MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 1538

May 18, 2006

Rufus Adewola, Administrator
Loving Care Home Care Services
501 North Dale Street #205
St. Paul, MN 55103

Re: Licensing Follow Up visit

Dear Mr. Adewola:

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on April 3, 4, 5, and 6, 2006.

The documents checked below are enclosed.

__X__ Informational Memorandum
Items noted and discussed at the facility visit including status of outstanding licensing correction orders.

__X__ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

__X__ Notices Of Assessment For Noncompliance With Correction Orders For Home Care Providers

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.

Feel free to call our office if you have any questions at (651) 201-4301.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: James C. Snyder, SR, Attorney at Law
Kelly Crawford, Minnesota Department of Human Services
Ramsey, County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Protecting, Maintaining and Improving the Health of Minnesotans

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NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOLLOWING A SUBSEQUENT REINSPECTION FOR HOME CARE PROVIDERS

May 18, 2006

RUFUS A ADEWOLA
LOVING CARE HOME CARE SERVICES
501 NORTH DALE STREET #205
ST PAUL, MN 55103

RE: QL21083006

Dear Mr. Adewola:

I) On April 3, 4, 5 and 6, 2006 a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of a correction order dated June 3, 2005 and issued during an inspection conducted on May 25, 26, and 27, 2005 and June 1, 3, 6, and 8, 2005 and found to be uncorrected during an inspection completed on November 29, 30, and December 1, 2005. This correction order was hand-delivered and received by the agency on June 3, 2005.

As a result of the correction order remaining uncorrected during the November 29, 30, and December 1, 2005 re-inspection, a penalty assessment in the amount of **$250.00** was imposed on January 18, 2006.

The following correction order dated June 3, 2005 remains uncorrected at the time of the subsequent re-inspection on April 3, 4, 5 and 6, 2006:

[Un-numbered] MN Statute §144A.44 Subd. 1(2) **$500.00**

Based on record review, interview and observation, the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for one of one (#2) ventilator dependent clients. The findings include:

Client #2 began receiving contracted care from the licensee on December 1, 2004 with a diagnosis of Amyotrophic Lateral Sclerosis, (ALS). Client #2 was ventilator dependent and had a gastrostomy tube for feeding and oral medication. Client #2 communicated with eye blinks towards a communication board and with a doorbell, used as a call system, through some cheek movement. Client #2 communicated via his board with his significant other and family. The service agreement dated December 1, 2004 did not contain a description of the services provided, their frequency, or fees for services. There were no required supervisory visits by a registered nurse, nor were there instructions in writing and documentation in the client's record on the procedures for cares or treatments. Client #2 received care from employees #2 and #3 licensed practical nurses (LPN) and employee #4 a home health aide (HHA). Employees # 2, #3, and #4's personnel records did not indicate orientation to home care, home health training, competency

evaluation, in-service education, infection control education, or tuberculin testing. These employees had not been oriented to tasks for the client by a registered nurse.

During a home visit May 26, 2005, there were three agency staff (#2, #3, #4,) present due to shift change. Employee #3, an LPN was observed working with client #2 May 26, 2005. Employee #3's nursing license had expired April 30, 2005 and had not been renewed.

The agency administrator made site visits with direct client contact. The administrator's personnel record had no criminal background check. His personnel record lacked evidence of orientation to home care, tuberculin testing, or infection control education.

During an interview May 26, 2005, both licensed practical nurses providing care to client #2 stated they had no training in home care or in ventilator care. Employee # 3, a licensed practical nurse stated the only training she received was from the client's significant other. There was no evidence of registered nurse (RN) involvement in client #2's care.

When interviewed May 26, 2005 the administrator stated he had no registered nurse in his employ and had not since November 2004. He then stated RN services were provided by the RNs' in his pool agency. When questioned about how often the nurses from his pool agency worked to provide service to his home care clients he stated "never. They always refuse to go." He confirmed he did not have a contract with any agency for other services including nursing services.

During a home visit, May 26, 2005, client #2's significant other stated "we have some competency issues here…he has sent people who have not been trained, you have medication errors, no staff person to relieve. I call – no answer. This is 24-hour service. I'm not sure if the settings (pointed to the ventilator) are appropriate. The notes are not being signed off – now the paper is gone." Client #2's significant other stated she had a form identifying the settings on the ventilator to be sure the settings were correct at the beginning of the shift. Caregivers were not filling out the form indicating the settings. During an interview, June 2, 2005, client #2's significant other stated she had utilized a form that was developed by another agency, to be sure all of the ventilator settings were correct and it had worked very well.

Client #2's significant other, stated that on May 13, 2005, employee #2 "cut off the end of the feeding tube and put it in the bag. His stomach contents were all over the bed and he laid in it all night. Today she tried to give an enema without removing the cap. I caught her in time." Client #2's significant other also stated "if [client name] refuses care it is because it is not being done right." Nurses notes dated May 13, 2005 stated "refused H.S. (hour of sleep) cares and nebulizer, took only meds." Client #2's significant other stated that was because "she was trying to stick it between the trach and the trach vent and it would not hook to anything." She indicated client #2 knows how his cares are to be done and will refuse rather than risk having them done improperly. Staff had been giving daily phosphate enemas and regularly administered medications. There were no doctors' orders for medications and treatments in the client record. There was no notification of the administration of a pro re nata (prn) medication to a registered nurse.

Client #2's significant other went on to state "neither one here today (the LPN nor PCA) know the communication system." The client uses a communication board system and a doorbell to communicate his needs. He "puts on the doorbell with his cheek when he needs suctioning or anything." Client #2 communicated via his board with his significant other and family. Client # 2's significant other stated he receives suctioning fifteen times per day. "One night staff went to the apartment door when the client rang for suctioning, not realizing the client was calling for help. "I have not had good nights sleep for a long time because of this. I live 20 minutes from here but have been staying because I don't dare leave." Client #2 indicated through eye movement, the communication board, and with the assistance of the significant other "[administrators name] keeps sending people fresh off the boat." Client #2 communicated via his board with his significant other and family only. Staff confirmed they had not been

trained to communicate with the client.

During a telephone interview June 2, 2005, client #2's significant other stated the administrator "came by to talk on Tuesday" May 31, 2005. "He asked if we could continue services and work with him." Client #2's significant other stated she told the administrator not to send employee #2 again. "She ripped his anus on Monday. She's more trouble than she's worth." She also stated, "a new L.P.N. came in today and called [administrator's name] and asked where the care plan signed by the registered nurse was?" She added the new LPN also told the administrator" to get an R.N. out here today." When interviewed June 3, 2005, client #2's significant other stated, "Wednesday" (June 1, 2005) "didn't have a nurse or a PCA. He sent out [name of office staff] to help with transfer."

TO COMPLY: 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;

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230, and Minnesota Rule 4668.0240 you are assessed the amount of: $500.00.

II) On April 3, 4, 5 and 6, 2006 a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of the correction orders dated October 20, 2005, issued during an inspection conducted on May 25, 26, and 27, 2005 and June 1, 3, 6, and 8, 2005 received by you on October 22, 2005 and found uncorrected during a reinspection on November 29, 30, and December 1, 2005. On January 18, 2006, a copy of the uncorrected orders were hand-delivered to you by a MDH representative.

As a result of the correction orders remaining uncorrected during the November 29, 30, and December 1, 2005 re-inspection, a penalty assessment in the amount of $3000.00 was imposed on January 18, 2006.

The following correction orders dated October 20, 2005 remained uncorrected at the time of the subsequent re-inspection on April 3, 4, 5 and 6, 2006:

3. MN Rule 4668.0040 Subp. 2 **$100.00**

Based on record review and interview, the licensee failed to provide to seven of seven clients (#1, #2, #3, #4, #5, #6 and #7) reviewed, a written notice that included the client's right to complain to the licensee about the services received; the name or title of the person or persons to contact with complaints; the method of submitting a complaint to the licensee; the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and a statement that the provider will in no way retaliate because of a complaint. The findings include:

Clients #1, #2, #3, #4, #5, #6 and #7 record and the licensee's admission packet were reviewed and were noted to lack information to indicate that the licensee had provided a written notice to each client that included the clients' right to complain about the services they were receiving, the method to submit the complaint to the licensee, the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints and a statement that the licensee will in no way retaliate against the client because of the complaint. When interviewed on June 1, 2005, the owner stated that the agency did not provide clients with a written notice of the agency's complaint procedure because he thought that the Home Care Bill of Rights that addressed complaints.

TO COMPLY: The system required by subpart 1 must provide written notice to each client that includes:

A. the client's right to complain to the licensee about the services received;
B. the name or title of the person or persons to contact with complaints;
C. the method of submitting a complaint to the licensee;
D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and
E. a statement that the provider will in no way retaliate because of a complaint.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) , Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $100.00.

5. MN Rule 4668.0065 Subp. 3 **$600.00**

Based on personnel record review and interview, the licensee failed to assure annual infection control in-service training for six of nine employees (#1, #2, #3, #5, #6, and #8) reviewed. The findings include:

The licensees' "Infection Control" policy stated "Staff is taught basic infection control measures, use of protective equipment, method and time of replacement during orientation and on an annual basis."

Employee #1 was hired January 8, 2004. Employee #2 was hired March 14, 2003. Employee #3 was hired May 2, 2002. Employee #6 was hired October 28, 2002. Employees #5 and #8 began working for the agency in 2000. Personal record review for employees #1, #2, #3, #5, #6, and #8 did not contain documentation of infection control in-service training within the last twelve months.

The owner when interviewed on June 1, 2005 stated that each employee was responsible for getting his or her own infection control training and keeping track of what they have taken. The owner verified that there were no in-service training records in the personnel files.

TO COMPLY: For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;
B. the need for and use of protective gloves, gowns, and masks;
C. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;
D. disinfecting reusable equipment; and
E. disinfecting environmental surfaces.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230, and Minnesota Rule 4668.0240, you are assessed in the amount of: $600.00.

6. MN Rule 4668.0075 Subp. 1 **$600.00**

Based on personnel record review and interview, the licensee failed to assure that nine of nine employees (#1, #2, #3, #4, #5, #6, #7, #8 and #9) reviewed received the required orientation to home care. The findings include:

Employee #1 was hired January 8, 2004. Employee #2 was hired March 14, 2003. Employee #3 was hired May 2, 2002. Employee #4 was hired May 4, 2005. Employees #5 and #8 began working for the agency in 2002. Employee #6 was hired October 28, 2002. Employee #7 was hired July 28, 2004 and employee #9 was hired January 20, 2005. When reviewed, personal files did not contain documentation to indicate that all nine employees had received the required orientation to home care.

When interviewed on June 1, 2005, the owner stated that the agency was not meeting this requirement for the employees. He stated that he thought he had met this requirement for himself by reading "A Guide To Home Care Services" which was mailed to Class A licensees by the Minnesota Department of Health in April of 2005. There was no evidence in the administrators personnel file to verify that he had done this. On June 8, 2005 the administrator stated he did not know where to get the Minnesota Rules that govern Class A licensees. This information is contained on page one of "A Guide To Home Care Services."

TO COMPLY: Every individual applicant for a license, and every person who provides direct care, supervision of direct care, or management of services for a licensee, shall complete an orientation to home care requirements before providing home care services to clients. This orientation may be incorporated into the training required of paraprofessionals under part 4668.0130. This orientation need only be completed once.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $600.00

7. MN Rule 4668.0100 Subp. 5 **$600.00**

Based on personnel record review and interview, the licensee failed to assure that four of five home health aides (#4, #7, # 8, and #9) were qualified to perform home health aide tasks. The findings include:

Personnel records for employees #4, #7, #8 and #9 were reviewed and were noted to lack documentation of the required training or competency evaluations for each of the four employees who perform home health aide (HHA) tasks. During an interview on May 27, 2005, the owner stated he did not have any training documentation for all four employees and was unsure what training any of his home health aides had. When asked about training documentation or training files the owner stated, "They keep that at home."

Employee #8 was hired by the agency in August of 2000 as a staffing coordinator. When interviewed, on June 6, 2005, employee #8 stated that in 2000 or 2001, when scheduled direct care staff were unavailable to provide care to clients, employee #8 would be sent out by the owner to "fill in" as a home health aide which she continues to do as needed. Employee #8 stated that she had not received any training as a home health aide from the current licensee. Employee #8 stated that she asks the client what to do and how to provide the care the clients need. When interviewed on June 6, 2005, the owner verified that employee #8 does work as a "fill in" HHA.

TO COMPLY: A person may only offer or perform home health aide tasks, or be employed to perform home health aide tasks, if the person has:

A. successfully completed the training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction substantially equivalent to that required by item A;

D. satisfied the requirements of Medicare for training or competency of home health aides, as provided by Code of Federal Regulations, title 42, section 484.36;

E. satisfied subitems (1) and (2):

(1) meets the requirements of title XVIII of the Social Security Act for nursing assistants in nursing facilities certified for participation in the Medicare program, or has successfully completed a nursing assistant training program approved by the state; and

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

F. before April 19, 1993, completed a training course of at least 60 hours for home health aides that had been approved by the department

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $600.00

8. MN Rule 4668.0100 Subp. 6 **$600.00**

Based on personnel file review and interview, the licensee failed to assure employees received at least eight hours of in-service training annually in topics relevant to the provision of home care services for five of five (#1, # 6, #7, #8, and #9) employees who performed home health aide tasks. The findings include:

Employees #8, #6, and #1 began employment in 2000, October 28, 2002, and January 8, 2004 respectively. Personnel file reviewed lacked evidence of in-service training in the past twelve months. Employees #6 and #1 had no evidence of in-service training since their dates of hire.

Employee #1 was interviewed on May 27, 2005 and stated he received his home health training in 1992 and has not received any further training.

During an interview June 6, 2005 employee #8 stated she received four hours of in-service training at another agency she worked for in March of 2004 but had not received any other training from this agency since she was hired in 2000.

When interviewed, May 27, 2005, the owner stated that employees keep their own record of training. When the owner was interviewed again on June 1, 2005, he stated he had no training records and was unsure what training his staff may have attended.

TO COMPLY: For each person who performs home health aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

C. If a person has not performed home health aide tasks for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence in the skills listed in part 4668.0130, subpart 3, item A, subitem (1).

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $600.00

9. MN Rule 4668.0100 Subp. 8 **$700.00**

Based on record review and interview, the licensee failed to provide orientation by a registered nurse for each person who is to perform home health aide tasks to each client and to the tasks to be performed for six of six (#1, #4, #6, #7, #8 and #9) home health aides records reviewed. The findings include:

Employee # 8 was hired in 2000 as a staffing coordinator. On June 6, 2005 she stated that she worked as a "fill in" for staff when they were unable to keep the assignment. She stated that she had been doing this since late 2000 or early 2001 and had never been oriented to the clients or the cares to be provided by a registered nurse. When interviewed on May 27, 2005, employee #8 stated that in 2005, the agency had a RN who worked for two days and terminated on December 1, 2004. Employee #8 stated that the agency had not had a RN on staff since December 1, 2004.

Employee #1 was hired January 8, 2004 and provides cares to client #1 who receives kidney dialysis three times a week. Employee #4 was hired on May 4, 2005 and provides cares for client #2 who has Amytrophic Lateral Sclerosis, is ventilator dependent and has tube feedings. Employee #6 was hired on October 28, 2002 and provides cares to client #5 who has a diagnosis of end stage renal disease and receives dialysis three times a week. Employee # 7 was hired July 28, 2004 and provides cares for client #4 who had a diagnosis of bipolar disorder. Employee #9 was hired January 20, 2005 and provides care for client #7 who has a diagnosis of HIV. There was no evidence to indicate that employees #1, #4, #6, #7 and #9 received orientation to each client and the tasks to be performed prior to performing the tasks.

TO COMPLY: Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $700.00

10. MN Rule 4668.0100 Subp. 9 **$700.00**

Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise home health aides to ensure work was being performed adequately for seven of seven (#1, #2, #3, #4, #5, #6, and #7) clients records reviewed. The findings include:

Client #1 was admitted to the agency September 26, 2003, Client #3 was admitted to the agency November 11, 2003 and expired January 6, 2005, Client #4 was admitted to the agency July 1, 2004, Client #5 was admitted July 14, 2004, Client # 6 was admitted on July 14, 2003 and expired January 6, 2005 (per county public health nurse interview, June 10, 2005), Client #7 was admitted April 22, 2004 and Client #2 was admitted on December 1, 2004. The records for clients #1, #2, #3, #4, #5, #6, and #7 did not contain any documentation of supervisory visits by a registered nurse. Employee #8 stated on May 27, 2005 there had not been a registered nurse since a registered nurse worked for two days and left on December 1, 2004. Employee #8 stated that, to date, the licensee did not have a RN on staff in 2005.

TO COMPLY: After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed

adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

A. within 14 days after initiation of home health aide tasks; and

B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or

C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4. If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse 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.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $700.00

11. MN Rule 4668.0140 Subp.2 **$100.00**

Based on record review and interview, the licensee failed to have written service agreements containing a description of the services to be provided, the frequency of the services, persons and category of person who are to provide the services, frequency of supervision, or fees for services for six of six clients (#1, #3, #4, #5, #6 and #7) reviewed. The findings include:

Clients' #6, #1, #7, #4, #5, and #3 began receiving services July 14, 2004, September 26, 2003, April 22, 2004, July 1, 2004, July 14, 2004, and November 1, 2004 respectively. The service agreements for clients #6, #1, #7, #4, #5, and #3 did not contain a description of the services to be provided, the frequency of the

services, persons and category of person to provide the services, frequency of supervision, or fees for services. During an interview on May 27, 2005, the owner verified that the service agreements were not complete.

TO COMPLY: The service agreement required by subpart 1 must include:

A. a description of the services to be provided, and their frequency;

B. 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, if any;

D. fees for services;

E. a plan for contingency action that includes:

(1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;

(3) who to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the licensee to contact a responsible person of the client, if any; and

(5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $100.00

12. MN Rule 4668.0160 Subp. 5 **$100.00**

Based on record review and interview, the licensee failed to assure that all entries in client records were authenticated and dated for two of seven (#1and #7) client records reviewed. The findings include:

Clients' #1 began receiving services on September 26, 2003. When reviewed, client #1's record contained a service agreement that had been authenticated by client #1's responsible party. A date to indicate when the agreement had been authenticated was lacking. This service agreement also had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Discontinuation of Service" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Contingency Plan" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Authorization for Emergency Procedure Plan" which had an area for client #1's responsible party to authenticate and date and an area for authentication and date by a witness. These areas were noted to be blank.

Client #1's record had a form called "Client Consent Form" which the client #1's responsible party had authenticated. The area for a date was noted to be blank.

Client #1's record had a form called "Home DNR/DNI Request Form" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for a witness and a physician to authenticate and date. This area was noted to be blank.

Client #1's record had a copy of the "Home Care Bill of Rights" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #7's record had a copy of an "Assessment/Care Plan" which client #7 had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #7's record had a copy of a form called "Home DNR/DNI request form" which had client #7's name listed on it and the initials "W.O." in the area that states "I hereby agree to the "Do Not Intubate" order." The document lacks client #7's authentication and date. This form had an area for authentication and date by a witness and the physician. These areas were noted to be blank.

Client #7's record had a copy of an "Service Agreement" which client #7's responsible party had authenticated and dated. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #7's record had a copy of an "Client Consent Form" which client #7's responsible party had authenticated and dated. This form had an area for authentication and date by a witness. This area was noted to be blank.

When shown the forms and interviewed on May 27, 2005, the agency's owner verified the above findings.

TO COMPLY: All entries in the client record must be:

A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or

B. recorded in an electronic media in a secure manner.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $100.00

13. MN Rule 4668.0160 Subp. 6 **$200.00**

Based on record review and interview, the licensee failed to have client records that included the dates services ended, medication and treatment orders, service agreements or a summary following the termination of services for one of one (#2) ventilator client and two of two (#3 and #6) discharged clients. The findings include:

Client #2 has a diagnosis of Amyotrophic Lateral Sclerosis, (ALS) is ventilator dependent and has a gastrostomy tube. Client #2's record was reviewed and was noted to lack physician's orders for his medications and treatments.

Client #3 began services on November 1, 2004. When reviewed, the last documentation in the record was dated in November 2004. The record lacked documentation of a service plan that described the services being provided, lacked a summary following the termination of service including the reason services were terminated. During a telephone interview on May 27, 2005, the spouse of client #3 stated that client #3 expired on January 6, 2005 and was a client of the licensee at the time of death. Documentation that the client expired was lacking.

Client #6 began services, on July 14, 2003. When reviewed, the last documentation in the record was dated November 2004. A service plan, discharge summary, documentation that services had terminated, and a summary following the termination of service was lacking. When interviewed on June 1, 2005, the licensee stated that client #6 had expired but he did not know when. Interview on June 10, 2005 with the county case manager for client #6 indicated that client #6 expired on January 6, 2005.

