Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 7021

September 21, 2010

Michele Grandner, Administrator
Transitional Healthcare LLC
4601 Excelsior Blvd STE 650
Minneapolis, MN 55416

Re: Results of State Licensing Survey

Dear Ms Grandner:

The above agency was surveyed on July 12, 13, 14, 19, 20, 21, 22 and 23, 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: 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 7021

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:	MICHELE GRANDNER	DATE: September 21, 2010
PROVIDER:	TRANSITION HEALTHCARE LLC	COUNTY: HENNEPIN
ADDRESS:	4601 EXCELSIOR BLVD STE 650 MINNEAPOLIS, MN 55416	HFID: 27184

On July 12, 13, 14, 19, 20, 21, 22 and 23, 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 HL27184001 was completed. The complaint is unsubstantiated.

Signed:____ Date: ________________________

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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 4668.0815 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 plan in accordance with accepted standards of nursing practice, that included the care and emergency services related to the client’s dialysis access site for two of two clients’ (A2 and B3) records reviewed who received dialysis services from an outside kidney dialysis unit. The findings include:

The home care provider did not develop a plan for client A2's and B3's potential emergency situations related to their dialysis access site and for monitoring the access sites for signs of infection.
Client B3 began receiving services from the home care provider May 1, 2010. The client had a diagnosis of end stage renal disease and received hemodialysis from an outside kidney dialysis center three times a week.

Client B3 was observed on July 19, 2010, at 2:00 p.m. to have a fistula dialysis access site that was located in her left upper arm for dialysis treatments.

Client B3's RN evaluation and service plan, dated May 10, 2010, did not include information about the client receiving dialysis nor that the client had a dialysis access site. The RN did not evaluate and develop a plan for the emergency care for the client should the dialysis access site begin to bleed nor was there a plan that identified precautions to take to prevent the access site from becoming infected. Client B3's nursing progress notes, dated June 29, 2010, indicated the following, "Resident pushed pendant due to dialysis shunt bleeding profusely. 911 called and resident transported to hospital. Resident returned this a.m. No new orders." An event report, dated July 16, 2010, for client B3 indicated the following, "Put on her pendant to let aide know she was bleeding. When aide entered room the bleed had stop. The Pines nursing was notified. Told the aide to call 911, however (client B3) refused the calling of 911 to aide and nurse that she didn't want 911 being called. (sic)"

When interviewed July 19, 2010, client B3 recalled the spontaneous bleeding from her fistula on June 29, 2010. Client B3 stated she pushed her pendant, because she could not stop the bleeding. The home health aide (HHA) entered the room and client B3 stated she requested some gauze and tape to apply pressure and another washcloth, because one washcloth had already become saturated with blood. Client B3 stated the HHA stated that he was "not allowed," but that he would call 911, which he did. Client B3 stated it was very scary for her waiting until the paramedics arrived and transported her to the hospital.

When interviewed July 19, 2010, employee BB (unlicensed staff) stated she was not aware of any special precautions with client B3's dialysis access site other than the client had had two episodes of bleeding from the site recently and she thought the client was to keep a bandage covering the site until her next dialysis, although employee BB stated she was not sure.

When interviewed July 19, 2010, employee BA (RN) confirmed client B3's evaluation and service plan did not address the client's fistula access site and the immediate emergency care and treatment of the site or measures to be taken to prevent infection to the access site. Employee BA stated she was not aware of any protocol for the emergency care and monitoring of the client's fistula dialysis access site.

Client A2 began receiving services from the home care provider on July 8, 2010. The client had a diagnosis of chronic kidney disease and received hemodialysis from an outside kidney dialysis center three times a week.

Client A2 was observed on July 14, 2010, at 10:00 a.m. to have a fistula dialysis access site on her left upper arm for dialysis treatments.

Client A2's RN evaluation, dated July 8, 2010, did not include information about the client's fistula dialysis access site. The evaluation only indicated that the client received dialysis three times a week. The RN did not evaluate and develop a plan for the emergency care for the client should the dialysis access site begin to bleed nor was there a plan that identified precautions to take to prevent the access site from becoming infected.

When interviewed July 14, 2010, employee AC (unlicensed staff) stated he did not have a "clue," if there was any special precautions he needed to take regarding client A2's dialysis access site. Employee AC stated there was nothing listed about the dialysis access site on his assignment sheet.

