Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7003 2260 0000 9971 7605

December 4, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
5701 Shingle Creek Parkway 110
Brooklyn Park, MN 55430

Re: Licensing Follow Up Visit

Dear Ms. Gurley:

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 October 7, 8, 9, 10, and 13, 2008.

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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

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 CLASS A HOME CARE PROVIDERS

December 4, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
5701 Shingle Creek Parkway 110
Brooklyn Park, MN 55430

RE: QL21374003

Dear Ms. Gurley:

1. On October 7, 8, 9, 10, and 13, 2008, 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 issued as a result of follow up visits to an original survey completed on November 26, 27, 28, 29, 30, 2007 and December 1, 3, 4, 5, 11, 12, 2007, and subsequent follow up visits made on March 17, 18, 19, 20, 2008, May 12, 13, and 14, 2008, and August 13, 14 and 15, 2008, with correction orders received by you on December 28, 2007, April 24, 2008, July 12, 2008, and October 7, 2008, and found to be uncorrected during an inspection completed on October 7, 8, 9, 10, and 13, 2008.

As a result of correction orders remaining uncorrected on the August 13, 14 and 15, 2008 re-inspection, a penalty assessment in the amount of **$250.00** was imposed on October 7, 2008.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on October 7, 8, 9, 10, and 13, 2008.

1. MN Rule 4668.0012 Subp. 15 **NO FINE**

Based on interviews and record review, the licensee failed to provide representatives of the commissioner access to portions of client records. The findings include:

Reviewers arrived at site A at 11:30 am on May 12, 2008. At 11:55 am Nurse IE arrived at site A and she informed the reviewers, the owner, sent her to the facility to assist the reviewers. Nurse IE was given

the current and discharged client rosters to fill out with specific instructions to list on the discharge and admission rosters; all discharged and admitted clients since the January 2008, including the location the clients had been discharged to, and all deaths that had occurred. The reviewers requested that the client roster list would be received by 2 pm on May 12, 2008. The reviewers also requested the complete client records for the two clients at site A. Clients A6 and I3 residing at site A began receiving services from the agency December 28, 2007 and September 17, 2007, respectively. Nurse IE left site A. At 12:10 pm on May 12, 2008, the reviewers telephoned nurse IE again requesting the client records. She stated the records were at the office because she had been auditing them. The reviewers requested that she bring the client records to site A.

At 12:35 pm on May 12, 2008, the reviewers telephoned nurse IE and informed her that the reviewers would be leaving site A to go to another residence since she had not provided the records as requested for site A. Nurse IE stated said that she was driving and she would be at site A shortly.

At 1:00 pm on May 12, 2008, the reviewer telephone nurse IE requesting the records. Nurse IE informed the reviewer she had been in a car accident and she was finishing up and would be coming to site A.

At 1:20 pm on May 12, 2008, nurse IE arrived at site A with portions of the requested two client records. The client records provided were incomplete and did not contain any supervisory visits. Provided were current documents such as physician orders, medication administration records, and personal care attendant documentation sheets for May, 2008.

At 1:50 pm on May 12, 2008, the reviewers requested the supervisory visits for site A and again the client rosters from nurse IE. Nurse IE stated those documents were at the office and she stated she called the owner inquiring about the requested documents.

At 2:42 pm on May 12, 2008, the reviewers telephoned nurse IE and repeated the request for the rosters and supervisory visits.

At 3:55pm on May 12, 2008, nurse IE returned to site A without the client rosters and supervisory visits. Nurse IE telephoned the owner. At this time the reviewer spoke with the owner and directly requested the rosters and supervisory visits from the owner. The owner told the reviewer if the reviewer would quit talking to her on the phone she could complete the forms. After 4:00 pm on May 12, 2008, employee MF, an unlicensed care staff (PCA), called the reviewers' supervisor and informed the supervisor the rosters were done. The supervisory visits were not provided.

The reviewers arrived at site J at 3:05 pm on May 13, 2008. The reviewers telephoned nurse IE the designated contact person, and requested the supervisory visits for sites A and J and for the client rosters that were said to have been readied the prior afternoon. At 3:35 pm on May 13, 2008, nurse IE arrived at site J with no rosters or supervisory visits. At 4:09 pm on May 13, 2008, twenty-eight hours and thirty minutes after the initial request, for the client rosters, the client rosters. The supervisory visits for clients at site J were sent to site J via the fax machine. The agency failed to provide documentation of the supervisory visits for site A.

