MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6970

September 15, 2010

Rhonda Schillinger, Administrator
Blaine White Pine
720 Main Street Suite 205
Mendota Heights, MN 55118

Re: Results of State Licensing Survey

Dear Ms. Schillinger:

The above agency was surveyed on July 7, 8, and 9, 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: Anoka 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 6970

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:	RHONDA SCHILLINGER	DATE: September 15, 2010
PROVIDER:	BLAINE WHITE PINE	COUNTY: ANOKA
ADDRESS:	720 MAIN STREET SUITE 205 MENDOTA HEIGHTS, MN 55118	HFID: 26857

On July 7, 8 and 9, 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 HL26857001 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 Information Bulletin 09-04: 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 D was hired as an unlicensed staff person to provide direct care to clients on April 23, 2010. There was no evidence of tuberculosis testing in employee D's records. When interviewed July 9, 2010, employee A (house manager) confirmed employee D 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 March 29, 2010. Employee C had a Mantoux test completed June 25, 2010, three months after providing direct care to clients. When interviewed July 9, 2010, employee A stated that employee C told her she had had a Mantoux test done prior to employment with another home care provider, but never brought evidence of the Mantoux test result so the licensee tested employee C.

Employee B was hired as the registered nurse to provide direct care to clients on February 12, 2010. Employee B had a Mantoux test on July 27, 2007. There was no further tuberculosis testing in employee B's records. When interviewed July 9, 2010, employee B stated July of 2007 was the last tuberculosis testing she had completed.

When interviewed July 9, 2010, regarding the agency's policy on two-step Mantouxs and screening employees for signs and symptoms of tuberculosis, employee A 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 A stated she was not aware of the Minnesota Department of Health Information Bulletin 09-04 related to Tuberculosis Screening.

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: Thirty (30) days

2. 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 central venous access site for one of one client (#2**)** 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 the central venous catheter access site and for monitoring the central venous access site for signs of infection.

Client #2 began receiving services from the home care provider on April 10, 2010. Client #2 was identified as having renal failure and received hemodialysis from an outside kidney dialysis unit three times a week.

Client #2 was observed on July 8, 2010, at 2:15 p.m. to have a central venous catheter access site that was located in the right upper chest area for dialysis treatment. The central venous access site was observed to have a dressing covering it.

Client #2's RN evaluation and service plan, dated April 10, 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 March 26, 2010, completed by the RN. The questionnaire indicated the client received dialysis three times a week.

The RN did not evaluate and develop a plan for the central venous catheter access site that included interventions to assist in preventing infection of the access site, in addition to what to do if the catheter dressings were to get wet. There was also no plan that identified emergency interventions if the central venous catheter was to leak or the end-caps became dislodged.

When interviewed July 8, 2010, client #2 stated that she had gotten the dressing covering the central venous catheter access site wet several times when showering. When questioned as to what she did after the dressing became wet, client #2 stated she just let it dry.

When interviewed July 8, 2010, employee C (unlicensed staff) stated that client #2 had a dressing with tape over it on her chest, but stated they did not have to be concerned about it.

When interviewed July 8, 2010, employee E (unlicensed staff) stated she was not aware that client #2 had a dialysis access site anywhere on her body and indicated she was not aware of any special cares or concerns related to the client receiving dialysis.

When interviewed July 9, 2010, employee B (RN) confirmed client #2's evaluation and service plan did not address the client's central venous catheter access site and the emergency care and treatment of the site or measures to be taken to prevent infection to the access site.

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

3. MN Rule 4668.0825 Subp. 4

Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) instructed and specified in writing the procedure for performing the delegated task of oxygen use, and had the unlicensed staff demonstrate to the RN their ability to competently perform the procedure for one of one employee (D) observed providing oxygen services. The findings include:

Client #4 began receiving services from the home care provider on November 6, 2009. Client #4's service plan, dated November 6, 2009, indicated the client received assistance with her activities of daily living and assistance with oxygen use.

Employee D (unlicensed staff) was observed on July 8, 2010, at 3:10 p.m. to fill client #4's portable liquid oxygen container from the large liquid oxygen container. The trans-filling of the portable liquid oxygen container took place in the client's room a few feet away from where the client was sitting. The large liquid oxygen container was located just inside the client's bedroom door directly in front of an electrical light switch and an electrical plug in. During approximately the last thirty seconds of filling the portable liquid container a continuous cold vapor was noted to be emitted from the oxygen containers into the surrounding air.