When interviewed July 14, 2010, contracted employee AB (RN) confirmed there were no special instructions for the unlicensed staff to follow regarding client A2's dialysis access site. Employee AB stated she was not aware of any protocol for the emergency care and monitoring of the client's fistula 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

2. MN Rule 4668.0815 Subp. 4

Based on observation, interview and record review, the licensee failed to ensure that the clients' service plans were complete for four of nine clients' (A1, A3, C1 and C3) records reviewed. The findings include:

Client A1 began receiving services from the home care provider on May 17, 2010, which included medication set-ups weekly by the nurse, medication administration by the unlicensed staff at least daily, assistance with oxygen and C-Pap machine. The client's service plan, dated May 17, 2010, indicated that home health aide visits were provided upon request and medication set-ups were provided as ordered. There was no frequency of the home health aide visits and medication set-ups identified on the service plan.

Client A3 began receiving services from the home care provider on May 1, 2010, which included assistance with bathing two times a week and medication set-ups weekly. The client's service plan, dated May 11, 2010, had a contingency action plan, but the plan did not include the name and telephone number of the person to contact in case of an emergency or significant adverse change in the client's condition.

When interviewed July 14, 2010, contracted employee AB (registered nurse/RN) confirmed client A1's and A3's service plans were not complete.

Client C1 and C2 began receiving services from the home care provider May 1, 2010. The services they received included assistance with activities of daily living at least one time a day and medication set-ups and medication administration. Client C1's and C2's service plan, dated May 11, 2010, indicated that home health aide visits were provided upon request and medication set-ups and medication administration were as ordered. The service plans did not include the frequency of the home health aide visits, medication set-ups and medication administration.

When interviewed July 20, 2010, employee CC (RN) confirmed client C1's and C2's service plan were not complete and were not an accurate reflection of the services that were being provided.

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 4668.0855 Subp. 5

Based on interview and record review, the licensee failed to ensure that the registered nurse (RN) was notified, either within twenty-four hours after a pro re nata (PRN, as needed) medication was administered by an unlicensed staff person or within a time period that was specified by a RN prior to the administration for two of five clients' (A1 and C2) records reviewed, who received PRN medications. The findings include:

When interviewed July 13, 2010, regarding the home care provider's policy on PRN medications, contracted employee AB (RN) stated that the RN was always called before the unlicensed staff administered any PRN medication to a client.

Client A4 began receiving services from the home care provider June 11, 2010, which included medication administration. Client A4 had prescriber's orders for Oxycodone 5 milligrams one to two tablets orally every four hours PRN pain, and ibuprofen 200 milligrams two tablets orally three times a day PRN pain. Client A4's medication administration record (MAR) for July 2010 indicated the client received the Oxycodone PRN on July 1, 3, 4, 5, 6, 7, 8, 12 and 13, 2010, and ibuprofen PRN on July 6, 8, 11, 12 and 13, 2010. There was no evidence that the RN had been notified that the client had received the PRN Oxycodone and PRN ibuprofen.

When interviewed July 14, 2010, employee AC (unlicensed staff) stated they do not need to call the nurse when administering a PRN medication to the client, unless the staff person had a question.

When interviewed July 14, 2010, employee AE (licensed practical nurse) confirmed a RN was not notified of client A4's PRN medication use.

Client C2 began receiving services from the home care provider May 1, 2010, which included medication administration. Client C2 had prescriber's orders for Ativan 1 milligram every 4 hours PRN for dementia/anxiety. Client C2's July 2010 MAR indicated the client received Ativan 1 milligram on July 6, 9, 10, 11, 13, 18, 19, 20 and 21, 2010. There was no evidence that the RN had been notified that the client had received the PRN Ativan.

When interviewed July 20, 2010, employee CC (RN) confirmed a RN was not notified of client C2's PRN Ativan use. Employee CC stated RN notification of PRN medication use was inconsistent.

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: Seven (7) days

4. MN Rule 4668.0855 Subp. 6

Based on observation, interview and record review, the licensee failed to ensure that unlicensed staff did not dial a client's insulin dosage on an insulin pen prior to the client self-administering the insulin for one of two clients (B1) observed receiving insulin via an insulin pen. The findings include:

Client B1 had prescriber's orders for Humalog insulin 25 units to be given via a pen before lunch. Employee BB (unlicensed staff person) was observed on July 19, 2010, at 11:30 a.m. to assist client B1 with her insulin. Employee BB was observed to check the client's medication administration record for the dosage of insulin and dialed the client's Humalog insulin pen to 25 units before handing the pen to client B1 to self-inject her insulin.

