MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6840

October 12, 2010

Rhonda Schillinger, Administrator
Inver Grove Heights WP II LLC
720 Main Street #205
Mendota Heights, MN 55118

Re: Results of State Licensing Survey

Dear Ms. Schillinger:

The above agency was surveyed on September 7 and 8, 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

01/07 CMR3199

CERTIFIED MAIL #: 7009 14100000 2303 6840

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 220, P.O. Box 64938, St. Paul, Minnesota 55164-0938
Home Care & Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	RHONDA SCHILLINGER	DATE: October 12, 2010
PROVIDER:	INVER GROVE HEIGHTS WP II LLC	COUNTY: DAKOTA
ADDRESS:	720 MAIN STREET #205 MENDOTA HEIGHTS, MN 55118	HFID: 27377

On September 7 and 8, 2010, a surveyor of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed:_____ Date: _____

In accordance with Minnesota Statute §144A.45, this correction order has been issued pursuant to a survey. If, upon re-survey, it is found that the violation or violations cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided in the section entitled "TO COMPLY." Where a rule contains several items, failure to comply with any of the items may be considered lack of compliance and subject to a fine.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

1. MN Rule 4668.0810 Subp. 6

Based on observation, interview and record review, the licensee failed to ensure that significant incidents such as falls were recorded in the client's record for one of one client's (#2) record reviewed who had fallen. The findings include:

Client #2 was observed on September 7 and 8, 2010, to have a cast on her left arm. When interviewed September 7, 2010, client #2 stated she had fallen a couple of weeks ago and broke her arm.

A review of accident/incident reports indicated client #1 "slipped out of bed" on July 10, 2010, and on August 28, 2010, the client was found on the floor with a swollen wrist. Neither of these two incidents were recorded in the client's record.

When interviewed September 7, 2010, employee D (Housing Director) stated the Incident/Accident Reports were not considered part of the client's record.

When interviewed September 7, 2010, employee A (registered nurse) stated client #2 fell on August 28, 2010, and was sent to the emergency room the following day. The client was noted to have a broken wrist which was splinted. Employee A stated on August 31 or September 1, 2010, the client went back to the clinic and had the wrist casted. Employee A confirmed the client's fall, emergency room and subsequent clinic visit 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

2. MN Rule 4668.0815 Subp. 1

Based on interview and record review, the licensee failed to ensure that no later than two weeks after the initiation of home care services, a service plan was established for two of three clients' (#2 and #6) records reviewed. The findings include:

Clients #2 and #6 began receiving services from the licensee on July 7, 2010, and August 6, 2010, respectively, which included medication set-ups, medication administration and assistance with activities of daily living. Clients #2 and #6 did have a service plan in their records.

When interviewed September 8, 2010, employee D (Housing Director) confirmed clients #2 and #6 did not have a service plan in their records. Employee D stated she thought she had developed service plans for the clients but had not reviewed the service plan with the client's family yet or gotten their signature on the service plan.

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: Fourteen (14) days

3. MN Rule 4668.0825 Subp. 4

Based on observation, interview and record review, the licensee failed to ensure that before performing the delegated nursing procedure of blood glucose monitoring, unlicensed staff demonstrated competency to a registered nurse (RN) their ability to follow the procedure for two of two employees (B and C) observed performing blood glucose monitoring. The findings include:

Employees B and C were observed on September 8, 2010, at 11:30 a.m. and September 7, 2010, at 11:30 a.m., checking client #7's and #5's blood glucose, respectively. Employee B's and C's instruction and competency records were reviewed and did not include instruction by the RN in the proper method to perform the procedure or demonstration to the RN their ability to competently follow the procedure.

When interviewed September 8, 2010, employee A (RN) confirmed that she had not instructed employees B and C in blood glucose testing. Employee A stated that both of the employees had worked for another licensed home care provider prior to their employment with the licensee and had been trained in blood glucose testing by their prior employment. Employee A stated she thought that training was sufficient.