When interviewed July 8, 2010, employee D stated to not worry about the vapor in the air and that it was "harmless." When questioned regarding her training on how to fill the portable liquid oxygen container and written instructions on the procedure, employee D stated she did not receive any training from the RN on how to fill the container, but stated she had filled liquid oxygen containers at other places she had worked and did not need further training. Employee D stated she was not aware of any written instructions on how to fill the portable liquid oxygen container.

When interviewed July 9, 2010, employee B (RN) confirmed there were no written instructions for the staff to follow on how to fill the portable liquid oxygen container, nor had she trained or competency tested employee D on how to fill the portable oxygen container.

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: Seven (7) days

4. MN Rule 4668.0840 Subp. 3

Based on interview and record review, the licensee failed to ensure that the registered nurse (RN) provided the core training to unlicensed staff that was required by this subpart for two of two unlicensed employees' (C and D) records reviewed. The findings include:

Employees C and D were hired to perform assisted living home care services on March 29, 2010, and April 23, 2010, respectively. Employee C's and D's training records indicated that employee A (house manager) conducted the training/competency related to the following topics: observing, reporting, and documenting client status and the care or services provided; basic infection control; maintaining a clean, safe, and healthy environment; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; and 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, instead of the RN as required by this subpart.

When interviewed July 9, 2010, employee B (RN) stated she was not part of teaching the core training/competency, and that employee A conducted the training on the required topics for all employees.

When interviewed July 9, 2010, employee A confirmed she conducted the core training on all of the required topics and was not aware that there were certain topics that only the RN could train on.

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 interview and record review, the licensee failed to ensure the registered nurse (RN) conducted a supervisory visit within fourteen days after initiation of services for three of three clients' (#1, #2 and #3) records reviewed. The findings include:

Client #1 began receiving services from the home care provider on January 31, 2010, which included assistance with activities of daily living, blood glucose checks and medication administration. Supervisory visits by the RN were documented on March 31, 2010, and June 11, 2010. There was no supervisory visit by the RN within fourteen days after initiation of services.

Client #2 began receiving services from the home care provider on April 10, 2010, which included medication administration. Supervisory visits by the RN were documented on May 5, 2010, and June 22, 2010. There was no supervisory visit by the RN within fourteen days after initiation of services.

Client #3 began receiving services from the home care provider on March 1, 2010, which included medication administration. Supervisory visits by the RN were documented on April 5, 2010, and May 20, 2010. There was no supervisory visit by the RN within fourteen days after initiation of services.

When interviewed July 9, 2010, employee B (RN) confirmed the lack of supervisory visits within fourteen days after initiation of services for clients #1, #2 and #3.

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 perform 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: Fourteen (14) days

6. MN Rule 4668.0855 Subp. 5

Based on interview and record review, the licensee failed to ensure that pro re nata (PRN) medications were reported to the registered nurse within 24 hours after administration or within a time period specified by the registered nurse (RN) prior to administration for one of one client's (#5) record reviewed who received PRN medications. The findings included:

The home care provider's policy and procedure related to PRN use indicated "The White Pine Health Aide will always check with the nurse PRIOR to administering a PRN medication to a resident." A PRN notification form in the medication administration record (MAR) book indicated the following, "Any PRN medication given must be written on this form. The licensed personnel are to be notified within 72 hours of the PRN medication administered."

Client #5 began receiving services from the home care provider March 31, 2010, which included medication administration. Documentation on the client's July 2010 MAR indicated the client received Vicodin PRN on July 3, 2010, at 11:30 a.m., Ativan PRN on July 3, 2010, at 2:35 p.m., Vicodin PRN on July 4, 2010, at 8:30 a.m., Ativan PRN on July 4, 2010, at 3:05 p.m., and Ativan PRN on July 5, 2010, at 7:00 p.m. There was no evidence that the RN was aware of client #5's PRN medication use.

When interviewed July 8, 2010, employee E (unlicensed staff) indicated she documented when a PRN medication was given on the front and back of the MAR and on the PRN Notification Form. Employee E stated she did not need to call or notify the RN when administering a PRN medication.