When interviewed July 19, 2010, client B1 stated that some of the unlicensed staff would dial the dose of insulin on the insulin pen prior to handing it to her to self-inject, but then some of the unlicensed staff had the client dial the dose of insulin herself. Client B1 stated she liked it when the unlicensed staff dialed the dose on the insulin pen, because her eye sight was failing and it was hard to see the numbers on the pen.

When interviewed July 19, 2010, employee BB stated that unlicensed staff were recently trained by the registered nurse (RN) to dial client B1's insulin dose on the pen because the client could not see well enough to do it herself. Employee BB stated all the unlicensed staff should be dialing the client's dose on her insulin pen prior to handing the pen to the client.

When interviewed July 19, 2010, employee BA (RN) stated that the unlicensed staff were not to dial client B1's insulin dosage, but rather the staff should be verifying the dose that client B1 dialed was correct. Employee BA stated she trained the staff on how to use the insulin pen, but not to dial the dose.

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

5. MN Rule 4668.0855 Subp. 9

Based on observation, interview and record review, the licensee failed to ensure that medications were administered as prescribed for three of seven clients' (A1, A2 and B1) records reviewed who received assistance with medication administration. The findings include:

Client A2 began receiving services from the home care provider July 8, 2010, which included medication administration. Client A2 had a prescriber's order, dated July 7, 2010, for Renvela 800 milligrams three times a day. Observation of the client's medi-set container on July 14, 2010, which is set-up by the nurse weekly revealed the Renvela was set-up to be administered two times a day on Mondays, Wednesday and Fridays, instead of three times a day as ordered. When interviewed July 14, 2010, employee AF (licensed practical nurse) confirmed the Renvela was not administered three times a day as prescribed on Monday, Wednesday and Fridays.

Client A2 had a prescriber's order, dated July 7, 2010, for Avelox 400 milligrams one every morning. Client A2's July 2010 medication administration record (MAR) did not include the administration of Avelox. When interviewed July 14, 2010, employee AF confirmed there was no evidence the Avelox was administered as prescribed. Observations on July 14, 2010, at 11:30 a.m., revealed a bottle of Avelox, dated July 10, 2010, sitting on the client A2's kitchen counter. Employee AF stated she was not sure why client A2's Avelox was on the counter as the client's medications were to be administered by staff and were locked in a box. Employee AF stated she did not know if the client was taking the Avelox.

Client A1 began receiving services from the home care provider May 17, 2010, which included medication administration. Employee AC (unlicensed staff person) was observed on July 14, 2010, at 8:05 a.m. to administer client A1's medications from a medi-set container that had been pre-set up by the nurse at an earlier date. Employee AC was observed to take the pills out of the Wednesday a.m. compartment of the medi-set container. Employe AC and the surveyor counted the pills twice, and noted that there were nine pills. Employee AC was observed to administer the pills to client A1. Client A1's July 2010 MAR indicated that there were 10 pills to be administered in the morning on Wednesday a.m., which included aspirin, clonidine, Colace, diltiazem, Effexor, hydralazine, isosorbide, Lasix, metoprolol and omeprazole. It could not be determined which medication was not administered as prescribed due to the client had already taken the medications.

Client B1 began receiving services from the home care provider May 1, 2010, which included medication administration and assistance with insulin injections. Client B1 was observed on July 19, 2010, at 11:30 a.m. to receive Humalog insulin 20 units. A review of the client's record revealed a prescriber's order, dated May 27, 2010, that read, "Add Novolog 20 units pre-lunch and pre-supper." A prescriber's order, dated June 4, 2010, indicated Novolog 44 units in a.m., 20 units at noon and 30 units at 4:00 p.m. Client B1's June 2010 MAR indicated "Novolog 100 u/ml (Humalog)" although Novolog and Humalog insulin are two different insulins.

When interviewed July 19, 2010, regarding the discrepancy between the Novolog and the Humalog, employee BA stated the notation "Novolog 100 u/ml (Humalog)" on the client's June 2010 MAR was written in error, as they are two different insulins. Employee BA contacted the client's pharmacy on July 19, 2010, and the pharmacy indicated they had never dispensed Novolog insulin for client B1 and was unaware that the client had an order for the Novolog.

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

6. MN Rule 4668.0860 Subp. 2

Based on interview and record review, the licensee failed to ensure that there were written prescriber's orders for medications that were administered for one of seven clients' (A2) records reviewed who received medication administration. The findings include:

Client A2 began receiving services from the home care provider July 8, 2010, which included medication administration. Client A2's July 2010 medication administration record (MAR) indicated the client received Phoslo 667 milligrams one capsule orally three times a day, Vitamin B-Complex one tablet orally every day and Vitamin C one tablet orally every day. There were no written prescriber's orders for these medications.