TO COMPLY: The client record must contain:

A. the following information about the client:
(1) name;
(2) address;
(3) telephone number;
(4) date of birth;
(5) dates of the beginning and end of services; and
(6) names, addresses, and telephone numbers of any responsible persons;

B. a service agreement as required by part 4668.0140;

C. medication and treatment orders, if any;

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

contact;

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

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

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $200.00

14. MN Rule 4668.0180 Subp. 9 **$200.00**

Based on record review and interview the licensee failed to establish and implement a quality assurance plan. The findings include:

The licensees' policy called "Orientation" stated that, "All employees attend orientation sessions that include: Introduction to the LOVINGCARE HOME CARE SERVICES, INC. Quality Improvement Program and the employees participation in the same." When interviewed on June 6, 2005, regarding the home care agency's quality assurance plan the administrator stated, "I don't have one."

TO COMPLY: The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

A. monitor and evaluate two or more selected components of its services at least once every 12 months; and

B. document the collection and analysis of data and the action taken as a result.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $200.00

15. MN Statute §144A.44 Subd. 1(13) **$1000.00**

Based on record review and interviews, the agency failed to assure that clients were served by staff who are properly trained for one of one ventilator client (#2) reviewed. The findings include:

When interviewed, May 26, 2005, the significant other of client #2 stated "we have some competency issues here…he has sent people who have not been trained, you have medication errors, no staff person to relieve. I call – no answer. This is 24-hour service. I'm not sure if the settings (pointed to the ventilator) are appropriate. The notes are not being signed off – now the paper is gone."

Client #2's significant other stated she had a form identifying the settings on the ventilator to be sure the settings were correct at the beginning of the shift but that caregivers were not filling out the form to indicate the settings at the start of the shift.

Client #2's significant other, stated that on May 13, 2005, employee #2, a Licensed Practical Nurse, "cut off the end of the feeding tube and put it in the bag. His stomach contents were all over the bed and he laid in it all night. Today she tried to give an enema without removing the cap. I caught her in time."

Client #2's significant other also stated "if [client name] refuses care it is because it is not being done right." Nurses notes dated May 13, 2005 stated, "refused H.S. (hour of sleep) cares and nebulizer, took only meds." Client #2's significant other stated that client #2 refused the nebulizer because "she was trying to stick it between the trach and the trach vent and it would not hook to anything." She indicated

client #2 knows how his cares are to be done and will refuse cares rather than risk having them done

improperly.

Staff had been giving daily phosphate enemas and regularly administered medications but there were no physician' orders for client #2's medications and treatments in his client record.

Staff were noted to administer pro re nata (prn) medication but did not report it to a registered nurse.

Client #2's significant other went on to state "neither one here today (the LPN nor PCA) know the communication system." Client #2 uses a communication board system and a doorbell to communicate his needs. Client #2, "puts on the doorbell with his cheek when he needs suctioning or anything." Client #2 communicated via his board with his significant other and family. Client # 2's significant other stated he receives suctioning fifteen times per day. "One night staff went to the apartment door when the client rang for suctioning, not realizing the client was calling for help. I have not had good nights sleep for a long time because of this. I live 20 minutes from here but have been staying because I don't dare leave." Staff confirmed they had not been trained to communicate with the client.

During a telephone interview on June 02,2005, client #2's significant other stated that the owner "came by to talk on Tuesday (May 31,2005)". He asked if they could continue services and work with client #2. Client #2 significant other stated she told the owner not to send not to send employee #2 to take care of client #2 because, "She ripped his anus on Monday (05/30/2005). She is more trouble than she is worth." Client #2 significant other stated in interview on June 3, 2005 that on June 01,2005, client #2 "didn't have a nurse or a PCA. He (administrator) sent out [name of office staff] to help with transfer".

TO COMPLY: A person who receives home care services has these rights: the right to be served by people who are properly trained and competent to perform their duties;

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), Minnesota Rule 4668.0230 and Minnesota Rule 4668.0240, you are assessed in the amount of: $1000.00

17. MN Statute §626.557 Subd.14(b) **No Assessment**

Based on record review and interview the licensee failed to develop individualized abuse prevention plans for seven of seven (#1, #2, #3, #4, #5, #6, and #7) clients reviewed and failed to adequately complete an individual abuse prevention assessment for three of seven (#1, #4 and #5) clients reviewed. The findings include:

When interviewed on June 1, 2005, employee #5 stated that all the client information is located in each client's record. When reviewed, clients #1, #2, #3, #4, #5, #6, and #7 records did not contain abuse prevention plans of the client's susceptibility to abuse.

Client #5's record was reviewed and was noted to lack an individual abuse prevention assessment. Client # 1 and #4's record contained an abuse prevention assessment. Employee #8, the staffing coordinator, authenticated that she completed the abuse prevention assessment. According to the Nurse Practice Act (Minnesota Statutes Chapter148), assessments are the responsibility of registered nurses and cannot be delegated. Employee #8 is not a registered nurse.

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 the person's susceptibility to abuse by other individuals, including other vulnerable adults, and a statement of the

specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

There is no assessment for this uncorrected violation.

III) On April 3, 4, 5 and 6, 2006 a subsequent re-inspection of the above provider was made by the survey staff of the Minnesota Department of Health to determine the status of a correction order dated January 18, 2006, issued as a result of an inspection conducted on November 29, 30 and December 1, 2005 and received by you on January 18, 2006.

The following correction order remained uncorrected at the time of the subsequent re-inspection on April 3, 4, 5, and 6, 2006 is as follows:

1. MN Rule 4668.0150 Subp.3 **$350.00**

Based on record review and interview the licensee failed to have prescriber's orders for medications and treatments for three of three (#1, #8, and #9) clients' records reviewed. The findings include:

Client #8's "Home Health Aide Note", for the weeks of November 5-11, 2005; November 12-18, 2005; and November 19-25, 2005 indicated that client #8 received a "bowel program." When interviewed, November 30, 2005, employee J, a personal care attendant for client #8 stated that the "bowel program" consisted of the staff administering a Dulcolax suppository every morning to client #8. Employee J also stated that client #8 had wounds on her coccyx and heel which the personal care attendants provided treatments to consisting of applying Silvadene ointment on gauze to the wounds daily. The record did not contain physician orders for the Dulcolax Suppository or the Silvadene ointment treatment.

Client # 1's record had medication reminders initialed every day on the home health aide note time card signed by employee A, an unlicensed direct care staff, for the weeks ending November 11, and 25, 2005. When interviewed by phone on November 30, 2005, employee A was asked about medications for client #1. Employee A stated he handed the client the pillbox. When asked how the pills got into the pill box employee A stated that he sets up the medications in the pillbox once a week by taking the pills out of the medication bottles and placing them into the pillbox. Client #1's record lacked any prescriber orders for medications.

Client # 9's record had " nebs + filters" marked with an "X" every day on the home health aide note time card signed by employee K, an unlicensed direct care staff, for the week ending November 20, 2005. When interviewed by phone on November 30, 2005 client # 9 confirmed he was receiving oxygen and nebulizer (nebs) treatments. When asked if he received any assistance with the oxygen and nebulizer treatments, client #9 stated that his personal care attendant (PCA), employee K, hooked up the oxygen and also helps him with a small tank of oxygen he had to have when he went out. Client # 9 also stated that the PCA got the nebulizer machine, opened packages of medication, placed the medication into the

nebulizer and assisted him in the administration of the treatment. Client # 9's record lacked prescriber orders for the nebulizer treatment, medications and oxygen.

TO COMPLY: All orders for medications and treatments must be dated and signed by the prescriber, except as provided by subpart 5.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), and MN Rule 4668.0230, you are assessed in the amount of: $350.00

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4), MN Rule 4668.0230 and Minnesota Rule 4668.0240, the total amount you are assessed is: **$6350.00**. **This amount is to be paid by check made payable to the Commissioner of Finance, Treasury Division MN Department of Health,** and sent to the Licensing and Certification Section of the MN Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 within 15 days of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Division of Compliance Monitoring, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0240, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0230, the correction orders have not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine.

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 will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

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.

If you have any questions, please feel free to give me a call at 651-201-4307.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: James C. Snyder, SR, Attorney at Law
Kelly Crawford, Minnesota Department of Human Services
Ramsey, County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Minnesota Department Of Health
Division of Compliance Monitoring
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: LOVING CARE HOME CARE SERVCS

DATE OF SURVEY: April 3, 4, 5, and 6, 2006

BEDS LICENSED:

HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

CENSUS:
HOSP: _____ NH: _____ BCH: _____ SLF: _____

BEDS CERTIFIED:
SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: Class A _____

NAMES AND TITLES OF PERSONS INTERVIEWED: Rufus Adewola, Administrator; Christina Hibbler, Staffing Coordinator/Personal Care Attendant; Marjenia Williams, Registered Nurse

SUBJECT: Licensing Survey _____ Licensing Order Follow Up #2

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on May 25, 26, 27 and June 1, 3, 6, and 8, 2005 and the follow-up visit on November 29, 30 and December 1, 2005. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the following correction order issued on June 3, 2005 as a result of the May 25, 26, 27 and June 1, 3, 6, and 8, 2005 visit that was received by the facility on June 3, 2005
and found not corrected during the November 29, 30 and December 1, 2005 follow-up visit is as follows:

[Un-numbered] MN Statute §144A.44 Subd.1(2) Not Corrected $500.00

Based on record review and interview the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for two of nine current client (#1 and #13) records reviewed. The findings include:

Client #1's Service Agreement was signed by the mother of the client and the licensee

but was not dated. The Service Agreement indicated that client #1 was to receive "PCA" services seven hours per day, seven days per week. The service agreement did not state what services the PCA was provide. The "HOME HEALTH AIDE NOTE" ending the week of March 24, and 31, 2006, signed by client #1and employee T, indicated that employee T provided medication reminders, foot soaks, toenail and nail care, a bath and range of motion from two to seven times a week to client #1. When interviewed on April 4, 2006, the registered nurse stated that the PCA was providing verbal medication reminders for client #1 and that she was unaware that client #1 was receiving range of motion exercises or foot soaks. When interviewed by phone on April 12, 2006, client #1 stated that employee T did range of motion to his knees for one-half hour twice daily; ordered his medications; helped him with his medications daily by bringing the medication bottles over to him, taking the medications out of the bottles, and giving to him with a glass of water to take his medications; and soaked his feet a couple times per week. Client #1s'record did not contain an up-to-date plan for the services provided to client #1 by employee T.

The status of the correction orders issued as a result of the May 25, 26, 27 and June 1, 3, 6, and 8, 2005 visit that were received by the facility on October 27, 2005 and found not corrected during the November 29, 30 and December 1, 2005 follow-up visit are as follows:

2. MN Rule 4668.0040 Subp. 1 **Corrected**

3. MN Rule 4668.0040 Subp. 2 **Not Corrected** **$100.00**

Based on record review and interview, the licensee failed to provide a written complaint procedure for eleven of eleven clients (#1, #8, #9, #11, #12, #13, #14, #15, #16, #17, and #18) whose records were reviewed. The findings include:

The Policy and Procedure Manual contained a policy/procedure form titled, "Investigation of Complaints." The form had been revised and when interviewed on April 4, 2006, the administrator confirmed that the complaint policy/procedure had been changed and stated that none of his clients had received the new complaint policy/procedure. This included client #1, #8, #9, #11, #12, #13, #14, #15, #16, #17, and #18, whose records were reviewed.

5. MN Rule 4668.0065 Subp. 3 **Not Corrected** **$600.00**

Based on record review and interview, the licensee failed to assure the completion of annual infection control in-service training for five of five employees (A, H, J, K, and M) who were employed by the licensee for more than one year. The findings include:

Employees A, H, K, and M were hired on January 8, 2004, February 2000, April 8, 2003, and March 31, 2005 respectively, as Home Health Aides/Personal Care Attendants. The records for employees A, H, K, and M indicated that they had received in-service training for infection control on December 9, 2005. The content of the in-service lacked training for the use of gowns and masks, disposal of contaminated materials and equipment, and the disinfecting of reusable equipment.

Employee J, a Home Health Aide/Personal Care Attendant, who was hired and provided client care since April 2, 2005, lacked any evidence of receiving infection control in-service training. When interviewed on April 6, 2006 the administrator stated that the reason employee J did not have infection control in-service training was that employee J worked in another health care facility and had received the training there. He confirmed there was no evidence of infection control in-service training for employee J.

6. MN Rule 4668.0075 Subp. 1 Not Corrected $600.00

Based on record review and interview, the licensee failed to assure that two of eleven employees (L and P) received the required orientation to home care. The findings include:

Employees L and P were hired October 1, 2005 and March 11, 2006 respectively as Home Health Aides/Personal Care Attendants. Employee L's record did not contain evidence to indicate that employee L had received the required orientation to home care. Employee P's record contained a copy of "A Guide to Home Care Services," a Minnesota Department of Health publication. The last page of this document contained the following, "I have participated in the Guide to Home Care Services, and understand it." There was an area for the employee and the agency's registered nurse to sign to indicate that the employee had completed this training. The signature area was blank for both employee P and the agency's registered nurse (RN). When interviewed on April 4, 2006, the RN confirmed there was no evidence of orientation to home care for employees L and P.

7. MN Rule 4668.0100 Subp. 5 Not Corrected $600.00

Based on record review and interview, the licensee failed to assure that seven of nine employees (H, K, M, O, P, Q and R) who performed home health aide tasks were qualified to perform home health aide tasks. The findings include:

Records for employees H, K, M, O, P, Q, and R indicate that they began performing home health aide tasks for clients as Home Health Aides/Personal Care Attendants on February 2000; April 8, 2003; March 31, 2005; February 1, 2006; March 11, 2006; February 15, 2006; and March 27, 2006, respectively. The records lacked evidence that these employees had successfully completed training and passed the competency evaluations in order to perform home health aide tasks. When interviewed on April 4, 2006, the administrator confirmed that training and competencies had not been done for employees H, K, M, O, P, Q, and R.

8. MN Rule 4668.0100 Subp. 6 Not Corrected $600.00

Based on record review and interview, the licensee failed to assure employees received eight hours of in-service training annually in topics relevant to the provision of home care services for five of five employees (A, H, J, K, and M) reviewed who were employed for more than one year. The findings include:

Employee A began employment as a Home Health Aide/Personal Care Attendant on January 8, 2004. Since employment, employee A has received a total of only four hours

of in-service training in the areas of infection control on December 9, 2005, Vulnerable Adults on December 16, 2006, Customer Services on January 13, 2006, and Renal Failure on January 27, 2006.

Employee H began employment as a Home Health Aide/Personal Care Attendant on February 2000. Since employment employee H has received a total of three hours of in-service training in the areas of Infection Control on December 9, 2005; Customer Services on January 13, 2006; and Vulnerable Adult on December 16, 2005. Employee J began employment as a Home Health Aide/Personal Care Attendant on April 2, 2005. Since employment, employee J received only one hour of in-service for Customer Service on January 13, 2006.

Employee K began employment as a Home Health Aide/Personal Care Attendant on April 8, 2003. Since employment, employee K has received a total of five hours of in-services training in the areas of Vulnerable Adults on December 16, 2005; Infection Control on December 9, 2005; Medication Reminders on February 24, 2006; Time Sheets on February 17, 2006; and Customer Services on January 13, 2006.

Employee M began employment as a Home Health Aide/Personal Care Attendant on March 31, 2005. Since employment, employee M received a total of two hours of in-services training in the areas of Infection Control on December 10, 2005 and Customer Services on January 13, 2006.

When interviewed on April 4, 2006, the administrator and registered nurse confirmed that employees A, H, J, K, and M had not received the required eight hours of annual in-service training.

9. MN Rule 4668.0100 Subp. 8 Not Corrected $700.00

Based on record review and interview, the licensee failed to assure that six of ten employees (H, M, O, P, R and T), who provided home health aide services to clients, received orientation to each client's cares from a registered nurse (RN). The findings include:

Interview with employee H on April 4, 2006 and a review of employee H's time sheets for April 2006 indicated that employee H provided Home Health Aide/Personal Care Attendant services to client #8 on April 1 and 2, 2006 which included a "bowel program." Employee H also stated that she did dressing changes on client #8 that were not documented on the time sheet. When asked if she had been oriented by the registered nurse to the tasks to be preformed for client #8, employee H stated that another Home Health Aide/Personal Care Attendant had trained and oriented her. When interviewed on April 4, 2006 the registered nurse confirmed she had not oriented employee H to client #8's cares.

Employee M began providing direct care as a Home Health Aide/Personal Care Attendant on March 31, 2005. Employee M's time sheets for March 2006, which documented all the cares provided for client #8, indicated employee M provided cares from March 4 to March 8, 2006 and March 27 to March 31, 2006. The time sheets indicated that employee M provided a "bowel program" for client #8. Upon phone interview on April 5, 2006, employee M stated that she provided administration of a

rectal suppository for client #8 and did dressing changes on three wound sites, one on the coccyx, and two on the lower extremities. She also stated she had received her orientation and training for the "bowel program" and dressing changes from another Home Health Aide/Personal Care Attendant who also provided these same cares to client #8. Employee M stated that the registered nurse had never personally observed employee M do the rectal suppository or the wound dressing changes for client #8 nor had the registered nurse orientated employee M to the "bowel program" and wound dressings. When interviewed on April 4, 2006, the registered nurse confirmed that employee M had not been oriented or trained by a registered nurse to administer suppositories or to do the wound dressing changes for client #8.

Employee O began providing direct care as a Home Health Aide/Personal Care Attendant on February 1, 2006. Employee O's time sheets for February and March 2006 indicated that employee O assisted client #15 with TED stocking application. The record for employee O lacked evidence that employee O had been oriented or trained by the registered nurse for the home health aide tasks for client #15 which included the application of TED stockings. When interviewed on April 4, 2006, the registered nurse confirmed employee O had not been oriented or trained for the care tasks for client #15.

Employee P began providing direct care as a Home Health Aide/Personal Care Attendant on March 11, 2006. Employee P's time sheets for March 2006 indicated that employee P provided care to client # 12, #13, and #14. The March 2006 time sheets indicated that employee P provided medication reminders for client # 12, #13, and #14 and the time sheets dated from March 25 to March 31, 2006 for client #13 indicated that employee P also "cleaned medical equipment" (oxygen). The record for employee P lacked evidence that employee P had been oriented or trained by the registered nurse for the home health aide tasks which included medication reminders for clients' #12, #13, and #14 and oxygen equipment care for client #13. When interviewed, April 4, 2006, the registered nurse confirmed that employee P had not been oriented or trained in medication reminders or oxygen care for clients #12, #13, or #14.

Employee R's time sheet for the week ending March 24, 2006 and March 31, 2006 indicated that employee R provided care to client #16 which included removal of TED hose and "Catheter bag care" every evening. Employee R's record lacked evidence that employee R had received orientation or training by the registered nurse for the home health aide tasks which included removal of TED hose and catheter bag care. When interviewed on April 4, 2006, the registered nurse confirmed that employee R had not been oriented or trained on the home health aide tasks for client #16.

Employee T began providing Home Health Aide/Personal Care Attendant services on June 29, 2005. Employee T's time sheets for the week ending March 24 and 31, 2006, indicated that employee T provided medication reminders, foot soaks, and range of motion for client #1. When interviewed by phone on April 12, 2006, client #1 stated that employee T did range of motion to both of his knees twice a day for one-half hour each time, reminded him to take his medications by taking the medication out of the bottle and handing the medication to him with a glass of water, and provided foot soaks a "couple times a week." When interviewed by phone on April 12, 2006, employee T stated that he had received his training for range of motion and medication reminders from a previous agency and that the agency's registered nurse had not orientated him to the medication reminders, foot soaks, or range of motion exercises for client #1. When interviewed on

April 4, 2006, the registered nurse confirmed that employee T had not been oriented or trained to the home health tasks for client #1 and stated that employee T was providing only verbal medication reminders for client #1 and that she was unaware that employee T was providing medication administration, range of motion exercises or foot soaks for client #1.

10. MN Rule 4668.0100 Subp. 9 Not Corrected $700.00

Based on record review and interview, the licensee failed to have a registered nurse (RN) conduct supervisory visits for staff who were providing home health aide tasks for five of eleven client's (#1, #9, #15, #16, and #17) reviewed. The findings include:

Employee T's time sheets for client #1 for the weeks ending March 17, 24 and 31, 2006 indicated that employee T was providing range of motion; medication reminders; and foot soaks for client #1. When interviewed by phone on April 12, 2006, client #1 stated that employee T did range of motion to both of his knees twice a day for one-half hour each time and gave him his medications by taking the medication out of the bottle and handing the medication to him with a glass of water. Client #1's record contained registered nurse supervisory visits dated October 25, 2005; November 15, 2005 (21 days later); and January 18, 2006 (63 days later). When interviewed on April 4, 2006, the registered nurse stated these were the only visits she had made to client #1's home and that she had called client #1 in March of 2006 to set up a visit date and was unable to reach client #1. She also stated she was unaware she needed to do supervisory visits every 14 days for client #1.