TO COMPLY: A person who satisfies the requirements of part 4668.0835, subpart 2, may perform delegated nursing procedures if:

A. before performing the procedures, the person is instructed by a registered nurse in the proper methods to perform the procedures with respect to each client;

B. a registered nurse specifies in writing specific instructions for performing the procedures for each client;

C. before performing the procedures, the person demonstrates to a registered nurse the person's ability to competently follow the procedures;

D. the procedures for each client are documented in the client's record; and

E. the class F home care provider licensee retains documentation by the registered nurse regarding the person's demonstrated competency.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

4. MN Rule 4668.0845 Subp. 2

Based on interview and record review, the licensee failed to ensure that the registered nurse (RN) conducted a supervisory visit within fourteen days after initiation of home care services for three of three clients' (#2, #4 and #5) records reviewed. The findings include:

Client #2 began receiving services from the licensee July 7, 2010, which included medication set-ups, medication administration and assistance with activities of daily living. A supervisory visit by the RN was not completed within fourteen days after initiation of services. The first supervisory visit was dated August 25, 2010.

Client #4 began receiving services from the licensee July 16, 2010, which included medication set-ups, medication administration and assistance with activities of daily living. A supervisory visit by the RN was not completed within fourteen days after initiation of services. The first supervisory visit was dated August 16, 2010.

Client #5 began receiving services from the licensee July 22, 2010, which included medication set-ups, medication administration and blood glucose checks. A supervisory visit by the RN was not completed within fourteen days after initiation of services. The first supervisory visit was dated August 13, 2010.

When interviewed September 8, 2010, employee A (RN) confirmed that clients #2, #4 and #5 did not have supervisory visits within fourteen days after initiation of services. Employee A stated she was behind in getting the supervisory visits done.

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

5. MN Rule 4668.0855 Subp. 4

Based on observation, interview and record review, the licensee failed to ensure that before the registered nurse (RN) delegated assistance with self-administration of medications to unlicensed staff, that the RN instructed unlicensed staff on the procedure for medication administration for two of two unlicensed staff (B and C) observed administering medications. The findings include:

Employees B and C were observed on September 8, 2010, at 9:10 a.m. and September 7, 2010, at 11:30 a.m. respectively, administering medications to clients. Employee B's and C's medication administration training records were reviewed and did not include instruction by the RN on the procedure for medication administration.

When interviewed September 8, 2010, employee A (RN) confirmed that she had not instructed employees B and C in medication administration. Employee A stated that both of the employees had worked for another licensed home care provider prior to their employment with the licensee and had

been trained in medication administration by their prior employment. Employee A stated she thought that training was sufficient.

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

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

(2) preparation of the medication for administration;

(3) administration of the medication to the client;

(4) assistance with self-administration of medication;

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

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

TIME PERIOD FOR CORRECTION: Fourteen (14) days

6. MN Rule 4668.0860 Subp. 2

Based on observation, interview and record review, the licensee failed to ensure that there were written prescriber's orders for medications that were administered for two of five clients (#1 and #2) observed receiving medications. The findings include:

Client #1 began receiving services from the licensee August 2, 2010, which included medication set-ups, medication administration, assistance with activities of daily living and a wound treatment. Client #2 was observed on September 7, 2010, at 12:00 noon to receive a packet of Arginaid (a supplement used to promote wound healing) mixed with a glass of water. Client #1's medication administration record for September 2010 indicated the client received one packet every day. There was no written prescriber's order for the Arginaid. When interviewed September 7, 2010, employee A (registered nurse/RN) confirmed there was not a current order for the Arginaid.

Client #2 began receiving services from the licensee July 7, 2010, which included medication set-ups, medication administration and assistance with activities of daily living. Client #2's medication administration record for September 2010 indicated the client received oxycodone/APAP 5 milligam/325 milligram one tablet on a PRN (pro ra nata, or as needed basis)on September 4, 5 and 6, 2010. There was no written prescriber's order for this medication. When interviewed September 7, 2010, employee A (RN) confirmed there was no written prescriber's order on record for client #2's oxycodone/APAP. Employee A stated that the client's family may have taken the prescription to the pharmacy to be filled, but she did not retain a copy of it for her records.