When interviewed July 14, 2010, employee AF (licensed practical nurse) confirmed there were no written prescriber's order for the Phoslo, Vitamin B-Complex and Vitamin C that client A2 received.

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

7. MN Statute §144A.44 Subd. 1(2)

Based on observation, interview and record review, the licensee failed to ensure that services were provided in accordance with acceptable medial and nursing standards related to assessment of falls and medication monitoring for one of one client's (C2) record reviewed on the memory care unit at housing with services site C. The findings include:

Client C2 began receiving services from the home care provider on May 1, 2010, and resided on the memory care unit. Client C2's record lacked an assessment and interventions related to the prevention of falls and there was no evidence in the client's record that the client was displaying behaviors that warranted the use of psychotropic medications.

Client C2's progress notes indicated the client fell May 3, 2010, "lost her balance and fell." On June 4, 2010, the client was found on the floor, on June 7, 2010, the client "lost her balance and fell," on June 10, 2010, the client fell on her knees at 5:30 p.m. and 7:30 p.m., on June 18, 29 and July 10, 2010, the client was found on the floor.

The client's July 2010 medication administration record (MAR) indicated the client received the following psychotropic medications: Ativan 1 milligram orally three times a day, Paxil 30 milligrams orally every day, Seroquel 25 milligrams orally three times a day, Trazodone 25 milligrams every bedtime and Ativan 1 milligram orally every four hours PRN for dementia with anxiety.

A "Vulnerable Adult Shared Risk Agreement" form, dated June 8, 2010, indicated that client C2 was at risk of frequent falls and to refer to the Fall Risk Assessment form. The plan of action for the home care agency was blank on the Vulnerable Adult Shared Risk Agreement form. The Fall Risk Assessment form, dated May 11, 2010, signed by a registered nurse (RN) had two items circled and the remainder of the assessment was blank. The two areas circled were that the client had adequate vision and the client was on psychotropic medications.

Client C2 was observed on July 21, 2010, from 9:00 a.m. until 11:00 a.m. to be seated in a chair in the living area asleep with her chin to her chest. At times during this observation staff attempted to wake her to eat breakfast and to participate in an activity, but the client would awake for only brief moments and then fall back to sleep. At one point employee CB (occupational therapist/OT) lifted the client's arms and legs and performed range of motion on them while speaking very loudly to the client. The client remained asleep not opening her eyes.

When interviewed July 21, 2010, employees CA (registered nurse) and employee CB (OT) stated they had noted that client C2 appeared sleepier in the last few days. Employee CA stated the client's falls usually occurred when the client would get up from her chair "real fast" and then she would fall. Employees CA and CB confirmed there was no assessment or evaluation of the client's falls and if the psychotropic medication use was contributing to the falls.

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

8. MN Statute §626.557 Subd. 14(b)

Baed on interview and record review, the licensee failed to develop an individualized abuse prevention plan for three of seven clients' (A1, C2 and C3) records reviewed, who had areas of vulnerability identified. The findings include:

Client A1 began receiving services from the home care provider on May 17, 2010, which included medication set-ups, medication administration, assistance with bathing, assistance with blood glucose checks and assistance with oxygen administration. There was no individualized assessment of the client's susceptibility to abuse.

When interviewed July 14, 2010, contracted employee AB (registered nurse) confirmed client A1 did not have an individualized assessment of her susceptibility to abuse. Contracted employee AB stated she did not get one done.

Client C2 began receiving services from the home care provider on May 1, 2010, and resided on the memory care unit of the facility. The client's Vulnerability, Safety and Risk Assessment form, dated May 11, 2010, identified the client as being vulnerable in the areas of orientation, inability to give accurate information consistently, inability to use the telephone, inability to manage her own personal finances, inability to follow directions consistently and inability to report abuse or neglect. There were no specific measures identified that would be taken to assist in minimizing the risk of abuse to the client in the areas the client was identified as being vulnerable.

Client C3 began receiving services from the home care provider on May 1, 2010. The client's Vulnerability, Safety and Risk Assessment form, dated May 11, 2010, identified the client as being vulnerable in the areas of range of motion limitations, chronic pain, and her environment not being safe due to clutter in her apartment. There were no specific measures identified that would be taken to assist in minimizing the risk of abuse to the client.

When interviewed July 21, 2010, employees CA and CC (registered nurses) confirmed client C2's and C3's vulnerability assessments did not include measures to be taken to assist in minimizing the risk of abuse to 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