Employee K's time sheets for client #9 for the months of February, and March 2006 indicated that employee K was providing catheter cares, exercise to legs, "Nebs and filters" and medication reminders. When interviewed by phone on April 6, 2006, client #9 stated that employee K puts the medication into the Nebulizer, sets up the machine, and assists him in the administration of the nebulizer treatment, catheterized him every day, filled the small oxygen tank from the larger liquid oxygen tank, and provided medication reminders. Client #9's record contained registered nurse supervisory visits dated October 4, 2005; November 4, 2005 (30 days later): December 31, 2005 (57 days later); January 14, 2006 (20 days later); January 31, 2006 (17 days later); February 14, 2006 (14 days later); and March 23, 2006 (37 days later). When interviewed, April 4, 2006, the registered nurse stated she was aware that she had missed some of client #9's supervisory visits.

Client # 15 started receiving services on February 9, 2006. Services received by client #15 included TED stocking application daily. There was no evidence of supervisory visits for client #15. When interviewed, April 5, 2006, the registered nurse stated she was unaware that supervisory visits needed to be done for client #15.

Client # 16 started receiving services on January 6 2006. Care to client #16 included application and removal of TED hose daily and "Catheter bag care" every evening. Client # 16's record only contained one supervisory visit by the registered nurse that was dated March 28, 2006 (81 days after the start of services). When interviewed, April 4, 2006, the registered nurse stated she was unaware that fourteen-day supervisory visits needed to be done.

Client #17 started receiving services on December 12, 2005. Employee U's time sheets for client #17 indicated that employee U provided medication reminders and assistance with eating, dressing, bathing and brushing teeth. The care plan for client #17, dated January 24, 2006, indicated that client #17 was to be encouraged to drink a nutritional supplement and to be weighed every two weeks. The record lacked documentation of a supervisory visit by the registered nurse until January 24, 2006 (42 days later). When interviewed by phone on April 3, 2006, the registered nurse confirmed she had not made any supervisory visits between her initial visit on November 26, 2005 (prior to client #17 receiving services) and her visit on January 24, 2006.

11. MN Rule 4668.0140 Subp.2 Not corrected $100.00

Based on record review and interview, the licensee failed to have complete service agreements for nine of eleven client (#1, #9, #11, #12, #13, #14, #15, #16 and #17) records reviewed. The findings include:

Client #1's service agreement was signed by the mother of the client and the licensee but not dated. The service agreement indicated that client #1 was to receive personal care attendant (PCA) services seven hours per day, seven days per week for a fee of $14.90. The service agreement did not indicate if the $14.90 was an hourly fee, daily fee or weekly fee, did not indicate the services the PCA was to provide or the schedule for supervisory visits by the registered nurse. The contingency plan did not contain a method for a client or responsible person to contact a representative of the licensee whenever staff was providing services, or who to contact in case of an emergency or significant adverse change in the client's condition.

Client #9's service agreement signed and dated April 9, 2003, indicated that a registered nurse (RN) was to provide three hours of services per week for a fee of $23.80, the home health aide/personal care attendant (HHA/PCA) was to provide 5.25 hours per day, seven days per week for $14.92 and the registered nurse was to provide a supervisory visits one time per month for a fee of $26.24. The service agreement did not indicate if the RN fee of $23.80 and the HHA/PCA fee of $14.92 was an hourly fee, daily fee or weekly fee. The service agreement did not indicate the services the HHA/PCA or the registered nurse was to provide for the client other than supervisory visits. The contingency plan did not contain a method for a client or responsible person to contact a representative of the licensee whenever staff was providing services.

Client #11's service agreement signed and dated December 6, 2005, indicated that the home health aide/personal care attendant (HHA/PCA) was to provide services ten hours a week for $14.92 and supervisory visits were to be done "bi monthly" by the registered nurse (RN) for $26.84. The service agreement did not indicate if the RN fee of $26.84 and the HHA/PCA fee of $14.92 were an hourly fee, a daily fee, a weekly fee or a bi-monthly fee. The service agreement did not indicate the services the HHA/PCA was to provide. The contingency plan attached to the service agreement did not contain a method for client #11 or a responsible person to contact a representative of the licensee whenever staff were providing services, who to contact in case of an emergency or significant change in client #11's condition, a the method for the licensee to contact a responsible person for client #11, or the circumstances in which emergency medical services were not to be summoned.

Client # 12's service agreement signed and dated February 20, 2003, indicated that the home health aide/personal care attendant (HHA/PCA) was to provide services six hours a day seven days a week for $14.92. The service agreement did not indicate if the HHA/PCA fee of $14.92 was an hourly fee, a daily fee, or a weekly fee. The service agreement did not indicate the services the HHA/PCA was to provide, or the schedule for supervisory services. The contingency plan attached to the service agreement did not contain a method for client #12 or a responsible person to contact a representative of the licensee whenever staff were providing services, who to contact in case of an emergency or significant adverse change in client #12's condition, the method for the licensee to contact a responsible person of the client, or the circumstances in which emergency medical services were not to be summoned.

Client # 13's service agreement signed and dated February 3, 2003, indicated that the HHA/PCA was to provide four hours of services per day seven days per week with a fee of $14.92. The service agreement did not indicate the services the HHA/PCA was to provide, the schedule for supervisory services or if the HHA/PCA fee of $14.92 was an hourly fee, a daily fee, or a weekly fee. The contingency plan attached to the service agreement did not contain a method for the client or responsible person to contact a representative of the licensee whenever staff were providing services, who to contact in case of an emergency or significant adverse change in client #13's condition, a the method for the licensee to contact a responsible person of the client, or the circumstances in which emergency medical services were not to be summoned.

Client #14's service agreement signed and dated February 20, 2003, indicated the PCA was to provide services seven days a week, "32 units " at $14.92 and supervisory visits by the registered nurse were to be done monthly. The service agreement did not indicate the fees for the supervisory visit by the RN, the services the PCA was to provide or if the PCA fee of $14.92 was a "unit" fee or a weekly fee. The contingency plan attached to the service agreement did not contain a method for a client or responsible person to contact a representative of the licensee whenever staff were providing services, who to contact in case of an emergency or significant adverse change in client #14's condition, the method for the licensee to contact a responsible person of the client, or the circumstances in which emergency medical services were not to be summoned.

Client #15's service agreement signed and dated February 9, 2006, indicated the HHA/PCA was to provide services 12 hours a day and supervisory visits by the registered nurse were to be provided every other month. The service agreement did not indicate the services the HHA/PCA was to provide. The contingency plan attached to the service agreement did not contain a method for a client or responsible person to contact a representative of the licensee whenever staff were providing services, who to contact in case of an emergency or significant adverse change in client #15's condition, the method for the licensee to contact a responsible person of the client, or the circumstances in which emergency medical services were not to be summoned.

Client # 16's service agreement signed and dated January 7, 2006, indicated the HHA/PCA was to provide cares seven days a week. The service agreement did not indicate the services the HHA/PCA was to provide. The contingency plan attached to the service agreement did not contain a method for a client or responsible person to contact a representative of the licensee whenever staff were providing services; who to contact in care of an emergency or significant adverse change in client #16's condition; the method

for the licensee to contact a responsible person of the client; or the circumstances in which emergency medical services were not to be summoned.

Client #17's service agreement, dated and signed January 24, 2006, indicated client #17 was to receive HHA/PCA services as "authorized" and to have supervisory visits by the registered nurse (RN) every other month. The Service Agreement lacked what services the HHA/PCA was to provide for the client, the frequency and the fees for the HHA/PCA services and the fees for the RN supervisory visits. The contingency plan lacked the method for the client or responsible person to contact a representative of the licensee whenever staff was providing services and who to contact in case of an emergency or significant adverse change in client #17's condition.

When interviewed April 4, 2006 the administrator confirmed the service agreements for client's #1, #9, #11, #12, #13, #14, #15, #16 and #17 were incomplete.

12. MN Rule 4668.0160 Subp. 5 Not Corrected $100.00

Based on record review and interview, the licensee failed to assure that all entries were authenticated and dated for seven of eleven client (#1, #9, #12, #13, #14, #15 and #17) records reviewed. The findings include:

Client #1's record contained forms titled "Loving Care Safety Checklist", "Intake Assessment", "Client Consent Form", and a "Service Agreement" that did not contain dates of completion for the forms.

Client #9's record contained forms titled "Loving Care Home Care Services, Inc. Assessment/Care Plan" and an "Intake Assessment" completed on April 9, 2003 that was not signed by the person who completed both documents.

Client # 12's record contained forms titled "Loving Care Home Care service, Inc. Assessment/Care Plan" and an "Authorization for Release of Medical information." The person completing these documents did not date them.

Client # 13's record contained forms titled "Loving Care Home Care Service, Inc. Assessment/Care Plan" and the "Loving Care Home Care Service, Inc.- intake report." The person completing these documents did not date or sign them.

Client # 14's record contained forms titled "Authorization for Release of Medical information" and "Loving Care Home Care service, Inc. Assessment/Care Plan." The person completing these documents did not date them.

Client # 15's record contained a form titled "Loving Care Home Care Services, Inc. Intake Assessment" form that was not signed or dated by the person completing the document.

Client #17's record contained forms titled "Safety Checklist" and "Loving Care Home Care Services, Inc. Intake Assessment" that were not signed by the person completing the documents

When interviewed on April 4, 2005, the administrator confirmed the forms described

above in client #1, #9, #12, #13, #14, #15 and #17 records lacked authentication and/or dates.

13. MN Rule 4668.0160 Subp. 6 Not Corrected $200.00

Based on record review and interview, the licensee failed to assure that client records were complete for three of eleven client (#1, #8, and #9) records reviewed. The findings include:

Employee T's time sheets for client #1 for the weeks ending March 17, 24 and 31, 2006 indicated that employee T was providing range of motion; medication reminders; and foot soaks daily for client #1. When interviewed on April 4, 2006, the registered nurse (RN) stated that the employee T provided verbal medication reminders for client #1 and she was unaware that employee T provided range of motion or foot soaks to client #1. When interviewed on April 12, 2006, client #1 stated that employee T did range of motion to his knees for one-half hour twice a day; ordered his medications; reminded him to take his medications by bringing the medication bottle to him, taking the medications out of the bottle and giving the medications to him with a glass of water; and soaked his feet a couple times per week. The record did not contain physician orders for the medications, range of motion, or foot soaks.

Client # 8 had prescriber's orders dated March 9, 2006 for daily dressing changes to the coccyx and leg. Clients #8's record lacked documentation that the daily dressing changes had been done as ordered. When interviewed on April 5, 2005 employee H stated that she had changed client # 8's dressing on April 1 and 2, 2006 and did not document the dressing changes in client # 8's record. When interviewed, April 5, 2006, the registered nurse confirmed that the dressing changes had not been documented.

Employee K's time sheets for client #9 for the months of February and March 2006 indicated that employee K was providing catheter cares, exercise to legs, "Nebs and filters," and medication reminders. Client # 9's record lacked prescriber orders for the nebulizer treatment, medications, oxygen and catheterizations. When interviewed by phone on April 6, 2006, client #9 stated that employee K opened packages of medication, put the medication into the Nebulizer, set up the nebulizer machine, and assisted him in the administration of the nebulizer treatment, catheterized him every day, hooked up the oxygen and also filled the small oxygen tank from the larger liquid oxygen tank, and provided medication reminders. When interviewed on April 4, 2006, the RN stated she had requested orders from the physician by fax on December 16, 2005 which stated "please mail /fax to us the most current medication/treatment orders, for the above named client who is receiving personal care from our agency. Public nurse approved 5.25 hrs of personal care assistance (PCA) per day. To assist with cleaning, laundry, errands, medical reminders, and other ADLS. Certification: 90 days." The orders were faxed back to the agency December 20, 2005, and stamped as received in the agency December 26, 2005. The fax was signed by the physician but without any orders for the catheter cares, exercises to legs, nebulizer treatments and medications.

14. MN Rule 4668.0180 Subp. 9 Not Corrected $200.00

Based on record review and interview the licensee failed to establish and implement a

quality assurance plan. The findings include:

When asked for the written quality assurance plan during the survey, the administrator stated on April 4, 2006 that the registered nurse had done "some monitoring." When interviewed on April 4, 2006, the registered nurse stated she did not have any documented data, analysis of the data, or the action taken as a result of the "monitoring." Neither the administrator nor the RN was able to indicate the topic of the quality assurance plan.

15. MN Statute §144A.44 Subd. 1(13) Not Corrected $1000.00

Based on record review and interviews, the agency failed to assure that properly trained staff served seven of eleven clients (#1, #8, #12, # 13, #14, #15 and #16) whose records were reviewed. The findings include:

The training and personnel records of employees H, J, K M, O, P, Q, and R with hire dates of February, 2000, April 2, 2005, April 8, 2003, March 31, 2005, February 1, 2006, March 11, 2006, February 15, 2006, and March 27, 2006, respectively, lacked evidence that these employees had been trained and passed competency evaluations to perform home health aide tasks.

Employee T began providing direct care as a Home Health Aide/Personal Care Provider (HHA/PCA) on June 29, 2005. Employee T's HHA time sheets, for the week ending March 24 and 31, 2006, indicated employee T provided medication reminders, foot soaks, and range of motion for client #1. During a phone interview on April 12, 2006, client #1 stated that employee T did range of motion to both of his knees twice a day for one-half hour each time, reminded him to take his medications by taking the medication out of the bottle and handing the medication to him with a glass of water, and provided foot soaks a "couple times a week." When interviewed by phone on April 12, 2006, employee T stated that he had received his training for range of motion and medication reminders from a previous agency and that the registered nurse had not orientated him to the medication reminders, foot soaks, or range of motion exercises for client #1. Employee T stated that stated that he had told Loving Care that he did not need any training as he had provided these same cares to another client at the previous agency he worked for. When interviewed on April 4, 2006, the registered nurse confirmed that employee T had not been oriented or trained to the home health tasks for client #1 and stated that employee T was providing only verbal medication reminders for client #1 and that she was unaware that employee T was providing medication administration, range of motion exercises or foot soaks for client #1.

Employees H and M began providing direct care as a HHA/PCA in February of 2000 and March 31, 2005 respectively. Employee H's home health aide time sheets for April 2006 indicated that employee H provided care to client # 8 on April 1 and 2, 2006. Employee M's home health aide time sheets for March 2006 for client #8 indicated employee M provided cares from March 4 to March 8, 2006 and from March 27 to March 31, 2006. The time sheets indicated employee H provided a "bowel program" for client #8. When interviewed on April 4, 2006 employee H stated she provided care for client #8 which included wound dressing changes that was not documented on the time sheet. When employee H was asked if she had been trained by the registered nurse in how to care for client #8, employee H stated that another HHA/PCA had trained her. When interviewed

by phone on April 5, 2006, employee M stated that she provided administration of a rectal suppository for client #8 and did dressing changes of client #8's three wound sites. She also stated she had received her training for the "bowel program" and dressing changes from another HHA/PCA who had also provided these cares to client #8. Employee M stated that the registered nurse had never observed her while she was performing client #8's bowel program or wound cares. When interviewed on April 4, 2006 the registered nurse confirmed she had not trained employees H or M.

Employee P began providing direct care as a HHA/PCA on March 11, 2006. Employee P's home health aide time sheets for March 2006 indicated that employee P provided medication reminders for clients # 12, #13, and #14. Client # 13's care plan dated January 24, 2006 indicated the client is at risk for hyper/hypoglycemia related to being insulin dependent. The treatment and plan of action was to encourage client # 13 to take insulin as ordered, stay on diabetic diet, maintain an exercise program, to do at home blood glucose checks as needed and as ordered, and to observe for signs and symptoms of hyper/hypoglycemia. The time sheets dated March 25 through 31, 2006 for client #13 indicated employee P "cleaned medical equipment" (oxygen) and prepared meals. The record for employee P lacked evidence that employee P had been trained by the registered nurse for the care tasks which included medication reminders for clients' #12, #13, and #14 and oxygen equipment care, or what to observe for signs and symptoms of hyper/hypoglycemia for client #13. When interviewed, April 4, 2006, the registered nurse confirmed employee P had not been trained in medication reminders, or oxygen care, or what to observe for signs and symptoms of hyper/hypoglycemia.

Employee O began providing direct care as a HHA/PCA on February 1, 2006. Employee O's home health aide time sheets for February and March 2006 indicated that employee O assisted client #15 with TED stocking application. The record for employee O lacked evidence that employee O had been oriented or trained by the registered nurse for the home health aide care tasks for client #15 which included the application of TED stockings. When interviewed on April 4, 2006, the registered nurse confirmed employee O had not been trained in the home care aide tasks including the application of TED stockings.

Employee R began providing direct care as a HHA/PCA on March 27, 2006. Employee R's home health aide time sheet for the week ending March 24, 2006 and March 31, 2006 indicated that employee R provided care to client #16 which included removal of TED hose and "Catheter bag care" every evening. Employee R's record lacked evidence employee R had received training by the registered nurse for the home health aide care tasks which included removal of TED hose and catheter bag care. When interviewed, April 4, 2006, the registered nurse confirmed employee R had not been trained on these items.

16. MN Statute §144A.46 Subd. 5(b) **Corrected**

17. MN Statute §626.557 Subd. 14(b) **Not corrected** **No Assmt.**

Based on record review and interview the licensee failed to develop individual abuse prevention for four of eleven (#11, #13, #15 and #16) clients reviewed. The findings include:

Client # 11's Assessment For Client Vulnerability and Safety dated December 20, 2005 indicated client # 11 was vulnerable in the following areas: ability to walk without assistive device, range of motion, endurance and strength, and pain. The assessment lacked a plan to address client #11's vulnerabilities.

Client #13's Assessment For Client Vulnerability and Safety dated March 7, 2003 indicated client # 13 was vulnerable in the following areas: following directions, range of motion, endurance and strength, pain, freedom from communicable disease and adhering to safety precautions. The assessment lacked a plan to address client # 13's vulnerabilities.

Client # 15's Assessment For Client Vulnerability and Safety dated February 9, 2006 indicated client # 15 was vulnerable in the following areas: range of motion, endurance and strength, pain, and sensation. The assessment lacked a plan to address client # 15's vulnerabilities.

Client # 16's Assessment For client vulnerability and Safety dated January 7, 2006 indicated client # 16 was vulnerable in the following areas: walking, range of motion, endurance and strength, and pain. The assessment lacked a plan to address client # 16's vulnerabilities.

When interviewed, April 4, 2006, the registered nurse confirmed the assessments lacked a plan to address client #11, #13, #15 and #16's vulnerabilities.

The status of the new correction orders issued as a result of the November 29, 30 and December 1, 2005 follow-up visit that were received by the facility on January 18, 2006 and found not corrected during the April 3, 4, 5, and 6, 2006 follow-up survey are as follows:

1. MN Rule 4668.0150 Subp. 3 Not corrected $350.00

Based on record review and interview the licensee failed to have prescriber's orders for medications and treatments for two of eleven (#1and #9) clients whose records were reviewed. The findings include:

Employee T's time sheets for client #1 for the weeks ending March 17, 24 and 31, 2006 indicated that employee T was providing range of motion; medication reminders; and foot soaks daily for client #1. When interviewed April 4, 2006, the registered nurse (RN) stated that employee T provided verbal medication reminders for client #1 and she was unaware that the employee T provided range of motion or foot soaks to client #1. When interviewed on April 12, 2006, client #1 stated that employee T did range of motion to his knees for one-half hour twice a day; ordered his medications; reminded him to take his medications by bringing the bottle over to him and taking the medications out of the bottle and giving to him with a glass of water; and soaked his feet a couple times per week. The record did not contain physician orders for the medications, range of motion, or foot soaks.

Employee K's time sheets for client #9 for the months of February, and March 2006 indicated employee K was providing catheter cares, exercise to legs, "Nebs and filters," and medication reminders. Client # 9's record lacked prescriber orders for the nebulizer

treatment, medications, oxygen and catheterization. When interviewed by phone on April 6, 2006, client #9 stated that employee K opened the package of medication, put the medication into the Nebulizer, set up the machine, and assisted him in the administration of the nebulizer treatment, catheterized him every day, hooked up the oxygen and also filled the small oxygen tank from the larger liquid oxygen tank, and provided medication reminders. When interviewed on April 4, 2006, the RN stated she had requested orders from the physician by facsimile on December 16, 2005. The facsimile stated, "please mail /fax to us the most current medication/treatment orders, for the above named client who is receiving personal care from our agency. Public nurse approved 5.25 hrs of personal care assistance (PCA) per day. To assist with cleaning, laundry, errands, medical reminders, and other ADLS. Certification: 90 days." The facsimile was sent back to the agency on December 20, 2005 and stamped by the agency as received on December 26, 2005. The facsimile was signed by the physician but did not contain any orders.