At 8:23 am on May 14, 2008, the reviewer telephoned the owner and requested the complete record for client A5, since admission to the agency on February 11, 2008 to be delivered to site I. The request included nursing notes, supervisory visits, PCA notes, medication sheets, prescriber orders, and service plans. At 11:40 am on May 14, 2008, the reviewers arrived at site I and inquired of nurse IM and PCA (IH), if records for client A5 had been delivered to the house. They both stated no. An attempt was made to contact the owner IE by telephone, but a voice mail message was received and the voice mailbox would not accept any messages.

At 11:45 am on May 14, 2008 the reviewer telephoned the Caremaxx office and spoke with employee MF. The reviewer told employee MF they were looking for the owner FG and the requested records. MF stated she had not seen the owner yet that day, but that she would forward the message to her.

At 11:51am on May 14, 2008, the owner was telephoned. Again a voice mail message was received and the voice mailbox would not accept any messages. At 11:52 am on May 14, 2008, the reviewer telephoned the Caremaxx office to inquire if the driver had the requested records and would deliver the records to site I. At 11:56am on May 14, 2008 the reviewer telephone the Caremaxx office and was informed that the owner FG was gathering client A5's paperwork and she'd drop it off at site I.

At 12:40pm on May 14, 2008 no records had been delivered to site I and the reviewers left the site.
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TO COMPLY: The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

I. destroys or makes unavailable any records or other evidence relating to the licensee's compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

J. refuses to initiate a background study under Minnesota Statutes, section 144.057 or 245A.04; or

K. has failed to timely pay any fines assessed under part 4668.0230 or 4668.0800, subpart 6.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: NO FINE.

3. MN Statute 144A.44 Subd. 1 (2) **$500.00**

Based on record review and interview, the licensee failed to ensure medications were received as ordered for one of two clients (I3) reviewed at site A and one of two clients (J3) reviewed at site J. The findings include:

Clients I3's record contained a physician's order dated April 16, 2008 for Darvocet N-50 to be administered four times per day. The May 2008 medication administration record did not contain documentation Darvocet N-50 had been administered from May 1, 2008 through May 12, 2008. The client's medi-set for the week starting of May 9, 2008 was observed and it did not contain any Darvocet N-50. When interviewed on May 12, 2008 nurse IE stated the Darvocet N-50 was intended to be ordered as a PRN (as needed) order and she had contacted the physician "recently," to get the order changed to PRN, but she had not yet received the order change. The nurse also stated she was unable to recall when she had called for the order change.

The medications in client I3's medi set-up for the week starting May 9, 2008, were counted by the reviewer and nurse IE on May 12, 2008. The medi-set contained thirteen pills in the 8am box and eight pills in the 8pm box. According to the document titled, "Number of tablets to be give (sic) to client by PCA" the client's medi-set was to contain twelve tablets in the 8am box and seven pills in the 8pm box. According to policy and interview, the medications in each client's medi-set box were counted at the start and end of each care attendant's shift. If there was a discrepancy in the count of the medications between the medi-set and the number of medications recorded on the document titled "Number of tablets to be give (sic) to client by PCA," the nurse was to be notified. When interviewed on May 14, 2008, unlicensed care giver (PCA) AH stated he had counted the medications according to policy, but he had not called any nurse with the discrepancy in the number of the medications, since the owner of the agency, had been in the facility on May 12, 2008 and had changed the number of the medications listed on the aforementioned document. The document was reviewed and it was noted for the week of May 9, 2008, the number of medications entered on the document was thirteen and there was a slash mark through the number thirteen and the number twelve had been written for 8am time slot. The number of medications entered on the document for 8pm was eight and there was a slash mark through that number and the number seven had been written in the 8pm time slot on the document. The client's current physician orders dated April 19, 2008 were reviewed and the correct numbers of medications to be administered at 8am were fourteen pills and nine pills at 8pm.

The reviewer and nurse IE counted the contents of client J3's medi-set on May 13, 2008. The client's medi-set contained Metoprolol ER 100 mg for May 13 and May 14, 2008.

Documentation on the May medication administration record completed by the owner of the agency indicated no Metoprolol ER 100 mg had been put into the client's medi-set for May 13 and 14, 2008. On the May 2008 medication administration record, the client's Metoprolol ER 100mg. was circled for May 12, 13 and 14, 2008, indicating the medication had not been set up in the medi-set. The medi-set contained the correct number of medications according to the current physician orders.

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 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $500.00.

2. On October 7, 8, 9, 10, and 13, 2008, a 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 issued as a result of a survey completed on August 13, 14 and 15, 2008 which were received by you on October 7, 2008.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on October 7, 8, 9, 10, and 13, 2008.