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 Rule 4668.0860 Subp. 6

Based on interview and record review, the licensee failed to ensure that verbal orders were forwarded to the prescriber for signature no later than seven days after receipt of the verbal order for one of two client's (#3) records reviewed who had verbal orders. The findings include:

Client #3 began receiving services July 5, 2010. Client #3's record contained eleven verbal orders from a prescriber for changes in the client's Coumadin and one for an antibiotic between July 9, 2010, and August 27, 2010, that were not sent to the prescriber for signature.

When interviewed September 7, 2010, employee A (registered nurse) confirmed that she does not forward verbal orders to a prescriber for signature for any of the clients. Employee A stated she was not aware she needed to do this.

TO COMPLY: Upon receiving an order verbally from a prescriber, a nurse must:

A. record and sign the order; and

B. forward the written order to the prescriber for the prescriber's signature no later than seven days after receipt of the verbal order.

TIME PERIOD FOR CORRECTION: Seven (7) days

8. MN Statute §144A.44 Subd. 1(2)

Based on observation, interview and record review, the licensee failed to ensure that care and services were provided in accordance with accepted medical and nursing standards for one of one client (#1) reviewed who was observed receiving a wound treatment. The findings include:

The agency did not follow current nursing standards related to infection control and the use of gloves and handwashing, nor did the agency follow the current prescriber's orders for client #1's wound treatment.

Client #1 began receiving services from the licensee on August 2, 2010, which included medication set-ups, medication administration, treatment to a wound on the client's foot and assistance with activities of daily living. A hospital history and physical, dated September 3, 2010, indicated the client had a two centimeter deep purulent ulcer on her right great toe which was cultured positive for methicillin resistant staphylococcus aureus (MRSA). The client was scheduled for a partial amputation on September 13, 2010.

Employee A (registered nurse) was observed on September 7, 2010, at 1:55 p.m. to perform client #1's wound care to her foot. After washing her hands, employee A was observed to put on three pair of gloves, layering one over each other. Employee A was observed to remove client #1's dressing that was covering the wound and also removed the Tegaderm Ag Mesh dressing which was lying in the wound bed. Once the dressing was removed, a very foul smelling odor was noted in the air. In addition, purulent drainage was noted on the outer dressing and the Tegaderm dressing when removed. Employee A removed the outer pair of gloves, but did not wash her hands after handling the soiled dressings, but

rather continued the treatment by cleansing the wound bed with Sodium Chloride, applying Solosite gel to the wound bed and then placing Tegaderm Ag Mesh into the wound bed before removing the second layer of gloves. Employee A then placed a dressing covering the wound bed and applied an ace bandage. Employee A removed the final pair of gloves she had covering her hands. Employee A placed another pair of gloves on her hands and put the supplies away, before removing the gloves and washing her hands.

When interviewed September 7, 2010, regarding the procedure of applying three pair of gloves at one time, employee A stated it was something she picked up while working in the hospital to save time. Employee A agreed that handwashing after removing a pair of gloves would have been a more appropriate practice.

A prescriber's order, dated August 16, 2010, indicated to start Tegaderm Ag Mesh (a nonwoven dressing containing silver sulfate) with Solosite gel to right foot every day. Client #1 was hospitalized September 3-4, 2010, for evaluation for gastrointestinal bleeding and transfusions due to low hemoglobin. Although the hospital discharge/transfer orders from the physician dated September 4, 2010, indicated the wound care as: "Daily wound care-sterile saline gauze and Kerlix or gauze tape then ace bandage," observations on September 7, 2010, revealed the employee followed the wound care orders of August 16, 2010, not the wound care orders dated September 4, 2010.

When interviewed September 7, 2010, regarding the wound treatment discrepancy, employee A stated that she had assumed the August 16, 2010, order was the wound treatment the prescriber wanted followed. Employee A agreed she should have called the prescriber to clarify the order when she received a different order for the wound treatment following the client's hospitalization on September 4, 2010.

TO COMPLY: A person who receives home care services has these rights:
(2) the right to receive care and services according to a suitable and up-to-date plan, and subject to accepted medical or nursing standards, to take an active part in creating and changing the plan and evaluating care and services;

TIME PERIOD FOR CORRECTION: Seven (7) days

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