2) Although a State licensing survey was not due at this time, correction orders were issued.

Class A Licensed-Only Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class A Licensed-Only Home Care Providers. Class A licensees may also use this form to monitor the quality of services provided to clients at any time. Licensees may use their completed Licensing Survey Form to help communicate with MDH nurses during an on-site regulatory visit.

During on-site visit/s, MDH nurses will interview staff, talk with clients and/or their representatives and make observations during home visits, and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class A Licensed-Only Home Care services. Completing this Licensing Survey Form in advance would facilitate the survey process.

Licensing requirements listed below are reviewed during a survey. A determination is made whether the requirements are met or not met for each Indicator of Compliance. This form must be used in conjunction with a copy of the Class A Licensed-Only Home Care regulations. Any violations of the Class A licensing requirements are noted at the end of the survey form. **[This form is NOT intended to be used for Class A Licensees who are also certified to participate in the Medicare program].**

Name of Class A Licensee: Loving Care Home Care Services

HFID # (MDH internal use): 21083

Date(s) of Survey: April 3, 4, 5, and 6, 2006

Project # (MDH internal use): QL21083006

Indicators of Compliance	Outcomes Observed	Comments
1. The Provider accepts and retains clients for whom it can meet the needs. • MN Rules 4668.0050 • MN Rule 4668.0060 Subpart 3 • MN Rule 4668.0060 Subpart 4 • MN Rule 4668.0060 Subpart 5 • MN Rule 4668.0140 • MN Rule 4668.0180 Subpart 8	• Clients are accepted based on the availability of staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement. • Service plans accurately describe the needs and services and contains all the required information. • Services agreed to are provided • Clients are provided referral assistance.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey # 2 ____ Met ____ Not Met __X__ New Correction Order(s) issued __X__ Education Provided
2. The Provider promotes client rights. • MN Statute §144A.44 • MN Rule 4668.0030 • MN Rule 4668.0040	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
Indicator of Compliance #2 continued: • MN Rule 4668.0170		Follow-up Survey # 2 ____ Met ____ Not Met _X_ New Correction Order(s) issued _X_ Education Provided
3. The Provider promotes and protects each client's safety, property, and well-being. • MN Rule 4668.0035 • MN Statutes §144A.46 Subdivision 5 • MN Statute §626.556 • MN Statutes §626.557 • MN Statute §626.5572	• Client's person, finances and property are safe and secure. • All criminal background checks are performed as required. • Clients are free from maltreatment. • There is a system for reporting and investigating any incidents of maltreatment. • Maltreatment assessments and prevention plans are accurate and current.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
4. The Provider maintains and protects client records. • MN Rule 4668.0160 [Note to MDH staff: See Informational Bulletin 99-11 for Class A variance for Electronically Transmitted Orders]	• **Client records are maintained and retained securely.** • **Client records contain all required documentation.** • Client information is released only to appropriate parties. • Discharge summaries are available upon request.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
5. The Provider employs and/or contracts with qualified and trained staff. • MN Rule 4668.0060 subpart 1 • MN Rule 4668.0065 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0100 [For subpart 2 see indicator #6] Indicator of Compliance #5 continued: • MN Rule 4668.0120	• Staff, employed or contracted, have received all the required training. • Staff, employed or contracted, meet the Tuberculosis and all other infection control guidelines. • Personnel records are maintained and retained. • Licensee and all staff have received the required Orientation to Home Care. • Staff, employed or contracted, are registered and licensed as required by law. • Documentation of medication administration procedures are available. • Supervision is provided as	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey # 2 ____ Met ____ Not Met _X_ New Correction Order(s) issued _X_ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
• MN Rule 4668.0130 • MN Statute 144A.45 Subdivision 5 • MN Statute 144A.461 [Note to MDH staff: See Informational Bulletin 99-7 for Class A variance in a Housing With Services setting]	required.	
6. The Provider obtains and keeps current all medication and treatment orders [if applicable]. • MN Rule 4668.0150 • MN Rule 4668.0100 [Subpart 2] [Note to MDH staff: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With Services setting with regards to medication administration, storage and disposition.]	• Medications and treatments administered are ordered by a prescriber. • Medications are properly labeled. • Medications and treatments are administered as prescribed. • Medications and treatments administered are documented. • Medications and treatments are renewed at least every three months.	Annual Licensing Survey ____ Not Applicable ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Not Applicable ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
7. The Provider is licensed and provides services in accordance with the license. • MN Rule 4668.0008 subpart 3 • MN Rule 4668.0012 subpart 8 • MN Rule 4668.0012 Subpart 17 • MN Rule 4668.0019 • MN Rule 4668.0060 subpart 2 • MN Rule 4668.0060 subpart 6 • MN Rule 4668.0180 subpart 2 • MN Rule 4668.0180 subpart 3 Indicator of Compliance #7 continued: • MN Rule 4668.0180 subpart 4	• Language requiring compliance with Home Care statutes and rules is included in contracts for contracted services. • License is obtained, displayed, and renewed. • Licensee's advertisements accurately reflects services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
• MN Rule 4668.0180 subpart 5 • MN Rule 4668.0180 subpart 6 • MN Rule 4668.0180 subpart 7 • MN Rule 4668.0180 subpart 9 • MN Statute 144A.47 [Note to MDH staff: Review 17 point contract if services provided in a Housing With Services]		

<u>Please note</u>: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other violations may be cited depending on what systems a provider has or fails to have in place and/or the severity of a violation. Also, the results of the focused licensing survey may result in an expanded survey where additional interviews, observations, and documentation reviews are conducted.

<u>SURVEY RESULTS</u>:
For Indicators of Compliance not met and/or education provided, list the number, regulation number, and example(s) of deficient practice noted:

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
1	2	MN Rule 4668.0030 Subp. 4 Bill of Rights	X	Based on record review and interview the licensee failed to ensure that clients received the updated telephone numbers for the Ombudsmen's office for nine of nine current clients (#1, #8, # 9, # 11, # 12, #13, # 14, # 15, and # 16), whose records were reviewed. The findings include: Records for client's # 1, # 8, # 9, #11, # 12, #13, # 14, #15 and # 16 lacked evidence that the clients were given the updated telephone number for the Ombudsmen office. The telephone numbers changed in November of 2005. When interviewed, April 4, 2006, the administrator stated the clients had not received the updated telephone number of the Ombudsmen. The administrator indicated he planned to have the registered nurse bring the updates to the clients when the registered nurse made her next visit to the clients.

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				Education: Provided
2	5	MN Rule 4668.0065 Subp. 1 Tuberculosis Screening	X	Based on record review and interview, the licensee failed to ensure that one of four employees (employee P) hired in 2006 provided documentation of having received a negative reaction to a Mantoux test prior to providing direct care to client #14. The findings include: Employee P started providing direct care services to client #14 on March 11, 2006. Employee P's record contained a tuberculosis screening that was read as being negative on March 16, 2006. When interviewed on April 3, 2006, the administrator confirmed that employee P began providing services to client #14 on March 11, 2006 prior to the agency receiving documentation of a negative reaction to a Mantoux test. **Education:** Provided
3	5	MN Rule 4668.0100 Subp. 4 Performance of Routine Procedures	X	Based on record review and interview the licensee failed to ensure that the registered nurse specified, in writing, specific instructions for performing procedures for each client and that the procedures were documented in the client record for one of nine current clients (#1), whose records were reviewed. The findings include: Employee T's "Home Health Aide Notes" for client #1 indicated that employee T was providing medication reminders, range of motion, and foot soaks to client #1. Client #1's record lacked documentation of procedures for client #1's cares. During a phone interview, April 12, 2006, employee T stated that there were no written instructions for performing medication reminders, range of motion, and foot soaks to client #1 and that client #1 told employee T what cares were to be done and how to do

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				them. **Education:** Provided
4	1	MN Rule 4668.0140 Subp. 1 Service Agreements	X	Based on record review and interviews, the licensee failed to ensure that modifications to the service agreements were made in writing for two of nine current clients (#9 and #18), whose records were reviewed. The findings include: Client #9's service agreement, dated April 9, 2003, indicated that client #9 was to receive a "Nurse, three hours per week," and the registered nurse was to make supervisory visits one time per month. When interviewed on April 4, 2006, the licensee's registered nurse stated that client #9 had not received these three hours per week of "nurse" service for several months. She also indicated that she did supervisory visits every fourteen days rather than monthly due to the delegated nursing cares the client was receiving. There were no written modifications to the service agreement. Client #18's service agreement, dated January 20, 2005, indicated that client #18 was to receive HHA/PCA (home health aide/personal care attendant) services seven days a week. The service agreement did not state what the HHA/PCA was to do. The time sheets for the HHA/PCA providing care to client #18 for the months of January and February 2006 indicated that client #18 was receiving services only three times a week. When interviewed, April 4, 2006, the registered nurse confirmed client #18 was now only receiving services three times a week and the service agreement had not been modified to reflect the change in services. **Education:** Provided

A draft copy of this completed form was left with Rufus Adeowla, Administrator at an exit conference on April 6, 2006. Any correction orders issued as a result of the on-site visit and the final Licensing Survey Form will arrive by certified mail to the licensee within 3 weeks of this exit conference (see Correction Order form HE-01239-03). If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 201-4301. After supervisory review, this form will be posted on the MDH website. General information about CLASS A Licensed-only Home Care Provider is also available on the MDH website: http://www.health.state.mn.us

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us

(Form Revision 3/06)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # Hand-delivered on January 18, 2006

January 18, 2006

Rufus A. Adewola, Administrator
Loving Care Home Care Services
501 North Dale Street #205
St. Paul, MN 55103

Re: Licensing Follow Up Revisit

Dear: Mr. Adewola

This is to inform you of the results of a facility visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program, on November 29, 30 and December 1, 2005.

The documents checked below are enclosed.

__X__ Informational Memorandum
Items noted and discussed at the facility visit including status of outstanding licensing correction orders.

__X__ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

__X__ Notices Of Assessment For Noncompliance With Correction Orders For Home Care Providers

Feel free to call our office if you have any questions at (651) 215-8703.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Rufus Adewola, President Governing Board
James C. Snyder, SR, Attorney at Law
Ramsey County Social Services
Gloria Lehnertz, Minnesota Department of Human Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # Hand-delivered on January 18, 2006

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR HOME CARE PROVIDERS

January 18, 2006

RUFUS A ADEWOLA
LOVING CARE HOME CARE SERVICES
501 NORTH DALE STREET #205 ST PAUL, MN 55103

RE: QL21083006

Dear Mr. Adewola:

I) On November 29, 30, and December 1, 2005 a re-inspection of the above agency was made by the survey staff of the Minnesota Department of Health, to determine the status of a correction order dated June 3, 2005 and issued during an inspection conducted on May 25, 26, and 27, 2005 and June 1, 3, 6, and 8, 2005. This correction order was hand-delivered and received by the agency on June 3, 2005.

The following correction order dated June 3, 2005 was not corrected in the time period allowed for correction:

[Un-numbered] MN Statute §144A.44 Subd. 1. (2) $250.00

Based on record review, interview and observation, the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for one of one (#2) ventilator dependent clients. The findings include:

Client #2 began receiving contracted care from the licensee on December 1, 2004 with a diagnosis of Amyotrophic Lateral Sclerosis, (ALS). Client #2 was ventilator dependent and had a gastrostomy tube for feeding and oral medication. Client #2 communicated with eye blinks towards a communication board and with a doorbell, used as a call system, through some cheek movement. Client #2 communicated via his board with his significant other and family. The service agreement dated December 1, 2004 did not contain a description of the services provided, their frequency, or fees for services. There were no required supervisory visits by a registered nurse, nor were there instructions in writing and documentation in the client's record on the procedures for cares or treatments. Client #2 received care from employees #2 and #3 licensed practical nurses (LPN) and employee #4 a home health aide (HHA). Employees # 2, #3, and #4's personnel records did not indicate orientation to home care, home health training, competency evaluation, in-service education, infection control education, or tuberculin testing. These employees had not been oriented to tasks for the client by a registered nurse.

During a home visit May 26, 2005, there were three agency staff (#2, #3, #4,) present due to shift change. Employee #3, an LPN was observed working with client #2 May 26, 2005. Employee #3's nursing license had expired April 30, 2005 and had not been renewed.

The agency administrator made site visits with direct client contact. The administrator's personnel record had no criminal background check. His personnel record lacked evidence of orientation to home care, tuberculin testing, or infection control education.

During an interview May 26, 2005, both licensed practical nurses providing care to client #2 stated they had no training in home care or in ventilator care. Employee # 3, a licensed practical nurse stated the only training she received was from the client's significant other. There was no evidence of registered nurse (RN) involvement in client #2's care.

When interviewed May 26, 2005 the administrator stated he had no registered nurse in his employ and had not since November 2004. He then stated RN services were provided by the RNs' in his pool agency. When questioned about how often the nurses from his pool agency worked to provide service to his home care clients he stated "never. They always refuse to go." He confirmed he did not have a contract with any agency for other services including nursing services.

During a home visit, May 26, 2005, client #2's significant other stated "we have some competency issues here…he has sent people who have not been trained, you have medication errors, no staff person to relieve. I call – no answer. This is 24-hour service. I'm not sure if the settings (pointed to the ventilator) are appropriate. The notes are not being signed off – now the paper is gone." Client #2's significant other stated she had a form identifying the settings on the ventilator to be sure the settings were correct at the beginning of the shift. Caregivers were not filling out the form indicating the settings. During an interview, June 2, 2005, client #2's significant other stated she had utilized a form that was developed by another agency, to be sure all of the ventilator settings were correct and it had worked very well.

Client #2's significant other, stated that on May 13, 2005, employee #2 "cut off the end of the feeding tube and put it in the bag. His stomach contents were all over the bed and he laid in it all night. Today she tried to give an enema without removing the cap. I caught her in time." Client #2's significant other also stated "if [client name] refuses care it is because it is not being done right." Nurses notes dated May 13, 2005 stated "refused H.S. (hour of sleep) cares and nebulizer, took only meds." Client #2's significant other stated that was because "she was trying to stick it between the trach and the trach vent and it would not hook to anything." She indicated client #2 knows how his cares are to be done and will refuse rather than risk having them done improperly. Staff had been giving daily phosphate enemas and regularly administered medications. There were no doctors' orders for medications and treatments in the client record. There was no notification of the administration of a pro re nata (prn) medication to a registered nurse.

Client #2's significant other went on to state "neither one here today (the LPN nor PCA) know the communication system." The client uses a communication board system and a doorbell to communicate his needs. He "puts on the doorbell with his cheek when he needs suctioning or anything." Client #2 communicated via his board with his significant other and family. Client # 2's significant other stated he receives suctioning fifteen times per day. "One night staff went to the apartment door when the client rang for suctioning, not realizing the client was calling for help. "I have not had good nights sleep for a long time because of this. I live 20 minutes from here but have been staying because I don't dare leave." Client #2 indicated through eye movement, the communication board, and with the assistance of the significant other "[administrators name] keeps sending people fresh off the boat." Client #2 communicated via his board with his significant other and family only. Staff confirmed they had not been trained to communicate with the client.

During a telephone interview June 2, 2005, client #2's significant other stated the administrator "came by to talk on Tuesday" May 31, 2005. "He asked if we could continue services and work with him." Client #2's significant other stated she told the administrator not to send employee #2 again. "She ripped his anus on Monday. She's more trouble than she's worth." She also stated, "a new L.P.N. came in today and called [administrator's name] and asked where the care plan signed by the registered nurse was?" She added the new LPN also told the administrator" to get an R.N. out here today." When interviewed June 3, 2005, client #2's significant other stated, "Wednesday" (June 1, 2005) "didn't have a nurse or a PCA. He sent out [name of office staff] to help with transfer."

TO COMPLY: 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;

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed the amount of: $ 250.00.

II) On November 29, 30, and December 1, 2005 a re-inspection of the above agency was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders dated October 20, 2005, issued during an inspection conducted on May 25, 26, and 27, 2005 and June 1, 3, 6, and 8, 2005. On November 2, 2005 at 5:42 p.m. you confirmed by telephone interview that you had received the October 20, 2005 correction orders on October 22, 2005. On November 3, 2005, you hand delivered to MDH a signed copy of the October 20, 2005 correction orders, on which you indicated that all of the October 20, 2005 correction orders were corrected as of November 1, 2005.

The following correction orders dated October 20, 2005 were not corrected in the time period allowed for correction:

2. MN Rule 4668.0040 Subp. 1 **$250.00**

Based on record review and interview, the licensee failed to establish a system for receiving, investigating and resolving complaints. The findings include:

When interviewed on May 26, 2005, client #2's significant other stated that she had made repeated telephone complaints to the owner, employee #5, regarding the poor care and lack of staff training. Client #2's significant other cited examples such as: employee #2 cutting off client #2's feeding tube such that his stomach contents spilled all over the bed and he laid in it all night: employee #2 trying to give an enema without removing the cap: that client #2's refused a nebulizer treatment on May 13, 2005 because staff were not hooking the nebulizer up to the ventilator correctly: there were no doctors' orders for medications and treatments in the client record: staff were not notifying the registered nurse when they administer pro re nata (prn) medications: and staff had not been trained on client #2's communication system resulting in staff not being aware that client #2 was calling for help.

The licensees' Policy and Procedure Manual contained a policy titled "Investigation of Complaints." The policy stated, "The client is instructed on admission to services to discuss their concerns with the nurse or therapist before it becomes a complaint. A complaint made by phone or letter will be directed to the (area left blank) or designee and will be promptly recorded. The (area left blank) will obtain the following information for investigative purposes: The name and address of the home health client, Date(s) of the complaint(s), Nature of the complaint(s), If possible, but not mandatory, the name address and phone number of the party making the complaint." It further indicated that all parties would be interviewed for investigation, the client would be kept current on the progress of the investigation, and the client or person making the complaint would be informed of the action taken and resolution.

Client #2's significant other stated that no one had interviewed the client about the complaints and as far as she knew none of the complaints had been investigated. Client #2 stated that she had not been kept current or received any feedback on an investigation or follow up to her complaints.

When interviewed on May 27, 2005, the owner stated he had not received any complaints or incidents that he had investigated because, "I have never had an incident or complaint since I've been in business."

TO COMPLY: A licensee that has more than one direct care staff person must establish a system for receiving, investigating, and resolving complaints from its clients.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $ 250.00.

3. MN Rule 4668.0040 Subp. 2 **$50.00**

Based on record review and interview, the licensee failed to provide to seven of seven clients (#1, #2, #3, #4, #5, #6 and #7) reviewed, a written notice that included the client's right to complain to the licensee about the services received; the name or title of the person or persons to contact with complaints; the method of submitting a complaint to the licensee; the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and a statement that the provider will in no way retaliate because of a complaint. The findings include:

Clients #1, #2, #3, #4, #5, #6 and #7 record and the licensee's admission packet were reviewed and were noted to lack information to indicate that the licensee had provided a written notice to each client that included the clients' right to complain about the services they were receiving, the method to submit the complaint to the licensee, the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints and a statement that the licensee will in no way retaliate against the client because of the complaint. When interviewed on June 1, 2005, the owner stated that the agency did not provide clients with a written notice of the agency's complaint procedure because he thought that the Home Care Bill of Rights that addressed complaints.

TO COMPLY: The system required by subpart 1 must provide written notice to each client that includes:

A. the client's right to complain to the licensee about the services received;
B. the name or title of the person or persons to contact with complaints;
C. the method of submitting a complaint to the licensee;
D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and
E. a statement that the provider will in no way retaliate because of a complaint.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $50.00 .

5. MN Rule 4668.0065 Subp. 3 **$300.00**

Based on personnel record review and interview, the licensee failed to assure annual infection control in-service training for six of nine employees (#1, #2, #3, #5, #6, and #8) reviewed. The findings include:

The licensees' "Infection Control" policy stated "Staff is taught basic infection control measures, use of protective equipment, method and time of replacement during orientation and on an annual basis."

Employee #1 was hired January 8, 2004. Employee #2 was hired March 14, 2003. Employee #3 was hired May 2, 2002. Employee #6 was hired October 28, 2002. Employees #5 and #8 began working for the agency in 2000. Personal record review for employees #1, #2, #3, #5, #6, and #8 did not contain documentation of infection control in-service training within the last twelve months.

The owner when interviewed on June 1, 2005 stated that each employee was responsible for getting his or her own infection control training and keeping track of what they have taken. The owner verified that there were no in-service training records in the personnel files.