1. MN Rule 4668.0150 Subp 4 **$350.00**

Based on record review and interview, the agency failed to assure medication orders were complete for one of one clients' (H1) medication records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008 after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. A document titled "ADMISSION ORDERS ADDITIONS AND CLARIFICATIONS" which was written by the owner/RN dated May 5, 2008 and provided to the reviewers as orders, listed: "Antacid liquid PRN (as needed), Disposable enema Fleet PRN, Ibuprofen 600 mg PRN, Lunesta 2mg. PRN, Milk of Magnesia PRN, Akwa tears, Certagen tab, Glucosamine & Condrotin, Oxybutin 5mg tab, Zyprexa SD 10 mg vial Inject 10 mg IM if she refuses Clozaril, Proctofoam Hcl-1% foam PRN, APAP 325 mg tabs PRN" and an unreadable reference to "Tylenol." There were no further dosages, names of drug, frequency of administration, or indications for use on the document. When interviewed August 15, 2008, the owner **stated these were the medication orders used for client H1 upon return to the agency.**

TO COMPLY: All orders for medications must contain the name of the drug, dosage and directions for use.

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

2. MN. Rule 4668.0160 Subp. 2 **$100.00**

Based on record review and interview, the licensee failed to retain records for portions of client records for one of three (H1) medication records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008 after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. The client's May medication administration records (MAR) noted that numerous medications had been changed on May 1, 2008. The medication changes noted on the May medication administration record dated May 1, 2008 were for Protonix, Clozapine, Akwa tears, Certagen, Glucosamine & Chondroitin, Mag-Ox, and Ditropan. When the client's record was reviewed on August 13, 2008 a medication error was noted by this reviewer. The original May 2008 physician orders were requested from the agency owner on August 14, 2008 at 3:30 pm so the order changes could be verified. It was requested that the May 2008 orders be available for review, in addition to other requested documents no later than the following day by 11:00 am. On August 15 around 2:00 pm, the requested documents were said to have been provided but did not contain any May 1, 2008 physician orders for client H1. Also there were no original documents provided from the hospital, nursing home or physician, only documents from Caremaxx. When interviewed on August 15, 2008 at approximately 1:20 pm, licensed nurse IE stated she thought the physician orders were at another office. No information was available at 3:00pm when the reviewers left the facility.

TO COMPLY: The licensee shall establish written procedures to control use and removal of client records from the provider's office and for security in client residences and to establish criteria for release of information. The client record must be readily assessable to personnel authorized by the licensee to use the client record.

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

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

Based on record review and interview, the licensee failed to ensure services provided to the client were documented in the client's record and that notes summarizing contact with the client were signed by each individual providing the service no later than two weeks after the contact in one of three client records (H1) reviewed at site H. The findings include:

Client H1 had physician's orders dated May 5, 2008 and again on June 23, 2008, indicating the client's lung sounds were to be checked every shift. Treatment records for June and July 2008 and the vital signs/communication form for August 2008 documented lung sounds were obtained once daily and the client's lungs were "clear." None of the entries documenting the clear lung sounds had a signature or initials indicating which staff member had assessed the client's lungs. The documentation indicating "clear" for all dates in June, July and August, 2008, appeared to be

entered by the same person. When interviewed on August 15, 2008, licensed nurse IE stated she had made the notation "clear" on all of the dates. She stated she worked the day shift twelve out of every fourteen days. She stated that after she had her two days off, when she returned to work, she contacted the nurse that worked her two days off and asked them the results of the client's lung sounds for each day. She then entered the results for those days that she had been off duty. When interviewed on August 15, 2008, the owner stated she had done the weekend lung sounds. There was no explanation given as to why one nurse would routinely need to call another to document her findings from the weekends.

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 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $100.00

4. MN Rule 4668.0220 Subp. 8 **$500.00**

Based on interviews and record review, the licensee failed to provide representatives of the commissioner access to portions of client records for one of three (H1) records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008, after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. The client's May medication administration records noted that numerous medications had been changed on May 1, 2008. The medication changes noted on the May medication administration record dated May 1, 2008 were for Protonix, Clozapine, Akwa tears, Certagen, Glucosamine & Chondroitin, Mag-Ox, and Ditropan. When the client's record was reviewed on August 13, 2008 a medication error was noted by this reviewer. The May 2008 physician orders were requested from the agency owner on August 14, 2008 at 3:30 pm so the order changes could be verified. It was requested that the May 2008 orders be available for review, in addition to other requested documents no later than the following day by 11:00 am. On August 15 around 2:00 pm, the requested documents were said to have been provided but did not contain any May 1, 2008 physician orders for client H1. Also there were no original documents provided from the hospital, nursing home or physician, only documents from Caremaxx. When interviewed on August 15, 2008 at approximately 1:20 pm, licensed nurse IE stated she thought the physician orders were at another office. No information was available at 3:00pm when the reviewers left the facility.