When interviewed July 9, 2010, employee B (RN) stated staff do not notify her prior to or after they administer a PRN medication to the client. Employee B stated the policy that staff were to check with the nurse prior to administering a PRN medication to a client was inaccurate. Employee B confirmed that staff logs a PRN medication on the PRN notification form, but stated she did not review the PRN use within 72 hours as stated on the form. The RN stated she reviewed the MARs for PRN use approximately weekly.

TO COMPLY: A person who satisfies the requirements of subpart 4 and has been delegated the responsibility by a registered nurse, may administer medications, orally, by suppository, through eye drops, through ear drops, by use of an inhalant, topically, by injection, or through a gastrostomy tube, if:

A. the medications are regularly scheduled; and

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

7. MN Rule 4668.0855 Subp. 6

Based on observation, interview and record review, the licensee failed to ensure that unlicensed staff did not draw up insulin for one of one client (#1) reviewed who received insulin. The findings include:

Client #1 began receiving services January 31, 2010, which included administration of insulin by unlicensed staff. Client #1 had a prescriber's order for Novolog mix insulin 70/30 via a Flex pen-inject 24 units subcutaneously every morning and before supper.

On July 8, 2010, at 10:20 a.m. employee C (unlicensed staff) was observed to dial client #1's NovoLog Flex pen insulin to 24 units and administer the client's insulin.

When interviewed July 9, 2010, employee B (registered nurse) confirmed that unlicensed staff dialed client #1's Flex Pen insulin to the prescribed dose prior to administering the insulin to the client. Employee B stated she was not aware that the unlicensed staff could not do this.

TO COMPLY: A person who administers medications under subpart 3 may not draw up injectables

TIME PERIOD FOR CORRECTION: Seven (7) days

8. MN Rule 4668.0855 Subp. 9

Based on interview and record review, the licensee failed to ensure that medications were administered as prescribed for three of three clients' (#1, #2 and #3) records reviewed. The findings include:

Client #1 began receiving services from the home care provider on January 31, 2010, which included medication administration. Client #1 had a prescriber's order, dated March 4, 2010, for an applicator full of estrogen cream to be administered three times a week vaginally. The client's July 2010 medication administration record (MAR) indicated a half an applicator full of the estrogen vaginal cream was being administered four times a week. There was no documentation in the client's record as to why the estrogen vaginal cream was not administered as prescribed. When interviewed July 9, 2010, employee B (registered nurse) confirmed client #1 did not receive the estrogen vaginal cream as ordered. Employee B stated the client's family wanted the vaginal cream administered more frequently.

Client #2 began receiving services from the home care provider on April 10, 2010, which included medication administration. Client #2 had a prescriber's order, dated April 7, 2010, for a multivitamin to be administered daily. Client #2's April, May, June and July 2010 MARs indicated the multivitamin was not administered as prescribed. When interviewed July 9, 2010, employee B confirmed client #2 did not receive the multivitamin as prescribed since she the client started care with the home care provider. Employee B stated that the client's insurance would not pay for the dispensing of the multivitamin, so the family planned to bring in the multivitamin, but never did.

Client #3 began receiving services from the home care provider on March 1, 2010, which included medication administration. Client #3 had a prescriber's order, dated January 20, 2010, for Vitamin D 50,000 units - one capsule weekly for twelve weeks. Client #3's July 2010 MAR indicated the client continued to receive the Vitamin D. There was no documentation in the client's record as to why the Vitamin D was continued past the twelve weeks. Client #3 had a prescriber's order, dated January 20, 2010 for Gabapentin 400 milligrams twice a day. The client's July 2010 MAR indicated the client received 600 milligrams of the Gabapentin twice a day. There was no documentation in the client's record as to why the client's Gabapentin was not administered as prescribed. When interviewed July 9, 2010, employee B confirmed client #3's Vitamin D and Gabapentin were not administered as prescribed.

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

9. MN Statute §144A.44 Subd. 1(2)

Based on observation and interview, the licensee failed ensure care and services were provided according to accepted nursing standards related to infection control for two of three clients (#1 and #6) observed receiving medications and/or treatments. The findings include:

The home care provider's procedure for testing blood sugar, administering insulin and administering eye drops included washing your hands with soap and water before putting on gloves and after removing the gloves.