TO COMPLY: For each 12 months of employment, all licensees and employees and contractors of licensees who have contact with clients in their residences, and their supervisors, shall complete in-service training about infection control techniques used in the home. This subpart does not apply to a person who performs only home management tasks. The training must include:

A. hand washing techniques;
B. the need for and use of protective gloves, gowns, and masks;
E. disposal of contaminated materials and equipment, such as dressings, needles, syringes, and razor blades;
D. disinfecting reusable equipment; and
E. disinfecting environmental surfaces.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $300.00.

6. MN Rule 4668.0075 Subp. 1 **$300.00**

Based on personnel record review and interview, the licensee failed to assure that nine of nine employees (#1, #2, #3, #4, #5, #6, #7, #8 and #9) reviewed received the required orientation to home care. The findings include:

Employee #1 was hired January 8, 2004. Employee #2 was hired March 14, 2003. Employee #3 was hired May 2, 2002. Employee #4 was hired May 4, 2005. Employees #5 and #8 began working for the agency in 2002. Employee #6 was hired October 28, 2002. Employee #7 was hired July 28, 2004 and employee #9 was hired January 20, 2005. When reviewed, personal files did not contain documentation to indicate that all nine employees had received the required orientation to home care.

When interviewed on June 1, 2005, the owner stated that the agency was not meeting this requirement for the employees. He stated that he thought he had met this requirement for himself by reading "A Guide To Home Care Services" which was mailed to Class A licensees by the Minnesota Department of Health in April of 2005. There was no evidence in the administrators personnel file to verify that he had done this. On June 8, 2005 the administrator stated he did not know where to get the Minnesota Rules that govern Class A licensees. This information is contained on page one of "A Guide To Home Care Services."

TO COMPLY: Every individual applicant for a license, and every person who provides direct care, supervision of direct care, or management of services for a licensee, shall complete an orientation to home care requirements before providing home care services to clients. This orientation may be incorporated into the training required of paraprofessionals under part 4668.0130. This orientation need only be completed once.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $300.00.

7. MN Rule 4668.0100 Subp. 5 **$300.00**

Based on personnel record review and interview, the licensee failed to assure that four of five home health aides (#4, #7, # 8, and #9) were qualified to perform home health aide tasks. The findings include:

Personnel records for employees #4, #7, #8 and #9 were reviewed and were noted to lack documentation of the required training or competency evaluations for each of the four employees who perform home health aide (HHA) tasks. During an interview on May 27, 2005, the owner stated he did not have any training documentation for all four employees and was unsure what training any of his home health aides had. When asked about training documentation or training files the owner stated, "They keep that at home."

Employee #8 was hired by the agency in August of 2000 as a staffing coordinator. When interviewed, on June 6, 2005, employee #8 stated that in 2000 or 2001, when scheduled direct care staff were unavailable to provide care to clients, employee #8 would be sent out by the owner to "fill in" as a home health aide which she continues to do as needed. Employee #8 stated that she had not received any training as a home health aide from the current licensee. Employee #8 stated that she asks the client what to do and how to provide the care the clients need. When interviewed on June 6, 2005, the owner verified that employee #8 does work as a "fill in" HHA.

TO COMPLY: A person may only offer or perform home health aide tasks, or be employed to perform home health aide tasks, if the person has:

A. successfully completed the training and passed the competency evaluation required by part 4668.0130, subpart 1;

B. passed the competency evaluation required by part 4668.0130, subpart 3;

C. successfully completed training in another jurisdiction substantially equivalent to that required by item A;

D. satisfied the requirements of Medicare for training or competency of home health aides, as provided by Code of Federal Regulations, title 42, section 484.36;

E. satisfied subitems (1) and (2):

(1) meets the requirements of title XVIII of the Social Security Act for nursing assistants in nursing facilities certified for participation in the Medicare program, or has successfully completed a nursing assistant training program
approved by the state; and

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

F. before April 19, 1993, completed a training course of at least 60 hours for home health aides that had been approved by the department

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $300.00.

8. MN Rule 4668.0100 Subp. 6 **$300.00**

Based on personnel file review and interview, the licensee failed to assure employees received at least eight hours of in-service training annually in topics relevant to the provision of home care services for five of five (#1, # 6, #7, #8, and #9) employees who performed home health aide tasks. The findings include:

Employees #8, #6, and #1 began employment in 2000, October 28, 2002, and January 8, 2004 respectively. Personnel file reviewed lacked evidence of in-service training in the past twelve months. Employees #6 and #1 had no evidence of in-service training since their dates of hire.

Employee #1 was interviewed on May 27, 2005 and stated he received his home health training in 1992 and has not received any further training.

During an interview June 6, 2005 employee #8 stated she received four hours of in-service training at another agency she worked for in March of 2004 but had not received any other training from this agency since she was hired in 2000.

When interviewed, May 27, 2005, the owner stated that employees keep their own record of training. When the owner was interviewed again on June 1, 2005, he stated he had no training records and was unsure what training his staff may have attended.

TO COMPLY: For each person who performs home health aide tasks, the licensee must comply with items A to C.

A. For each 12 months of employment, each person who performs home health aide tasks shall complete at least eight hours of in-service training in topics relevant to the provision of home care services, including that required by part 4668.0065, subpart 3, obtained from the licensee or another source.

B. Licensees shall retain documentation of satisfying this part and shall provide documentation to persons who have completed the in-service training.

C. If a person has not performed home health aide tasks for a continuous period of 24 consecutive months, the person must demonstrate to a registered nurse competence in the skills listed in part 4668.0130, subpart 3, item A, subitem (1).

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $300.00.

9. MN Rule 4668.0100 Subp. 8 **$350.00**

Based on record review and interview, the licensee failed to provide orientation by a registered nurse for each person who is to perform home health aide tasks to each client and to the tasks to be performed for six of six (#1, #4, #6, #7, #8 and #9) home health aides records reviewed. The findings include:

Employee # 8 was hired in 2000 as a staffing coordinator. On June 6, 2005 she stated that she worked as a "fill in" for staff when they were unable to keep the assignment. She stated that she had been doing this since late 2000 or early 2001 and had never been oriented to the clients or the cares to be provided by a registered nurse. When interviewed on May 27, 2005, employee #8 stated that in 2005, the agency had a RN who worked for two days and terminated on December 1, 2004. Employee #8 stated that the agency had not had a RN on staff since December 1, 2004.

Employee #1 was hired January 8, 2004 and provides cares to client #1 who receives kidney dialysis three times a week. Employee #4 was hired on May 4, 2005 and provides cares for client #2 who has Amytrophic Lateral Sclerosis, is ventilator dependent and has tube feedings. Employee #6 was hired on October 28, 2002 and provides cares to client #5 who has a diagnosis of end stage renal disease and receives dialysis three times a week. Employee # 7 was hired July 28, 2004 and provides cares for client #4 who had a diagnosis of bipolar disorder. Employee #9 was hired January 20, 2005 and provides care for client #7 who has a diagnosis of HIV. There was no evidence to indicate that employees #1, #4, #6, #7 and #9 received orientation to each client and the tasks to be performed prior to performing the tasks.

TO COMPLY: Prior to the initiation of home health aide tasks, a registered nurse or therapist shall orient each person who is to perform home health aide tasks to each client and to the tasks to be performed.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $350.00.

10. MN Rule 4668.0100 Subp. 9 **$350.00**

Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise home health aides to ensure work was being performed adequately for seven of seven (#1, #2, #3, #4, #5, #6, and #7) clients records reviewed. The findings include:

Client #1 was admitted to the agency September 26, 2003, Client #3 was admitted to the agency November 11, 2003 and expired January 6, 2005, Client #4 was admitted to the agency July 1, 2004,

Client #5 was admitted July 14, 2004, Client # 6 was admitted on July 14, 2003 and expired January 6, 2005 (per county public health nurse interview, June 10, 2005), Client #7 was admitted April 22, 2004 and Client #2 was admitted on December 1, 2004. The records for clients #1, #2, #3, #4, #5, #6, and #7 did not contain any documentation of supervisory visits by a registered nurse. Employee #8 stated on May 27, 2005 there had not been a registered nurse since a registered nurse worked for two days and left on December 1, 2004. Employee #8 stated that, to date, the licensee did not have a RN on staff in 2005.

TO COMPLY: After the orientation required by subpart 8, a therapist or a registered nurse shall supervise, or a licensed practical nurse, under the direction of a registered nurse, shall monitor persons who perform home health aide tasks at the client's residence to verify that the work is being performed adequately, to identify problems, and to assess the appropriateness of the care to the client's needs. This supervision or monitoring must be provided no less often than the following schedule:

A. within 14 days after initiation of home health aide tasks; and

B. every 14 days thereafter, or more frequently if indicated by a clinical assessment, for home health aide tasks described in subparts 2 to 4; or

C. every 60 days thereafter, or more frequently if indicated by a clinical assessment, for all home health aide tasks other than those described in subparts 2 to 4.

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse 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.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $350.00.

11. MN Rule 4668.0140 Subp.2 **$50.00**

Based on record review and interview, the licensee failed to have written service agreements containing a description of the services to be provided, the frequency of the services, persons and category of person who are to provide the services, frequency of supervision, or fees for services for six of six clients (#1, #3, #4, #5, #6 and #7) reviewed. The findings include:

Clients' #6, #1, #7, #4, #5, and #3 began receiving services July 14, 2004, September 26, 2003, April 22, 2004, July 1, 2004, July 14, 2004, and November 1, 2004 respectively. The service agreements for clients #6, #1, #7, #4, #5, and #3 did not contain a description of the services to be provided, the frequency of the services, persons and category of person to provide the services, frequency of supervision, or fees for services. During an interview on May 27, 2005, the owner verified that the service agreements were not complete.

TO COMPLY: The service agreement required by subpart 1 must include:

A. a description of the services to be provided, and their frequency;

B. 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, if any;

D. fees for services;

E. a plan for contingency action that includes:

(1) the action to be taken by the licensee, client, and responsible persons, if scheduled services cannot be provided;

(2) the method for a client or responsible person to contact a representative of the licensee whenever staff are providing services;

(3) who to contact in case of an emergency or significant adverse change in the client's condition;

(4) the method for the licensee to contact a responsible person of the client, if any; and

(5) circumstances in which emergency medical services are not to be summoned, consistent with the Adult Health Care Decisions Act, Minnesota Statutes, chapter 145B, and declarations made by the client under that act.

Class C licensees need not comply with items B and C and this item, subitems (2) and (5). Subitems (3) and (5) are not required for clients receiving only home management services.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $50.00.

12. MN Rule 4668.0160 Subp. 5 **$50.00**

Based on record review and interview, the licensee failed to assure that all entries in client records were authenticated and dated for two of seven (#1and #7) client records reviewed. The findings include:

Clients' #1 began receiving services on September 26, 2003. When reviewed, client #1's record contained a service agreement that had been authenticated by client #1's responsible party. A date to indicate when the agreement had been authenticated was lacking. This service agreement also had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Discontinuation of Service" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Contingency Plan" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Authorization for Emergency Procedure Plan" which had an area for client #1's responsible party to authenticate and date and an area for authentication and date by a witness. These areas were noted to be blank.

Client #1's record had a form called "Client Consent Form" which the client #1's responsible party had authenticated. The area for a date was noted to be blank.

Client #1's record had a form called "Home DNR/DNI Request Form" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for a witness and a physician to authenticate and date. This area was noted to be blank.

Client #1's record had a copy of the "Home Care Bill of Rights" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #7's record had a copy of an "Assessment/Care Plan" which client #7 had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #7's record had a copy of a form called "Home DNR/DNI request form" which had client #7's name listed on it and the initials "W.O." in the area that states "I hereby agree to the "Do Not Intubate" order." The document lacks client #7's authentication and date. This form had an area for authentication and date by a witness and the physician. These areas were noted to be blank.

Client #7's record had a copy of an "Service Agreement" which client #7's responsible party had authenticated and dated. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #7's record had a copy of an "Client Consent Form" which client #7's responsible party had authenticated and dated. This form had an area for authentication and date by a witness. This area was noted to be blank.

When shown the forms and interviewed on May 27, 2005, the agency's owner verified the above findings.

TO COMPLY: All entries in the client record must be:
A. legible, permanently recorded in ink, dated, and authenticated with the name and title of the person making the entry; or
D. recorded in an electronic media in a secure manner.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $50.00.

13. MN Rule 4668.0160 Subp. 6 **$100.00**

Based on record review and interview, the licensee failed to have client records that included the dates services ended, medication and treatment orders, service agreements or a summary following the termination of services for one of one (#2) ventilator client and two of two (#3 and #6) discharged clients. The findings include:

Client #2 has a diagnosis of Amyotrophic Lateral Sclerosis, (ALS) is ventilator dependent and has a gastrostomy tube. Client #2's record was reviewed and was noted to lack physician's orders for his medications and treatments.

Client #3 began services on November 1, 2004. When reviewed, the last documentation in the record was dated in November 2004. The record lacked documentation of a service plan that described the services being provided, lacked a summary following the termination of service including the reason services were terminated. During a telephone interview on May 27, 2005, the spouse of client #3 stated that client #3 expired on January 6, 2005 and was a client of the licensee at the time of death. Documentation that the client expired was lacking.

Client #6 began services, on July 14, 2003. When reviewed, the last documentation in the record was dated November 2004. A service plan, discharge summary, documentation that services had terminated, and a summary following the termination of service was lacking. When interviewed on June 1, 2005, the licensee stated that client #6 had expired but he did not know when. Interview on June 10, 2005 with the county case manager for client #6 indicated that client #6 expired on January 6, 2005.

TO COMPLY: The client record must contain:
A. the following information about the client:
(1) name;
(2) address;
(3) telephone number;
(4) date of birth;
(5) dates of the beginning and end of services; and
(6) names, addresses, and telephone numbers of any responsible persons;
B. a service agreement as required by part 4668.0140;
C. medication and treatment orders, if any;
D. notes summarizing each contact with the client in the client's residence, signed by each individual providing service including volunteers, and entered in the record no later than two weeks after the contact;
E. names, addresses, and telephone numbers of the client's medical services providers and other home care providers, if known;
F. a summary following the termination of services, which includes the reason for the initiation and termination of services, and the client's condition at the termination of services.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $100.00

14. MN Rule 4668.0180 Subp. 9 **$100.00**

Based on record review and interview the licensee failed to establish and implement a quality assurance plan. The findings include:

The licensees' policy called "Orientation" stated that, "All employees attend orientation sessions that include: Introduction to the LOVINGCARE HOME CARE SERVICES, INC. Quality Improvement Program and the employees participation in the same." When interviewed on June 6, 2005, regarding the home care agency's quality assurance plan the administrator stated, "I don't have one."

TO COMPLY: The licensee shall establish and implement a quality assurance plan, described in writing, in which the licensee must:

A. monitor and evaluate two or more selected components of its services at least once every 12 months; and

B. document the collection and analysis of data and the action taken as a result.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $100.00.

15. MN Statute §144A.44 Subd. 1 (13) **$500.00**

Based on record review and interviews, the agency failed to assure that clients were served by staff who are properly trained for one of one ventilator client (#2) reviewed. The findings include:

When interviewed, May 26, 2005, the significant other of client #2 stated "we have some competency issues here…he has sent people who have not been trained, you have medication errors, no staff person to relieve. I call – no answer. This is 24-hour service. I'm not sure if the settings (pointed to the ventilator) are appropriate. The notes are not being signed off – now the paper is gone."

Client #2's significant other stated she had a form identifying the settings on the ventilator to be sure the settings were correct at the beginning of the shift but that caregivers were not filling out the form to indicate the settings at the start of the shift.

Client #2's significant other, stated that on May 13, 2005, employee #2, a Licensed Practical Nurse, "cut off the end of the feeding tube and put it in the bag. His stomach contents were all over the bed and he laid in it all night. Today she tried to give an enema without removing the cap. I caught her in time."

Client #2's significant other also stated "if [client name] refuses care it is because it is not being done right." Nurses notes dated May 13, 2005 stated, "refused H.S. (hour of sleep) cares and nebulizer, took only meds." Client #2's significant other stated that client #2 refused the nebulizer because "she was trying to stick it between the trach and the trach vent and it would not hook to anything." She indicated client #2 knows how his cares are to be done and will refuse cares rather than risk having them done improperly.

Staff had been giving daily phosphate enemas and regularly administered medications but there were no physician' orders for client #2's medications and treatments in his client record.

Staff were noted to administer pro re nata (prn) medication but did not report it to a registered nurse.

Client #2's significant other went on to state "neither one here today (the LPN nor PCA) know the communication system." Client #2 uses a communication board system and a doorbell to communicate his needs. Client #2, "puts on the doorbell with his cheek when he needs suctioning or anything." Client #2 communicated via his board with his significant other and family. Client # 2's significant other stated he receives suctioning fifteen times per day. "One night staff went to the apartment door when the client rang for suctioning, not realizing the client was calling for help. I have not had good nights sleep for a long time because of this. I live 20 minutes from here but have been staying because I don't dare leave." Staff confirmed they had not been trained to communicate with the client.

During a telephone interview on June 02,2005, client #2's significant other stated that the owner "came by to talk on Tuesday (May 31,2005)". He asked if they could continue services and work with client #2. Client #2 significant other stated she told the owner not to send not to send employee #2 to take care of client #2 because, "She ripped his anus on Monday (05/30/2005). She is more trouble than she is worth." Client #2 significant other stated in interview on June 3, 2005 that on June 01,2005, client #2 "didn't have a nurse or a PCA. He (administrator) sent out [name of office staff] to help with transfer".

TO COMPLY: A person who receives home care services has these rights: the right to be served by people who are properly trained and competent to perform their duties;

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4) and MN Rule 4668.0230 subparts 2 and 3, you are assessed in the amount of: $500.00.

16. MN Statute §144A.46 Subd. 5 (b) **No Assessment**

Based on record review and interview, the licensee failed to have background studies for two of eight (#5, and #9) employees with direct client contact reviewed. The findings include:

Employee #5, had direct client contact in client's homes, began working for the agency in 2000 and employee #9, a direct caregiver, began working for the agency in January 20, 2005. When reviewed, employees #5, and #9 's personnel file did not contain the required background checks. When interviewed on June 1, 2005, employee #5 stated that background checks were submitted but the results had not been received. Employee #5 stated that he thought his background check had been done and that he had it at home but could not locate it.

TO COMPLY: Employees, contractors, and volunteers of a home care provider are subject to the background study required by section 144.057. These individuals shall be disqualified under the provisions of chapter 245C. Nothing in this section shall be construed to prohibit a home care provider from requiring self-disclosure of criminal conviction information.

There is no assessment for this uncorrected violation.

17. MN Statute §626.557 Subd.14 (b) **No Assessment**

Based on record review and interview the licensee failed to develop individualized abuse prevention plans for seven of seven (#1, #2, #3, #4, #5, #6, and #7) clients reviewed and failed to adequately complete an individual abuse prevention assessment for three of seven (#1, #4 and #5) clients reviewed. The findings include:

When interviewed on June 1, 2005, employee #5 stated that all the client information is located in each client's record. When reviewed, clients #1, #2, #3, #4, #5, #6, and #7 records did not contain abuse prevention plans of the client's susceptibility to abuse.

Client #5's record was reviewed and was noted to lack an individual abuse prevention assessment. Client # 1 and #4's record contained an abuse prevention assessment. Employee #8, the staffing coordinator, authenticated that she completed the abuse prevention assessment. According to the Nurse Practice Act (Minnesota Statutes Chapter148), assessments are the responsibility of registered nurses and cannot be delegated. Employee #8 is not a registered nurse.

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 the person's susceptibility to abuse by other individuals, including other vulnerable adults, and a statement of the specific measures to be taken to minimize the risk of abuse to that person. For the purposes of this clause, the term "abuse" includes self-abuse.

There is no assessment for this uncorrected violation.

Therefore, in accordance with Minnesota Statutes 144.653 Subdivision 6 and 144A.45, subdivision 2, clause (4**)** and MN Rule 4668.0230 subparts 2 and 3, **the total amount you are assessed is**: **$3250.00**. This amount is to be paid by check made payable to the **Commissioner of Finance, Treasury Division, MN Department of Health,** and sent to this Department within 15 days of this notice.

You may request a hearing on the above assessment provided that a written request is made to the Department of Health, Health Policy and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0240, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0230, the correction order/s have not been corrected, another fine may be assessed. This fine shall be double the amount of the previous fine

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 will be considered lack of compliance. Lack of compliance on re-inspection with any item of a multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection has been corrected.

