registered nurse) stated she "had no idea" the employee was disqualified from direct contact and that she required direct supervision. Employee B stated that employee D had not been directly supervised and as part of her job duties, the employee was in and out of client's rooms independently.

When interviewed September 3, 2010, regarding the disqualification, employee A (housing director) stated that it was her understanding the disqualification had been resolved and requested that employee D come into the office to discuss this.

When interviewed September 3, 2010, employee D stated that after she received the letter that her disqualification was not set aside she requested a hearing, which was held in May of 2010. Employee D stated she had not heard or had any correspondence since the hearing. Employee D stated it was her understanding that she needed to be supervised until she heard the results of the hearing. Employee D stated she was not sure what "supervised" meant.

TO COMPLY: The commissioner of health shall contract with the commissioner of human services to conduct background studies of: (1) individuals providing services which have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; residential care homes licensed under chapter 144B, and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17; (2) individuals specified in section 245C.03, subdivision 1, who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A or a boarding care home licensed under sections 144.50 to 144.58, and if the individual under study resides outside Minnesota, the study must be at least as comprehensive as that of a Minnesota resident and include a search of information from the criminal justice data communications network in the state where the subject of the study resides; (3) beginning July 1, 1999, all other employees in nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services; (4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities;

and (5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70. If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

TIME PERIOD FOR CORRECTION: One (1) day

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