On July 8, 2010, at 10:00 a.m. employee C (unlicensed staff) was observed to administer Refresh eye drops to client #6. Employee C was observed to put gloves on before administering the client's eye drops but did not wash her hands before applying the gloves, or after removing her gloves. Employee C was observed to administer client #6's Refresh eye drops and Erythromycin eye ointment on July 8, 2010, at 2:00 p.m. Employee C was observed to put on a pair of gloves, administer the Refresh eye drop into the client's right eye, and then administered the Erythromycin eye ointment into the client's right eye. Employee C's cell phone rang and employee C was observed to push a button on the phone to stop the ringing, before removing her gloves. Client #6 offered the employee a cookie. After removing her gloves, employee C was observed to open the client's refrigerator, open a container of cookies and take out a cookie and began eating the cookie. Employee C did not wash her hands after removing her gloves.

Employee C was observed on July 8, 2010, at 10:20 a.m. to check client #1's blood glucose and administer the client's insulin. Employee C was observed to put on a pair of gloves, but did not wash her hands prior to applying the gloves. Employee C pricked the client's finger and tested her blood glucose. After prepping the client's skin, employee C injected the client's insulin into the client's

abdomen. Employee C removed her gloves, but did not wash her hands. Employee C then administered another client's medications.

When interviewed July 9, 2010, employee B (registered nurse) stated that staff should be washing their hands before applying gloves and after removing the gloves.

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: Fourteen (14) days

10. MN Statute §144A.441

Based on interview and record review, the licensee failed to ensure that clients were provided a copy of the current MN Home Care Bill of Rights for Assisted Living Clients to three of three clients' (#1, #2 and #3) records reviewed. The findings include:

Clients #1, #2 and #3 began receiving assisted living services from the licensee on January 31, 2010, April 10, 2010, and March 1, 2010, respectively. Clients #1, #2 and #3 were provided a copy of the Minnesota Home Care Bill of Rights, but the content did not include the current language for assisted living clients in clause 16, which included the right to at least a thirty day advance notice of termination of a service by the provider.

When interviewed July 7, 2010, employee A (house manager) confirmed that all the clients under their Class F license received assisted living services. Employee A stated she was not aware there was a version of the Home Care Bill of Rights specifically for clients that received assisted living services. Employee A stated all their clients had not received the current version of the bill of rights.

TO COMPLY: Assisted living clients, as defined in section 144G.01, subdivision 3, shall be provided with the home care bill of rights required by section 144A.44, except that the home care bill of rights provided to these clients must include the following provision in place of the provision in section 144A.44, subdivision 1, clause (16):

"(16) the right to reasonable, advance notice of changes in services or charges, including at least 30 days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment as specified in the employment contract between the home care provider and the individual providing home care services, or creates an abusive or unsafe work environment for the individual providing home care services;

(ii) (ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the home care provider; or

(iii) the provider has not received payment for services, for which at least ten days' advance notice of the termination of a service shall be provided."

TIME PERIOD FOR CORRECTION: Thirty (30) days

11. MN Statute §626.557 Subd. 14(b)

Based on interview and record review, the licensee failed to ensure that when areas were identified that a client was at risk for abuse, that statements of specific measures to be taken to minimize the risk of abuse in that area were documented for two of three clients' (#1 and #3) records reviewed. The findings include:

Client #1 began receiving services from the home care provider on January 31, 2010. Client #1's "Vulnerability and Safety Information" form, dated January 21, 2010, indicated the client was vulnerable in the following areas; not oriented to place and time, not able to give accurate information, not able to ambulate safely without assistive devices, lack of strength or endurance and not able to communicate needs without difficulty. There were no specific measures documented that would assist in minimizing the risk of abuse to the client in the areas that she was identified as being vulnerable.

Client #3 began receiving services from the home care provider on March 1, 2010. Client #3's "Vulnerability and Safety Information" form, dated November 23, 2009, indicated the client lacked a social support system, was anxious and depressed, had a chronic condition that restricted physical activity and the client's sense of touch was impaired. There were no specific measures documented that would assist in minimizing the risk of abuse to the client in the areas that he was identified as being vulnerable.

When interviewed July 9, 2010, employee B (registered nurse) confirmed there was a lack of measures identified that would assist in minimizing the risk of abuse to clients #1 and #3. Employee B stated she was not aware this was a requirement.

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