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Rufus Adewola, President Governing Board
James C. Snyder, SR, Attorney at Law
Kelly Crawford, Minnesota Department of Human Services
Ramsey, County Social Services
Sherilyn Moe, Office of Ombudsman for Older Minnesotans
Jocelyn Olson, Assistant Attorney General
Mary Henderson, Program Assurance Unit
Case Mix Review File

Minnesota Department Of Health
Division of Compliance Monitoring
Case Mix Review Section

INFORMATIONAL MEMORANDUM

PROVIDER: LOVING CARE HOME CARE SERVCS

DATE OF SURVEY: November 29, 30, and December 1, 2005

BEDS LICENSED:

HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

CENSUS:

HOSP: _____ NH: _____ BCH: _____ SLF: _____

BEDS CERTIFIED:

SNF/18: _____ SNF 18/19: _____ NFI: _____ NFII: _____ ICF/MR: _____ OTHER: Class A

NAMES AND TITLES OF PERSONS INTERVIEWED:
Rufus Adewola, Administrator/owner
Christina Hibbler, Staffing coordinator/PCA
Keith Hayes, PCA
Donell Anderson, PCA
Margenia Williams, RN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up # 1

ITEMS NOTED AND DISCUSSED:

1) An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on May 25, 26, 27, and June 1, 3, 6, and 8, 2005. The results of the survey were delineated during the exit conference. Refer to Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

The status of the Correction Order dated June 3, 2005 is as follows:

[Un-numbered] MN Statute § 144A.44 subd.1 (2) Not Corrected $250.00

Based on record review and interview the licensee failed to ensure that care was provided according to a suitable and up-to-date plan and subject to accepted medical or nursing standards for three of three (#1, #8, and #9) clients. The findings include:

Client #8 began receiving services from the licensee on April 1, 2005. When interviewed, November 30, 2005, employee J, client #8's personal care attendant, (PCA) stated she provided wound care for client #8 to her coccyx and heel. When interviewed, December 1, 2005, client #8 also verified that the PCA provided wound care every day, which consisted of applying Silvadene to gauze and taping the

gauze to the wound areas. Client #8's record lacked documentation of an assessment of the wounds or the wound care provided for the client. A registered nurse (RN) note dated November 14, 2005, did not indicate that client #8 had any wounds or that the PCA was providing wound care. When interviewed on December 1, 2005, the RN stated she was unaware of client #8's wounds or that the PCA was providing wound care for the client. When interviewed, December 1, 2005, client #8 stated she had informed the RN during the November 14, 2005 visit, that she had these wounds and that the PCA was providing treatment to the wounds. A plan of care to address the wound care was lacking.

Client # 1's record had medication reminders initialed every day on the home health aide note time card signed by employee A, an unlicensed direct care staff, for the weeks ending November 11, and 25, 2005. The record did not contain a plan of care for medication reminders or medication administration. When interviewed by phone on November 30, 2005, employee A was asked about medications for client #1. Employee A stated that he handed client #1 the pillbox. When asked how the pills got into the pill box, employee A stated that he sets up the medications once a week by taking the pills out of medication bottles and placing them into the pillbox. Employee A stated he had not been trained to do medication set-ups or administration by a registered nurse (RN). When interviewed December 1, 2005 the RN verified that employee A had not been trained.

Client # 9's record had " nebs + filters" were marked with an "X" every day on the home health aide note time card signed by employee K for the week ending November 20, 2005. The record did not contain a plan of care for providing oxygen administration or nebulizer treatments. When interviewed by phone November 30, 2005 client # 9 confirmed he was receiving oxygen and nebulizer (nebs) treatments. When asked if he received any assistance with his oxygen and nebulizer treatments, client #9 stated that his personal care attendant (PCA), employee K, did the hook up of the oxygen and helped him with a small tank of oxygen he had to have when he went out. When asked about the nebulizer treatments, client # 9 stated that the PCA got the machine, opened the packages of medication, put the medication into the nebulizer and assisted him in the administration of the treatment. There was no evidence of training for nebulizer or oxygen treatments for employee K. When interviewed December 1, 2005 the RN stated she had not trained employee K.

The statuses of the Correction Orders dated October 20, 2005 are as follows:

1. MN Rule 4668.0019 Corrected

2. MN Rule 4668.0040 Subp. 1 Not corrected Fine $250.00

Based on record review and interview, the licensee failed to establish a system for receiving, investigating and resolving complaints. The findings include:

The policy and procedure for investigating complaints Called "Investigation of Complaints" was reviewed with the Administrator on December 1, 2005. This was noted to be the same policy as the one quoted on the original survey, except that an addition was made to the line which states: "A complaint made by phone or letter will be directed to the *Administrator/Case Manager* or designee and will be promptly recorded." When asked whom the case manager would be that a client could complain to by phone or letter, the administrator stated the case manager would be the county case manager. The area to list the person who will obtain information for investigative purposes was observed to be blank.

On 12/1/05 the owner stated that to comply with this rule he will provide new clients with a copy of his "Investigation of Complaints" policy as well as a copy of the "External Reporting of Maltreatment of Vulnerable Adults" policy. The phone numbers listed on the "External Reporting of Maltreatment of

Vulnerable Adults" policy were reviewed and found to be inaccurate. For example, the toll free number listed for the Office of Health Facility Complaints was 1-800-369-8712 which is not the correct number for OHFC but is a number for a phone card; the numbers listed for the Ombudsman's office as 651-293--0382 is the number for a business called Capital Hill Associates and the toll free number listed for the Ombudsman's office as 1-800-657-9591 is not the Ombudsman's toll free number but is a toll free number for a business called Christopher Builder Inc.

3. MN Rule 4668.0040 Subp. 2 Not corrected Fine $50.00

Based on record review and interview, the licensee failed to provide a complete notice related to the procedure for making a complaint for three of three clients' (#1, #8, and #9) records reviewed. The findings include:

On 12/1/05 the owner stated that to comply with this rule he will provide new clients with a copy of his "Investigation of Complaints" policy as well as a copy of the "External Reporting of Maltreatment of Vulnerable Adults" policy. Records for clients #1, #8, and #9, whose dates of service began prior to 11/5/2005, were reviewed and noted to lack evidence that the licensee had provided each client with an updated written notice of the agency's complaint policy.

When interviewed, November 30, 2005, client #9 could not recall receiving a copy of the agencies complaint procedure and stated he would call "the boss" indicating the administrator, for a complaint. When asked whom he would call if the complaint was not taken care of, client #9 stated he didn't know.

4. MN Rule 4668.0065 Subp. 1 Corrected

5. MN Rule 4668.0065 Subp. 3 Not corrected Fine $300.00

Based on record review and interview, the licensee failed to assure annual infection control in-service training for two of two employees (A and K). The findings include:

Employee A and K were hired January 8, 2004, and April 9, 2003, respectively as unlicensed direct care staff. Their records did not contain documentation of infection control in-service training. When interviewed, November 30, 2005, employee A stated he had not received any infection control training. Employee L, the agency's Registered Nurse hired on 10/1/2005, stated during a 12/1/2005 interview that she was not aware that the agency had been surveyed and issued correction orders and therefore had not provided the required training.

The licensees' "Infection Control" policy stated "Staff is taught basic infection control measures, use of protective equipment, method and time of replacement during orientation and on an annual basis."

6. MN Rule 4668.0075 Subp. 1 Not Corrected Fine $300.00

Based on record review and interview, the licensee failed to assure that three of three employees (A, J, and K) received the required orientation to home care. The findings include:

Employees A, J, and K were hired on January 8, 2004, April 2, 2005, and April 9, 2003, respectively. Their records did not contain evidence to indicate that they had received the required orientation to home care. When interviewed on November 30, 2005, employees A and J stated they had not received the required orientation to home care.

Employee L, the agency's Registered Nurse hired on 10/1/2005, stated during a 12/1/2005 interview that she was not aware that the agency had been surveyed and issued correction orders and therefore had not provided the required training.

7. MN Rule 4668.0100 Subp. 5 Not corrected Fine $300.00

Based on record review and interview, the licensee failed to assure that four of four employees (A, J, K, and M) who were providing home health aide tasks were qualified to perform home health aide tasks. The findings include:

Employees A, J, K, and M performed home health aide tasks. Employees A, J, K, and M's records lacked evidence of the required training or competency evaluations. During an interview on November 29, 2005 the owner stated he had " Smile International Learning Center" provide two days, six hours each day, of training for home health aide competency evaluation and provided a certificate with the "Smile" heading. The certificate was dated October 15 2005.There was no indication of dates of training, the hours, or the content of training on the certificate. The certificate was signed with a single name rather than a full name as the instructor. When asked for a business card or telephone number for the Smile International Learning Center, the curriculum, course content, or credentials of the instructor, the owner was unable to provide any information or documentation. He stated he had located the business through the Yellow pages of the phone directory. During an interview the afternoon of November 29, 2005 the owner then stated " Smile International Learning Center" had been located in the same building as his business but was no longer there. The printed DEX telephone directory for 2004, 2005 was checked and no listing was found. When interviewed November 30, 2005 employee A stated he did not know about or attended any training by Smile.

Smile International Learning Center was located through DEX Online. On December 15, 2005 a manager from Smile International Learning Center was interviewed. The manager was asked and sent via facsimile a listing of agencies Smile International Learning Center had provided training to from June 2005 through November of 2005. Loving Care Home Care Services was not on the list. On January 6, 2006, the manager of Smile International Learning Center sent a facsimile that verified that employees A, J, K, and M had not been trained by his learning center in the past two years.

Employee L, the agency's Registered Nurse hired on 10/1/2005, stated during a 12/1/2005 interview that she was not aware that the agency had been surveyed and issued correction orders and therefore had not provided the required training.

8. MN Rule 4668.0100 Subp. 6 Not Corrected Fine $300.00

Based on record review and interview, the licensee failed to assure employees received eight hours of in-service training annually in topics relevant to the provision of home care services for two of two employees (A and K) reviewed who were employed for greater than one year. The findings include:

Employees A and K began employment January 9, 2004, and April 8, 2003, respectively, as unlicensed direct care staff. Records reviewed on November 30, 2006 lacked evidence of in-service training for employees A and K. Employee A was interviewed on November 30, 2005 and stated he had not had any training since employment began with Loving Care Home Care Services.

Employee L, the agency's Registered Nurse hired on 10/1/2005, stated during a 12/1/2005 interview that she was not aware that the agency had been surveyed and issued correction orders and therefore had not provided the required training.

9. MN Rule 4668.0100 Subp. 8 Not Corrected Fine $350.00

Based on record review and interview, the licensee failed to assure that four of four employees (A, J, K and M), who were providing home health services to clients, received orientation to each client's cares from a registered nurse. The findings include:

Employees J and M were hired on April 2, 2005 and March 31, 2005 respectively as unlicensed direct care staff and were providing home health aide cares to clients. Both employees provided care to client #8, which included a rectal suppository every morning and daily applications of a topical medication and dressing to client #8's wounds. When interviewed on November 30, 2005, employee J stated that client #8, who is not a registered nurse, had orientated her to the cares. Employee J also stated she trained employee M on the tasks performed for client #8. When interviewed, December 1, 2005, the registered nurse confirmed she had not oriented or trained employees J or M to client #8's care.

Employee A was hired January 8, 2004, as an unlicensed direct care staff and provided home health aide cares to client #1 including medication reminders. When interviewed, November 30, 2005, employee A was asked what he did for client #1 when he needed his medication. Employee A stated he gave client #1 a pillbox which had medications that he sets up once a week from medication bottles. Employee A documented that he did "medication reminders: on his home health aide note timecard for the month of November 2005. During an interview on December 1, 2005, the registered nurse confirmed she had not oriented or trained employee A to client #1's cares, medication reminders, or medication administration.

Employee K was hired on April 9, 2003 as an unlicensed direct care staff and provided home health aide cares to client #9 which included assistance with oxygen administration and nebulizer treatments. The client was interviewed November 30, 2005 and stated employee K set up his oxygen and nebulizer treatments for him. During an interview December 1, 2005 the registered nurse confirmed she had not oriented employee K to the client's care tasks.

10. MN Rule 4668.0100 Subp. 9 Not Corrected Fine $350.00

Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise, every fourteen days, unlicensed direct care staff, who were providing medication administration, to ensure that work was being performed adequately for three of three clients (#1, #8, and #9). The findings include:

Client #8 was admitted to the agency on April 1, 2005. When interviewed on November 30, 2005, employee J, a personal care attendant (PCA) for client #8, stated that the unlicensed staff for client #8 provided a bowel program, which consisted of a rectal suppository every morning and the application of a topical medication and dressings to client #8's wounds, every day. Client #8's record contained a note by the registered nurse (RN) dated November 14, 2005, which indicated the RN had visited client #8. The next visit would have been due on November 28, 2005. When interviewed on December 1, 2005, the RN verified that the only visit she made to client #8 was on November 14, 2005 and stated that she was scheduled to do another visit on December 12, 2005. The RN also stated she had not seen the unlicensed staff at the time of her visit with the client, however, she was attempting to have the unlicensed staff present when she made her next visit.

Client #1 was admitted to the agency September 26, 2003 and client #9 was admitted April 9, 2003. Employee A provided medication administration for client #1 and employee K provided oxygen and medications for a nebulizer treatment for client #9 The records lacked fourteen day supervisory visits by the RN. The records for clients #1 and #9 contained nurses' notes that indicated the RN visited client #1 on October 25, and November 15, 2005 and client #9 on October 4, and November 4, 2005. On December 1, 2005, the RN stated she was not aware that she needed to do supervisory visits every fourteen days to supervise the cares provided by the personal care attendants.

11. MN Rule 4668.0140 Subp.2 Not corrected Fine $50.00

Based on record review and interview, the licensee failed to have complete service agreements for three of three clients (#1, #8, and #9) reviewed. The findings include:

Clients' # 1, #8, and #9 began receiving services on September 26, 2003, April 1, 2005, and April 9, 2003 respectively. When reviewed on November 29, 2005, the service agreements for clients #1, #8, and #9 did not contain a description of the services to be provided, the frequency of the services, persons and category of persons to provide the services, frequency of supervision, or fees for services. During an interview on November 29, 2005, the owner verified that the service agreements were not complete.

12. MN Rule 4668.0160 Subp. 5 Not Corrected Fine $50.00

Based on record review and interview, the licensee failed to assure that all entries in two of two client records (client #1 and #8) were authenticated and dated for client records reviewed. The findings include:

Client #1 began receiving services on September 26, 2003. When reviewed on November 29, 2005, client #1's record contained a service agreement that had been authenticated by client #1's responsible party. A date to indicate when the agreement had been authenticated was lacking. This service agreement also had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Discontinuation of Service" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Contingency Plan" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #1's record had a form called "Authorization for Emergency Procedure Plan" which had an area for client #1's responsible party to authenticate and date and an area for authentication and date by a witness. These areas were noted to be blank.

Client #1's record had a form called "Client Consent Form" which the client #1's responsible party had authenticated. The area for a date was noted to be blank.

Client #1's record had a form called "Home DNR/DNI Request Form" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for a witness and a physician to authenticate and date. This area was noted to be blank.

Client #8's record had a copy of an "Assessment/Care Plan" which client #8 had not authenticated. Client #8 was her own responsible party. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank.

Client #8's record had a copy of a form called "Home DNR/DNI request form" which had client #8's name listed on it and the clients' initials in the area that stated "I hereby agree to the "Do Not Intubate" order." This form had an area for authentication and date by a witness and the physician. These areas were noted to be blank.

Client #8's record had a form called "Discontinuation of Service" which client #8 had authenticated. This form had an area for authentication and date by the agency. This area was noted to be blank.

When shown the forms and interviewed on November 29, 2005, the agency's owner verified that authentication and dates were lacking in client #1 and #8's record.

13. MN Rule 4668.0160 Subp. 6 Not Corrected Fine $100.00

Based on record review and interview, the licensee failed to assure that client records included the dates services ended, and medication and treatment orders for three of three (#1, #8, and #9) clients reviewed. The findings include:

Client #8's "Home Health Aide Note" for the weeks of November 5-11, 2005; November 12-18, 2005; and November 19-25, 2005 indicated the client received a "bowel program." On interview November 30, 2005, employee J, a personal care attendant for client #8 stated that the "bowel program" consisted of the administration of a Dulcolax suppository every morning. Employee J also stated that client #8 had wounds on her coccyx and heel that the personal care attendants provided treatments to consisting of applying Silvadene on gauze to the wounds daily. The record did not contain physician orders for the Dulcolax Suppository or the Silvadene.

Client # 1's record was reviewed on November 29, 2005 and medication reminders were initialed every day on the home health aide note time card signed by employee A, a personal care attendant for client#1, for the weeks ending November 11 and 25, 2005. When interviewed by phone on November 30, 2005, employee A stated he sets up and administers client #1's medications. Client #1's record lacked medication orders by a prescriber.

Client # 9's record had " nebs + filters" which were marked with an "X" every day on the home health aide note time card signed by employee K for the week ending November 20, 2005. When interviewed by phone on November 30, 2005, client # 9 confirmed he was receiving oxygen and nebulizer (nebs) treatments. He also stated his personal care attendant (PCA), employee K, did the hook up of his oxygen, helped him with the small tank of oxygen he had to have when he went out and the PCA, put the nebulizer medication into the nebulizer machine and assisted him in the administration of the nebulizer treatment. Client # 9's record lacked medication orders by a prescriber.

14. MN Rule 4668.0180 Subp. 9 Not Corrected Fine $100.00

Based on record review and interview the licensee failed to establish and implement a quality assurance plan. The findings include:

There was no documentation of a quality assurance plan during the survey. When interviewed on November 29, 2005, the owner stated he did not have a quality assurance plan**.**

15. MN Statute §144A.44 Subd. 1 (13) Not corrected Fine $500.00

Based on record review and interviews, the agency failed to assure that three of there clients reviewed (#1, #8 and #9) were served by staff who were properly trained. The findings include:

Documentation in client #8's record and interview with employee J on November 30, 2005 indicated that employees J and M provide home health aide cares for client #8. Documentation in client #1's record indicated that employee A provided home health aide cares for client #1.
Documentation in client #9's record indicated that employee K provided home health aide cares for client #9.

When reviewed, the agencies record for employees A, J, K, and M, who are unlicensed personnel, lacked documentation of training or competency evaluations.

When interviewed, November 30, 2005, employee J stated that client #8, who is not a licensed nurse, had orientated her to the cares. Employee J also stated that she trained employee M on the home health aide tasks performed for client #8. On December 1, 2005, the agency's registered nurse confirmed she had not trained employees A, J, K, or M.

During an interview on November 29, 2005 the owner stated he had " Smile International Learning Center" provide two days, six hours each day, of training for home health aide competency evaluation and showed a certificate with the "Smile" heading. The certificate was dated October 15 2005.There was no indication of dates of training, the hours, or the content of training on the certificate. The certificate was signed with a single name rather than a full name as the instructor. When asked for a business card or telephone number for the Smile International Learning Center, the curriculum, course content, or credentials of the instructor, the owner was unable to provide any information or documentation. He stated he had located the business through the Yellow pages of the phone directory. During an interview the afternoon of November 29, 2005 the owner then stated " Smile International Learning Center" had been located in the same building as his business but was no longer there. The printed DEX telephone directory for 2004, 2005 was checked and no listing was found. When interviewed November 30, 2005 employee A stated he did not know about or attended any training by Smile.

Smile International Learning Center was located through DEX Online. On December 15, 2005 a manager from Smile International Learning Center was interviewed. The manager was asked and sent via facsimile a listing of agencies Smile International Learning Center had provided training to from June 2005 through November of 2005. Loving Care Home Care Services was not on the list. On January 6, 2006, the manager of Smile International Learning Center sent a facsimile that verified that employees A, J, K, and M had not been trained by his learning center in the past two years. When interviewed November 30, 2005 employee A stated he did not know about or attend any training by an outside agency.

16. MN Statute §144A.46 Subd. 5 (b) Not corrected No Assessment

Based on record review and interview, the licensee failed to ensure that a Department of Human Services (DHS) background study was completed for two of six employees (E, and H) reviewed who had direct client contact. The findings include:

Employees E and H had direct client contact. Employee E's record did not contain a background study form from DHS. When interviewed December 1, 2005 employee E stated he had not gotten the required background study from DHS. He stated he had a background study from the Bureau of Criminal Apprehension.

Client #1's record contained an undated vulnerable adult assessment that is signed by employee H and client #8's record contained a vulnerable adult assessment dated March 23, 2005 that is signed by employee H demonstrating that employee H has client contact. Employee H did not have a background study conducted by the facility. On 12/15/05, interview with staff from the Department of Human Services again verified that a background study for Employee H had not been submitted by the agency.

17. MN Statute §626.557 Subd.14 (b) Not corrected No Assessment

Based on record review and interview the licensee failed to develop individualized abuse prevention plans or individual abuse prevention for three of three (#1, #8, and #9) clients reviewed. The findings include:

When interviewed on November 29, 2005, the owner stated that all the client information was located in each client's record. When reviewed, clients #1, #8, and #9 records did not contain individual abuse prevention plans of the client's susceptibility to abuse.

Client #9's record was reviewed and was noted to lack an individual abuse prevention assessment. Client # 1 and #8's records contained an abuse prevention assessment authenticated by employee H to reflect that she did the assessments. Employee H is not a registered nurse. According to the Nurse Practice Act (Minnesota Statutes Chapter 148), assessments are the responsibility of registered nurses and cannot be delegated. When interviewed on November 29, 2005 employee H confirmed that she had done the abuse prevention assessments.

2) Although a State licensing survey was not due at this time, correction orders were issued.

Class A Licensed-Only Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class A Licensed-Only Home Care Providers. Class A licensees may also use this form to monitor the quality of services provided to clients at any time. Licensees may use their completed Licensing Survey Form to help communicate with MDH nurses during an on-site regulatory visit.

During on-site visit/s, MDH nurses will interview staff, talk with clients and/or their representatives and make observations during home visits, and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class A Licensed-Only Home Care services. Completing this Licensing Survey Form in advance would facilitate the survey process.

Licensing requirements listed below are reviewed during a survey. A determination is made whether the requirements are met or not met for each Indicator of Compliance. This form must be used in conjunction with a copy of the Class A Licensed-Only Home Care regulations. Any violations of the Class A licensing requirements are noted at the end of the survey form. **[This form is NOT intended to be used for Class A Licensees who are also certified to participate in the Medicare program].**

Name of Class A Licensee: LOVING CARE HOME CARE SERVCS

HFID # (MDH internal use): 21083

Date(s) of Survey: November 29, 30, and December 1, 2005

Project # (MDH internal use): QL21083006

Indicators of Compliance	Outcomes Observed	Comments
1. The Provider accepts and retains clients for whom it can meet the needs. • MN Rules 4668.0050 • MN Rule 4668.0060 Subpart 3 • MN Rule 4668.0060 Subpart 4 • MN Rule 4668.0060 Subpart 5 • MN Rule 4668.0140 • MN Rule 4668.0180 Subpart 8	• Clients are accepted based on the availability of staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement. • Service plans accurately describe the needs and services and contains all the required information. • Services agreed to are provided • Clients are provided referral assistance.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
2. The Provider promotes client rights. • MN Statute §144A.44 • MN Rule 4668.0030 • MN Rule 4668.0040 Indicator of Compliance #2	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____

Indicators of Compliance	Outcomes Observed	Comments
continued: • MN Rule 4668.0170		____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
3. The Provider promotes and protects each client's safety, property, and well-being. • MN Rule 4668.0035 • MN Statutes §144A.46 Subdivision 5 • MN Statute §626.556 • MN Statutes §626.557 • MN Statute §626.5572	• Client's person, finances and property are safe and secure. • All criminal background checks are performed as required. • Clients are free from maltreatment. • There is a system for reporting and investigating any incidents of maltreatment. • Maltreatment assessments and prevention plans are accurate and current.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
4. The Provider maintains and protects client records. • MN Rule 4668.0160 [Note to MDH staff: See Informational Bulletin 99-11 for Class A variance for Electronically Transmitted Orders]	• **Client records are maintained and retained securely.** • **Client records contain all required documentation.** • Client information is released only to appropriate parties. • Discharge summaries are available upon request.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
5. The Provider employs and/or contracts with qualified and trained staff. • MN Rule 4668.0060 subpart 1 • MN Rule 4668.0065 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0100 [For subpart 2 see indicator #6] Indicator of Compliance #5 continued: • MN Rule 4668.0120 • MN Rule 4668.0130 • MN Statute 144A.45	• Staff, employed or contracted, have received all the required training. • Staff, employed or contracted, meet the Tuberculosis and all other infection control guidelines. • Personnel records are maintained and retained. • Licensee and all staff have received the required Orientation to Home Care. • Staff, employed or contracted, are registered and licensed as required by law. • Documentation of medication administration procedures are available. • Supervision is provided as required.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
Subdivision 5 • MN Statute 144A.461 [Note to MDH staff: See Informational Bulletin 99-7 for Class A variance in a Housing With Services setting]		
6. The Provider obtains and keeps current all medication and treatment orders [if applicable]. • MN Rule 4668.0150 • MN Rule 4668.0100 [Subpart 2] [Note to MDH staff: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With Services setting with regards to medication administration, storage and disposition.]	• Medications and treatments administered are ordered by a prescriber. • Medications are properly labeled. • Medications and treatments are administered as prescribed. • Medications and treatments administered are documented. • Medications and treatments are renewed at least every three months.	Annual Licensing Survey ____ Not Applicable ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey#__1____ ____ Not Applicable ____ Met ____ Not Met _X_ New Correction Order(s) issued _X_ Education Provided
7. The Provider is licensed and provides services in accordance with the license. • MN Rule 4668.0008 subpart 3 • MN Rule 4668.0012 subpart 8 • MN Rule 4668.0012 Subpart 17 • MN Rule 4668.0019 • MN Rule 4668.0060 subpart 2 • MN Rule 4668.0060 subpart 6 • MN Rule 4668.0180 subpart 2 • MN Rule 4668.0180 subpart 3 Indicator of Compliance #7 continued: • MN Rule 4668.0180 subpart 4 • MN Rule 4668.0180 subpart 5 • MN Rule 4668.0180 subpart 6	• Language requiring compliance with Home Care statutes and rules is included in contracts for contracted services. • License is obtained, displayed, and renewed. • Licensee's advertisements accurately reflects services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	Annual Licensing Survey ____ Met ____ Correction Order(s) issued ____ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
• MN Rule 4668.0180 subpart 7 • MN Rule 4668.0180 subpart 9 • MN Statute 144A.47 [Note to MDH staff: Review 17 point contract if services provided in a Housing With Services]		

<u>Please note</u>: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other violations may be cited depending on what systems a provider has or fails to have in place and/or the severity of a violation. Also, the results of the focused licensing survey may result in an expanded survey where additional interviews, observations, and documentation reviews are conducted.

<u>SURVEY RESULTS:</u>
For Indicators of Compliance not met and/or education provided, list the number, regulation number, and example(s) of deficient practice noted:

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
1	6	MN Rule 4668.0150 Subp. 2 Medication and treatment orders	X	Based on record review and interview the licensee failed to have prescriber's orders for medications and treatments for three of three (#1, #8, and #9) clients' records reviewed. The findings include: Client #8's "Home Health Aide Note", for the weeks of November 5-11, 2005; November 12-18, 2005; and November 19-25, 2005 indicated that client #8 received a "bowel program." When interviewed, November 30, 2005, employee J, a personal care attendant for client #8 stated that the "bowel program" consisted of the staff administering a Dulcolax suppository every morning to client #8. Employee J also stated that client #8 had wounds on her coccyx and heel which the personal care attendants provided treatments to consisting of applying Silvadene ointment on gauze to the wounds daily. The record did not contain physician orders for the Dulcolax Suppository or the Silvadene ointment treatment. Client # 1's record had medication reminders initialed every day on the home health aide note time card signed by

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				employee A, an unlicensed direct care staff, for the weeks ending November 11, and 25, 2005. When interviewed by phone on November 30, 2005, employee A was asked about medications for client #1. Employee A stated he handed the client the pillbox. When asked how the pills got into the pill box employee A stated that he sets up the medications in the pillbox once a week by taking the pills out of the medication bottles and placing them into the pillbox. Client #1's record lacked any prescriber orders for medications. Client # 9's record had " nebs + filters" marked with an "X" every day on the home health aide note time card signed by employee K, an unlicensed direct care staff, for the week ending November 20, 2005. When interviewed by phone on November 30, 2005 client # 9 confirmed he was receiving oxygen and nebulizer (nebs) treatments. When asked if he received any assistance with the oxygen and nebulizer treatments, client #9 stated that his personal care attendant (PCA), employee K, hooked up the oxygen and also helps him with a small tank of oxygen he had to have when he went out. Client # 9 also stated that the PCA got the nebulizer machine, opened packages of medication, placed the medication into the nebulizer and assisted him in the administration of the treatment. Client # 9's record lacked prescriber orders for the nebulizer treatment, medications and oxygen. **Education:** Provided

A draft copy of this completed form was left with Rufus Adewola at an exit conference on December 1 2005. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will arrive by certified mail to the licensee within 3 weeks of this exit conference (see Correction Order form HE-01239-03). If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 215-8703. After supervisory review, this form will be posted on the MDH website. General information about CLASS A Licensed-only Home Care Provider is also available on the MDH website: http://www.health.state.mn.us . Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us

(Form Revision 5/05)

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1160 0004 8711 8901

October 20, 2005

Mr. Rufus Adewola, Administrator
Loving Care Home Care Services
501 North Dale Street, #205
St. Paul, MN 55103

Re: Results of State Licensing Survey

Dear Mr. Adewola:

The above agency was surveyed on May 25, 26, and 27, 2005 and June 1, 3, 6, and 8, 2005 for the purpose of assessing compliance with state licensing regulations. The state licensing deficiencies that were found 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, or the RN Program Coordinator.

A final version of the Licensing Survey Form is enclosed. As agreed by you during our 9:00 a.m. in-person conference on October 19, 2005, the enclosed licensing deficiencies have a time period for correction of Fourteen (14) days. 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 feel free to call our office with any questions at (651) 215-8703.

Sincerely,

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Rufus Adewola, President Governing Body
Kelly Crawford, Minnesota Department of Human Services
Ramsey County Social Services
Sherilyn Moe, Office of the Ombudsman
James C. Snyder, SR, Attorney at Law
CMR File

Class A Licensed-Only Home Care Provider

LICENSING SURVEY FORM

Registered nurses from the Minnesota Department of Health (MDH) use this Licensing Survey Form during on-site visits to evaluate the care provided by Class A Licensed-Only Home Care Providers. Class A licensees may also use this form to monitor the quality of services provided to clients at any time. Licensees may use their completed Licensing Survey Form to help communicate with MDH nurses during an on-site regulatory visit.

During on-site visit/s, MDH nurses will interview staff, talk with clients and/or their representatives and make observations during home visits, and review documentation. The survey is an opportunity for the licensee to explain to the MDH nurse what systems are in place to provide Class A Licensed-Only Home Care services. Completing this Licensing Survey Form in advance would facilitate the survey process.

Licensing requirements listed below are reviewed during a survey. A determination is made whether the requirements are met or not met for each Indicator of Compliance. This form must be used in conjunction with a copy of the Class A Licensed-Only Home Care regulations. Any violations of the Class A licensing requirements are noted at the end of the survey form. **[This form is NOT intended to be used for Class A Licensees who are also certified to participate in the Medicare program].**

Name of Class A Licensee: LOVING CARE HOME CARE SERVCS

HFID # (MDH internal use): 21083

Date(s) of Survey: May 25, 26, and 27, 2005, and June 1, 3, 6 and 8, 2005

Project # (MDH internal use): QL21083006

Indicators of Compliance	Outcomes Observed	Comments
1. The Provider accepts and retains clients for whom it can meet the needs. • MN Rules 4668.0050 • MN Rule 4668.0060 Subpart 3 • MN Rule 4668.0060 Subpart 4 • MN Rule 4668.0060 Subpart 5 • MN Rule 4668.0140 • MN Rule 4668.0180 Subpart 8	• Clients are accepted based on the availability of staff, sufficient in qualifications and numbers, to adequately provide the services agreed to in the service agreement. • Service plans accurately describe the needs and services and contains all the required information. • Services agreed to are provided • Clients are provided referral assistance.	Annual Licensing Survey ____ Met _X_ Correction Order(s) issued _X_ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
2. The Provider promotes client rights. • MN Statute §144A.44 • MN Rule 4668.0030 • MN Rule 4668.0040 Indicator of Compliance #2	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	Annual Licensing Survey ____ Met _X_ Correction Order(s) issued _X_ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
continued: • MN Rule 4668.0170		Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
3. The Provider promotes and protects each client's safety, property, and well-being. • MN Rule 4668.0035 • MN Statutes §144A.46 Subdivision 5 • MN Statute §626.556 • MN Statutes §626.557 • MN Statute §626.5572	• Client's person, finances and property are safe and secure. • All criminal background checks are performed as required. • Clients are free from maltreatment. • There is a system for reporting and investigating any incidents of maltreatment. • Maltreatment assessments and prevention plans are accurate and current. .	Annual Licensing Survey ____ Met _X_ Correction Order(s) issued _X_ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
4. The Provider maintains and protects client records. • MN Rule 4668.0160 [Note to MDH staff: See Informational Bulletin 99-11 for Class A variance for Electronically Transmitted Orders]	• **Client records are maintained and retained securely.** • **Client records contain all required documentation.** • Client information is released only to appropriate parties. • Discharge summaries are available upon request.	Annual Licensing Survey ____ Met _X_ Correction Order(s) issued _X_ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
5. The Provider employs and/or contracts with qualified and trained staff. • MN Rule 4668.0060 subpart 1 • MN Rule 4668.0065 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0100 [For subpart 2 see indicator #6] Indicator of Compliance #5 continued: • MN Rule 4668.0120	• Staff, employed or contracted, have received all the required training. • Staff, employed or contracted, meet the Tuberculosis and all other infection control guidelines. • Personnel records are maintained and retained. • Licensee and all staff have received the required Orientation to Home Care. • Staff, employed or contracted, are registered and licensed as required by law. • Documentation of medication administration procedures are available. • Supervision is provided as	Annual Licensing Survey ____ Met _X_ Correction Order(s) issued _X_ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
• MN Rule 4668.0130 • MN Statute 144A.45 Subdivision 5 • MN Statute 144A.461 [Note to MDH staff: See Informational Bulletin 99-7 for Class A variance in a Housing With Services setting]	required.	
6. The Provider obtains and keeps current all medication and treatment orders [if applicable]. • MN Rule 4668.0150 • MN Rule 4668.0100 [Subpart 2] [Note to MDH staff: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With Services setting with regards to medication administration, storage and disposition.]	• Medications and treatments administered are ordered by a prescriber. • Medications are properly labeled. • Medications and treatments are administered as prescribed. • Medications and treatments administered are documented. • Medications and treatments are renewed at least every three months.	Annual Licensing Survey ____ Not Applicable _X_ Met ____ Correction Order(s) issued _X_ Education Provided Follow-up Survey #_____ ____ Not Applicable ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided
7. The Provider is licensed and provides services in accordance with the license. • MN Rule 4668.0008 subpart 3 • MN Rule 4668.0012 subpart 8 • MN Rule 4668.0012 Subpart 17 • MN Rule 4668.0019 • MN Rule 4668.0060 subpart 2 • MN Rule 4668.0060 subpart 6 • MN Rule 4668.0180 subpart 2 • MN Rule 4668.0180 subpart 3 Indicator of Compliance #7 continued: • MN Rule 4668.0180 subpart 4 • MN Rule 4668.0180 subpart 5 • MN Rule 4668.0180	• Language requiring compliance with Home Care statutes and rules is included in contracts for contracted services. • License is obtained, displayed, and renewed. • Licensee's advertisements accurately reflects services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	Annual Licensing Survey ____ Met _X_ Correction Order(s) issued _X_ Education Provided Follow-up Survey #_____ ____ Met ____ Not Met ____ New Correction Order(s) issued ____ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
subpart 6 • MN Rule 4668.0180 subpart 7 • MN Rule 4668.0180 subpart 9 • MN Statute 144A.47 [Note to MDH staff: Review 17 point contract if services provided in a Housing With Services]		

<u>Please note</u>: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other violations may be cited depending on what systems a provider has or fails to have in place and/or the severity of a violation. Also, the results of the focused licensing survey may result in an expanded survey where additional interviews, observations, and documentation reviews are conducted.

<u>SURVEY RESULTS:</u>
For Indicators of Compliance not met and/or education provided, list the number, regulation number, and example(s) of deficient practice noted:

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
1	7	MN Rule 4668.0019	X	Based on a review of the agency's advertising pamphlet, personnel file review, observation, and interviews, the licensee failed to accurately advertise to potential clients the availability, nature and scope of the available home care services. The findings include: a) The agency's advertising pamphlet stated, "Lovingcare Homecare Services thoroughly screens all applicants during our rigorous interviewing process. All of our successful applicants have a minimum of one year of current work experience in homecare services, and must be able to provide at least two satisfactory employer references." When reviewed, personnel records for employees #1, #2, #3, #4, #6, #7, #8, and #9 did not contain any evidence of "two satisfactory employer references." Personnel records reviewed indicated that employees #3, #4, and #9 had no prior home care experience. b) The agency's advertising pamphlet

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				stated, "We closely check all employment data, work performance records and evaluations, and clinical competencies" and " PCA/HHAs all complete rigorous training." Employee #1 was hired January 8, 2004 and was providing care to client #1, a dialysis client. Employee #1 documented that the personal cares he provided for client #1included daily hair combing. During a home visit on May 27, 2005, client #1 was observed not to have any hair to comb. A review of employee #1's personnel file and client #1's record lacked evidence of a competency evaluation or any "clinical competencies" for employee #1. Employee #4 was hired on May 4, 2005 and provided care for client #2 who had Amyotrophic Lateral Sclerosis, was ventilator dependent and had tube feedings. When reviewed, employee #4's personnel record did not contain any training to home care, competency evaluation tests, or "clinical competencies." During an interview on June 8, 2005, employee #5 confirmed that he did not have any records for training, competency evaluation or "clinical competencies" for employee #4. Employee #6 was hired on October 28, 2002 and provided care to client #5 who received dialysis three times a week. When interviewed on June 6, 2005, client # 5 stated that he took thirteen or fourteen pills in the morning and the afternoon and that employee #6 helps him set them up by taking the pills from the pharmacy container and "puts them in the little boxes for me." Training records, competency evaluation or "clinical competencies" for employee #6 was lacking. Employee # 7 was hired on July 28, 2004 as a home health aide and was providing direct care for client #4. Documentation of employee #7's training, competency evaluation or was lacking. Employee # 8 was hired August 7, 2000 as a staffing coordinator. On June 6, 2005 employee #8 stated that she provided client

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				care as a "fill in" for staff when they were unable to keep their assignment. She further stated that she had been doing direct care as a "fill in" since late 2000 or early 2001. There was no evidence of employee #8's training, competency evaluation or "clinical competencies." Employee #9 was hired by the agency on January 20, 2005 and provided direct care client #7 who had HIV. There was no evidence of employee #8's training, competency evaluation or "clinical competencies." Personnel files for employees #1, #2, #3, #4, #6, #7, #8, and #9 did not contain evidence of performance records or performance evaluations. c) The agency's advertising pamphlet stated, "Before employment begins, we verify that each of our RNs and LPNs possesses valid and current Minnesota licenses." Employee #3 was hired on May 2, 2005 as a LPN. During a visit at client #2's home on May 26,2005, employee #3 was observed providing cares. Client #2 has a diagnosis of Amyotrophic Lateral Sclerosis, was ventilator dependent and was tube feed. Upon verification of licensure with the Minnesota Board of Nursing it was noted that employee #3 was working as a LPN with out a license. Employee #3s nursing license expired April 30, 2005 and was not renewed until June 6, 2005. d) The agency's advertising pamphlet stated, "We complete background and history checks on all staff." Employee #5 began working for the agency in 2000 and employee #9 began working for the agency in January 20, 2005 as direct care staff. When reviewed, employees #5, and #9 's personnel file did not contain the required background checks. When interviewed on June 1, 2005, employee #5 stated that background checks were submitted but the results had not been received. Employee #5 stated that he

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				thought his background check had been done and that he had it at home but could not locate it. e) The agency's advertising pamphlet stated, "All applicants are required to have completed Mantoux testing before being hired, and each new employee must provide proof they have been vaccinated for rubella measles." Employee #4 was hired on May 4, 2005 and provided direct care for client #2 who had Amyotrophic Lateral Sclerosis, was ventilator dependent and had tube feedings. There was no documentation of a Mantoux test in employee #4's personnel record. When interviewed on June 8, 2005, employee #5 confirmed he did not have any records on Mantoux testing for employee #4. Employee #5 began working for the agency in 2000. Employee #5's personnel file did not have evidence of Mantoux testing. When interviewed on June 1, 2005, employee #5 stated that he didn't think he needed a Mantoux because he didn't do direct client care. Employee #5 did state that he did go out and do home visits with clients. Personnel records for employee #7 and #9 were reviewed and were noted to lack documentation of Mantoux testing. Employee #5 verified that there were no Mantoux for employees #7 and #9 and they would need to get them done. Employee # 8 was hired August 7, 2000 as a staffing coordinator. On June 6, 2005 employee #8 stated that she provided client care as a "fill in" for staff when they were unable to keep their assignment. She further stated that she had been doing this since late 2000 or early 2001. There was no evidence of Mantoux testing in her personnel file. Documentation to indicated that employees #1, #2, #3, #4, #5, #6, #7, #8, and #9 had been vaccinated for rubella measles was lacking.

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				f) The agency's advertising pamphlet stated, "All RNs and LPNs maintain current CPR certificates." Employees #2 and 3# were working as LPNs for the agency. When reviewed, employee #2 and #3's personnel record did not contain any evidence of "CPR"(cardiopulmonary resuscitation) training or certification. g) The advertising pamphlet also stated that registered nurses "are available for short- and long-term homecare assignments. Lovingcare is fully staffed and committed to meeting your needs." The advertising pamphlet goes on to state that the services provided by the agency include Registered Nurses. When interviewed on May 27, 2005, employee #8 stated that in 2004, the agency had a RN who worked for two days and terminated on December 1, 2004. Employee #8 stated that prior to that, the agency has not had a RN on staff since December 1, 2004. When interviewed on May 27, 2005, employee #5 stated that he had five RNs working for his supplemental nursing service agency that could work for his home care agency but none of his supplemental nursing service RNs would consent to work for his home care agency and non of his supplemental nursing service agency RN's had provided home service for the home care agency. On June 8, 2005, surveyors from the Minnesota Department of Health (MDH) surveyed the licensees' supplemental nursing service agency and determined, based on the supplemental agency records and interview with the owner, that there were no RN's employed at the supplemental nursing service agency. **Education:** Provided
2	2	MN Rule 4668.0040 Subp. 1	X	Based on record review and interview, the licensee failed to establish a system for receiving, investigating and resolving complaints. The findings include:

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				When interviewed on May 26, 2005, client #2's significant other stated that she had made repeated telephone complaints to the owner, employee #5, regarding the poor care and lack of staff training. Client #2's significant other cited examples such as: employee #2 cutting off client #2's feeding tube such that his stomach contents spilled all over the bed and he laid in it all night: employee #2 trying to give an enema without removing the cap: that client #2's refused a nebulizer treatment on May 13, 2005 because staff were not hooking the nebulizer up to the ventilator correctly: there were no doctors' orders for medications and treatments in the client record: staff were not notifying the registered nurse when they administer pro re nata (prn) medications: and staff had not been trained on client #2's communication system resulting in staff not being aware that client #2 was calling for help. The licensees' Policy and Procedure Manual contained a policy titled "Investigation of Complaints." The policy stated, "The client is instructed on admission to services to discuss their concerns with the nurse or therapist before it becomes a complaint. A complaint made by phone or letter will be directed to the (area left blank) or designee and will be promptly recorded. The (area left blank) will obtain the following information for investigative purposes: The name and address of the home health client, Date(s) of the complaint(s), Nature of the complaint(s), If possible, but not mandatory, the name address and phone number of the party making the complaint." It further indicated that all parties would be interviewed for investigation, the client would be kept current on the progress of the investigation, and the client or person making the complaint would be informed of the action taken and resolution. Client #2's significant other stated that no one had interviewed the client about the complaints and as far as she knew none of

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				the complaints had been investigated. Client #2 stated that she had not been kept current or received any feedback on an investigation or follow up to her complaints. When interviewed on May 27, 2005, the owner stated he had not received any complaints or incidents that he had investigated because, "I have never had an incident or complaint since I've been in business." **Education:** Provided
3	2	MN Rule 4668.0040 Subp.2	X	Based on record review and interview, the licensee failed to provide to seven of seven clients (#1, #2, #3, #4, #5, #6 and #7) reviewed, a written notice that included the client's right to complain to the licensee about the services received; the name or title of the person or persons to contact with complaints; the method of submitting a complaint to the licensee; the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and a statement that the provider will in no way retaliate because of a complaint. The findings include: Clients #1, #2, #3, #4, #5, #6 and #7 record and the licensee's admission packet were reviewed and were noted to lack information to indicate that the licensee had provided a written notice to each client that included the clients' right to complain about the services they were receiving, the method to submit the complaint to the licensee, the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints and a statement that the licensee will in no way retaliate against the client because of the complaint. When interviewed on June 1, 2005, the owner stated that the agency did not provide clients with a written notice of the agency's complaint procedure because he thought that the Home Care Bill of Rights that addressed complaints. **Education:** Provided

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
4	5	MN Rule 4668.0065 Subp. 1	X	Based on record review and interview, the licensee failed to assure that all employees received a Mantoux test before having direct contact with clients for five of nine employees (#4, #5, #7, #8 and #9) reviewed. The findings include: Employee #4 was hired May 4, 2005. Employees #5 and #8 began working under this agency's license in February 2000. Employee #7 was hired July 28, 2004 and employee #9 was hired January 20, 2005. All five employees have direct contact with the agency's clients. When reviewed, personnel files did not contain documentation of Mantoux tests. When interviewed on June 8, 2005, employee #5, the owner, stated that the Mantoux test for employee #4 had just been done and he was waiting for results. Employee #5 stated that he had not had a Mantoux test stating that he did not think he needed the Mantoux test because he did not do direct client care. Employee #5 stated that he did go out and do home visits with his clients. Employee #5 confirmed that there were no Mantoux tests for employees #7 and #9 and they would need to get them done. **Education:** Provided
5	5	MN Rule 4668.0065 Subp. 3	X	Based on personnel record review and interview, the licensee failed to assure annual infection control in-service training for six of nine employees (#1, #2, #3, #5, #6, and #8) reviewed. The findings include: The licensees' "Infection Control" policy stated "Staff is taught basic infection control measures, use of protective equipment, method and time of replacement during orientation and on an annual basis." Employee #1 was hired January 8, 2004. Employee #2 was hired March 14, 2003. Employee #3 was hired May 2, 2002. Employee #6 was hired October 28, 2002. Employees #5 and #8 began working for the agency in 2000. Personal record review for employees #1, #2, #3, #5, #6, and #8 did not contain documentation of infection control

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				in-service training within the last twelve months. The owner when interviewed on June 1, 2005 stated that each employee was responsible for getting his or her own infection control training and keeping track of what they have taken. The owner verified that there were no in-service training records in the personnel files. **Education:** Provided
6	5	MN Rule 4668.0075 Subp. 1	X	Based on personnel record review and interview, the licensee failed to assure that nine of nine employees (#1, #2, #3, #4, #5, #6, #7, #8 and #9) reviewed received the required orientation to home care. The findings include: Employee #1 was hired January 8, 2004. Employee #2 was hired March 14, 2003. Employee #3 was hired May 2, 2002. Employee #4 was hired May 4, 2005. Employees #5 and #8 began working for the agency in 2002. Employee #6 was hired October 28, 2002. Employee #7 was hired July 28, 2004 and employee #9 was hired January 20, 2005. When reviewed, personal files did not contain documentation to indicate that all nine employees had received the required orientation to home care. When interviewed on June 1, 2005, the owner stated that the agency was not meeting this requirement for the employees. He stated that he thought he had met this requirement for himself by reading "A Guide To Home Care Services" which was mailed to Class A licensees by the Minnesota Department of Health in April of 2005. There was no evidence in the administrators personnel file to verify that he had done this. On June 8, 2005 the administrator stated he did not know where to get the Minnesota Rules that govern Class A licensees. This information is contained on page one of "A Guide To Home Care Services." **Education:** Provided

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
7	5	MN Rule 4668.0100 Subp.5	X	Based on personnel record review and interview, the licensee failed to assure that four of five home health aides (#4, #7, # 8, and #9) were qualified to perform home health aide tasks. The findings include: Personnel records for employees #4, #7, #8 and #9 were reviewed and were noted to lack documentation of the required training or competency evaluations for each of the four employees who perform home health aide (HHA) tasks. During an interview on May 27, 2005, the owner stated he did not have any training documentation for all four employees and was unsure what training any of his home health aides had. When asked about training documentation or training files the owner stated, "They keep that at home." Employee #8 was hired by the agency in August of 2000 as a staffing coordinator. When interviewed, on June 6, 2005, employee #8 stated that in 2000 or 2001, when scheduled direct care staff were unavailable to provide care to clients, employee #8 would be sent out by the owner to "fill in" as a home health aide which she continues to do as needed. Employee #8 stated that she had not received any training as a home health aide from the current licensee. Employee #8 stated that she asks the client what to do and how to provide the care the clients need. When interviewed on June 6, 2005, the owner verified that employee #8 does work as a "fill in" HHA. **Education:** Provided
8	5	MN Rule 4668.0100 Subp. 6	X	Based on personnel file review and interview, the licensee failed to assure employees received at least eight hours of in-service training annually in topics relevant to the provision of home care services for five of five (#1, # 6, #7, #8, and #9) employees who performed home health aide tasks. The findings include:

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				Employees #8, #6, and #1 began employment in 2000, October 28, 2002, and January 8, 2004 respectively. Personnel file reviewed lacked evidence of in-service training in the past twelve months. Employees #6 and #1 had no evidence of in-service training since their dates of hire. Employee #1 was interviewed on May 27, 2005 and stated he received his home health training in 1992 and has not received any further training. During an interview June 6, 2005 employee #8 stated she received four hours of in-service training at another agency she worked for in March of 2004 but had not received any other training from this agency since she was hired in 2000. **Education:** Provided
9	5	MN Rule 4668.0100 Subp. 8	X	Based on record review and interview, the licensee failed to provide orientation by a registered nurse for each person who is to perform home health aide tasks to each client and to the tasks to be performed for six of six (#1, #4, #6, #7, #8 and #9) home health aides records reviewed. The findings include: Employee # 8 was hired in 2000 as a staffing coordinator. On June 6, 2005 she stated that she worked as a "fill in" for staff when they were unable to keep the assignment. She stated that she had been doing this since late 2000 or early 2001 and had never been oriented to the clients or the cares to be provided by a registered nurse. When interviewed on May 27, 2005, employee #8 stated that in 2005, the agency had a RN who worked for two days and terminated on December 1, 2004. Employee #8 stated that the agency had not had a RN on staff since December 1, 2004. Employee #1 was hired January 8, 2004 and provides cares to client #1 who receives kidney dialysis three times a week. Employee #4 was hired on May 4, 2005 and

Correction Order Number	Indicator of Compliance Number	Rule/ Statute Referenced	Education provided	Statement(s) of Deficient Practice/Education:
				provides cares for client #2 who has Amyotrophic Lateral Sclerosis, is ventilator dependent and has tube feedings. Employee #6 was hired on October 28, 2002 and provides cares to client #5 who has a diagnosis of end stage renal disease and receives dialysis three times a week. Employee # 7 was hired July 28, 2004 and provides cares for client #4 who had a diagnosis of bipolar disorder. Employee #9 was hired January 20, 2005 and provides care for client #7 who has a diagnosis of HIV. There was no evidence to indicate that employees #1, #4, #6, #7 and #9 received orientation to each client and the tasks to be performed prior to performing the tasks. **Education:** Provided
10	5	MN Rule 4668.0100 Subp. 9	X	Based on record review and interview, the licensee failed to have a registered nurse (RN) supervise home health aides to ensure work was being performed adequately for seven of seven (#1, #2, #3, #4, #5, #6, and #7) clients records reviewed. The findings include: Client #1 was admitted to the agency September 26, 2003, Client #3 was admitted to the agency November 11, 2003 and expired January 6, 2005, Client #4 was admitted to the agency July 1, 2004, Client #5 was admitted July 14, 2004, Client # 6 was admitted on July 14, 2003 and expired January 6, 2005 (per county public health nurse interview, June 10, 2005), Client #7 was admitted April 22, 2004 and Client #2 was admitted on December 1, 2004. The records for clients #1, #2, #3, #4, #5, #6, and #7 did not contain any documentation of supervisory visits by a registered nurse. Employee #8 stated on May 27, 2005 there had not been a registered nurse since a registered nurse worked for two days and left on December 1, 2004. Employee #8 stated that, to date, the licensee did not have a RN on staff in 2005. **Education:** Provided
11	1	MN Rule 4668.0140 Subp.2	X	Based on record review and interview, the licensee failed to have written service agreements containing a description of the

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				services to be provided, the frequency of the services, persons and category of person who are to provide the services, frequency of supervision, or fees for services for six of six clients (#1, #3, #4, #5, #6 and #7) reviewed. The findings include: Clients' #6, #1, #7, #4, #5, and #3 began receiving services July 14, 2004, September 26, 2003, April 22, 2004, July 1, 2004, July 14, 2004, and November 1, 2004 respectively. The service agreements for clients #6, #1, #7, #4, #5, and #3 did not contain a description of the services to be provided, the frequency of the services, persons and category of person to provide the services, frequency of supervision, or fees for services. During an interview on May 27, 2005, the owner verified that the service agreements were not complete. **Education:** Provided
12	4	MN. Rule 4668.0160 Subp. 5	X	Based on record review and interview, the licensee failed to assure that all entries in client records were authenticated and dated for two of seven (#1and #7) client records reviewed. The findings include: Clients' #1 began receiving services on September 26, 2003. When reviewed, client #1's record contained a service agreement that had been authenticated by client #1's responsible party. A date to indicate when the agreement had been authenticated was lacking. This service agreement also had an area for authentication and date by the agency. This area was noted to be blank. Client #1's record had a form called "Discontinuation of Service" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank. Client #1's record had a form called "Contingency Plan" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be

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				blank. Client #1's record had a form called "Authorization for Emergency Procedure Plan" which had an area for client #1's responsible party to authenticate and date and an area for authentication and date by a witness. These areas were noted to be blank. Client #1's record had a form called "Client Consent Form" which the client #1's responsible party had authenticated. The area for a date was noted to be blank. Client #1's record had a form called "Home DNR/DNI Request Form" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for a witness and a physician to authenticate and date. This area was noted to be blank. Client #1's record had a copy of the "Home Care Bill of Rights" which client #1's responsible party had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank. Client #7's record had a copy of an "Assessment/Care Plan" which client #7 had authenticated. The area for a date was noted to be blank. This form had an area for authentication and date by the agency. This area was noted to be blank. Client #7's record had a copy of a form called "Home DNR/DNI request form" which had client #7's name listed on it and the initials "W.O." in the area that states "I hereby agree to the "Do Not Intubate" order." The document lacks client #7's authentication and date. This form had an area for authentication and date by a witness and the physician. These areas were noted to be blank. Client #7's record had a copy of an "Service Agreement" which client #7's responsible party had authenticated and dated. This form had an area for authentication and date by the agency. This area was noted to be

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				blank. Client #7's record had a copy of an "Client Consent Form" which client #7's responsible party had authenticated and dated. This form had an area for authentication and date by a witness. This area was noted to be blank. When shown the forms and interviewed on May 27, 2005, the agency's owner verified the above findings. **Education:** Provided
13	4	MN Rule 4668.0160 Subp, 6	X	Based on record review and interview, the licensee failed to have client records that included the dates services ended, medication and treatment orders, service agreements or a summary following the termination of services for one of one (#2) ventilator client and two of two (#3 and #6) discharged clients. The findings include: Client #2 has a diagnosis of Amyotrophic Lateral Sclerosis, (ALS) is ventilator dependent and has a gastrostomy tube. Client #2's record was reviewed and was noted to lack physician's orders for his medications and treatments. Client #3 began services on November 1, 2004. When reviewed, the last documentation in the record was dated in November 2004. The record lacked documentation of a service plan that described the services being provided, lacked a summary following the termination of service including the reason services were terminated. During a telephone interview on May 27, 2005, the spouse of client #3 stated that client #3 expired on January 6, 2005 and was a client of the licensee at the time of death. Documentation that the client expired was lacking. Client #6 began services, on July 14, 2003. When reviewed, the last documentation in the record was dated November 2004. A service plan, discharge summary, documentation that services had terminated, and a summary following the termination of service was lacking. When interviewed on

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				June 1, 2005, the licensee stated that client #6 had expired but he did not know when. Interview on June 10, 2005 with the county case manager for client #6 indicated that client #6 expired on January 6, 2005. **Education:** Provided
14	1	MN Rule 4668.0180 Subp. 9	X	Based on record review and interview the licensee failed to establish and implement a quality assurance plan. The findings include: The licensees' policy called "Orientation" stated that, "All employees attend orientation sessions that include: Introduction to the LOVINGCARE HOME CARE SERVICES, INC. Quality Improvement Program and the employees participation in the same." When interviewed on June 6, 2005, regarding the home care agency's quality assurance plan the administrator stated, "I don't have one." **Education:** Provided
15	2	MN Statute §144A.44 Subd. 1 (13)		Based on record review and interviews, the agency failed to assure that clients were served by staff who are properly trained for one of one ventilator client (#2) reviewed. The findings include: When interviewed, May 26, 2005, the significant other of client #2 stated "we have some competency issues here…he has sent people who have not been trained, you have medication errors, no staff person to relieve. I call – no answer. This is 24-hour service. I'm not sure if the settings (pointed to the ventilator) are appropriate. The notes are not being signed off – now the paper is gone." Client #2's significant other stated she had a form identifying the settings on the ventilator to be sure the settings were correct at the beginning of the shift but that caregivers were not filling out the form to indicate the settings at the start of the shift.

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				Client #2's significant other, stated that on May 13, 2005, employee #2, a Licensed Practical Nurse, "cut off the end of the feeding tube and put it in the bag. His stomach contents were all over the bed and he laid in it all night. Today she tried to give an enema without removing the cap. I caught her in time." Client #2's significant other also stated "if [client name] refuses care it is because it is not being done right." Nurses notes dated May 13, 2005 stated, "refused H.S. (hour of sleep) cares and nebulizer, took only meds." Client #2's significant other stated that client #2 refused the nebulizer because "she was trying to stick it between the trach and the trach vent and it would not hook to anything." She indicated client #2 knows how his cares are to be done and will refuse cares rather than risk having them done improperly. Staff had been giving daily phosphate enemas and regularly administered medications but there were no physician' orders for client #2's medications and treatments in his client record. Staff were noted to administer pro re nata (prn) medication but did not report it to a registered nurse. Client #2's significant other went on to state "neither one here today (the LPN nor PCA) know the communication system." Client #2 uses a communication board system and a doorbell to communicate his needs. Client #2 "puts on the doorbell with his cheek when he needs suctioning or anything." Client #2 communicated via his board with his significant other and family. Client # 2's significant other stated he receives suctioning fifteen times per day. "One night staff went to the apartment door when the client rang for suctioning, not realizing the client was calling for help. I have not had good nights sleep for a long

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				time because of this. I live 20 minutes from here but have been staying because I don't dare leave." Staff confirmed they had not been trained to communicate with the client. During a telephone interview on June 02,2005, client #2's significant other stated that the owner "came by to talk on Tuesday (May 31,2005)". He asked if they could continue services and work with client #2. Client #2 significant other stated she told the owner not to send not to send employee #2 to take care of client #2 because, "She ripped his anus on Monday (05/30/2005). She is more trouble than she is worth." Client #2 significant other stated in interview on June 3, 2005 that on June 01,2005, client #2 "didn't have a nurse or a PCA. He (administrator) sent out [name of office staff] to help with transfer". **Education**: Provided
16	3	MN Statute§ 144A.46 Subd.5	X	Based on record review and interview, the licensee failed to have background studies for two of eight (#5, and #9) employees with direct client contact reviewed. The findings include: Employee #5, had direct client contact in client's homes, began working for the agency in 2000 and employee #9, a direct caregiver, began working for the agency in January 20, 2005. When reviewed, employees #5, and #9 's personnel file did not contain the required background checks. When interviewed on June 1, 2005, employee #5 stated that background checks were submitted but the results had not been received. Employee #5 stated that he thought his background check had been done and that he had it at home but could not locate it. **Education:** Provided
17	3	MN Statute §626.557 subd.14 (b)	X	Based on record review and interview the licensee failed to develop individualized abuse prevention plans for seven of seven (#1, #2, #3, #4, #5, #6, and #7) clients reviewed and failed to adequately complete an individual abuse prevention assessment

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				for three of seven (#1, #4 and #5) clients reviewed. The findings include: When interviewed on June 1, 2005, employee #5 stated that all the client information is located in each client's record. When reviewed, clients #1, #2, #3, #4, #5, #6, and #7 records did not contain abuse prevention plans of the client's susceptibility to abuse. Client #5's record was reviewed and was noted to lack an individual abuse prevention assessment. Client # 1 and #4's record contained an abuse prevention assessment. Employee #8, the staffing coordinator, authenticated that she completed the abuse prevention assessment. According to the Nurse Practice Act (Minnesota Statutes Chapter148), assessments are the responsibility of registered nurses and cannot be delegated. Employee #8 is not a registered nurse. **Education:** Provided

A draft copy of this completed form was left with Rufus Adewola at an exit conference on June 8, 2005. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will arrive by certified mail to the licensee within 3 weeks of this exit conference (see Correction Order form HE-01239-03). If you have any questions about the Licensing Survey Form or the survey results, please contact the Minnesota Department of Health, (651) 215-8703. After supervisory review, this form will be posted on the MDH website. General information about CLASS A Licensed-Only Home Care Provider is also available on the MDH website: http://www.health.state.mn.us

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us

(Form Revision 5/05)