TO COMPLY: Upon the commissioner's request, licensees shall provide to the commissioner information identifying some or all of its clients and any other information about the licensee's services to the clients.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **$1550.00**. 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 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 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, 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 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

01/07 CMR 3RD VISIT 2697

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: October 7, 8, 9, 10, and 13, 2008

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 _____

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
George Safo, RN, Director of Nursing
Charles Monger, PCA
Esther Geegbae, LPN
Erlinda Pickley, PCA
Josephine Gurley, RN/Owner
Flora McArthur, PCA
Susanna Vourjolo, PCA
Connie Ziaryo, LPN
Amy Kuehn- RX Express Pharmacy
Romato Cooma, LPN
Tammy Perin, Pharmacy Technician
Nate Seidhahn, Pharmacist

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #4 ___

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 survey conducted on November 26, 27, 28, 29, 30, 2007 and December 1, 3, 4, 5, 11, 12, 2007 and subsequent follow up visits conducted on March 17, 18, 19, 20, 2008, May 12, 13, and 14, 2008, and August 13, 14 and 15, 2008. 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 orders issued as a result of a follow up visit made on May 12, 13, and 14, 2008 and not corrected at a subsequent follow up visit made on August 13, 14 and 15, 2008 is as follows:

1. MN Rule 4668.0012 Subp. 15 Not Corrected No Fine

Based on record review and interview, the agency failed to provide representatives of the commissioner access to portions of client records for one of two client's (D3) records reviewed at site D. The findings include:

Client D3 had a physician's order form dated September 15, 2008, that included an order to check the client's blood glucose four times a day, and administer Novolin insulin per a sliding scale based on the client's blood glucose results. The client left the facility Monday, Wednesday and Fridays for dialysis and was gone from the facility from approximately 9:00 a.m.-3:00 p.m. Documentation on the client's October 2008 medication administration record indicated that the client's blood glucose was not checked at noon on October 1, 3, 6, and 7, 2008 and no insulin was given. When interviewed October 8, 2008 at 9:30 a.m. the nurse stated that he/she thought that the client had a physician's order to omit checking the client's blood glucose and insulin per the sliding scale on the days he went to dialysis, because the employees at dialysis would not "have anything to do with his insulin." The nurse stated he/she would look for the order. At 10:15 a.m. on October 8, 2008, the nurse was questioned if he/she found the physician's order to omit the client's noon blood glucose check/insulin coverage on days he went to dialysis. The nurse stated he/she looked at the records that were kept at the facility, and it was not there, but stated he/she had called at nurse at site C, who was checking for the physician's order at another house where they kept more records. At 10:55 a.m. on October 8, 2008, the nurse was questioned if she heard from the site C nurse concerning the client's blood glucose check/insulin order. The nurse stated that he/she was "suppose to get a fax from (site C nurse) with the order." The requested information was not received when the reviewer left the facility at 11:30 a.m. The reviewer went back to the facility at 3:30 p.m. October 8, 2008 the nurse stated he/she never received a fax from the site C nurse concerning an order to omit checking client D3's blood sugar and insulin coverage at noon on the days he went to dialysis.

3. MN Statute 144A.44 Subd. 1 (2) Not Corrected $500.00

Based on record review and interview, the licensee failed to ensure care and services were delivered according to accepted nursing standards for five of five clients' (C3, D3, I1, G1, and D6) records reviewed. The findings include:

Client C3's record contained a physician's order dated September 24, 2008 for blood glucose monitoring to completed every six hours, with Novolog insulin to be administered according to a sliding scale based on the client's blood glucose results. A portion of the physician ordered sliding scale of insulin read that if the client's blood glucose was 71-119, no units of Novolog insulin were to be administered. If the client's blood glucose was 120-149, one unit of Novolog insulin was to be administered. If the client's blood glucose was 150-199, two units of Novolog insulin were to be administered. On September 26, 2008 at 12:00 a.m., the client's blood glucose was 187. No insulin was documented as being administered, when according to the sliding scale; two units of insulin should have been administered. On October 1, 2008 at 6:00 p.m., the client's blood glucose was

documented as 163 and one unit of Novolog insulin was administered. According to the sliding scale, two units should have been administered. On October 4, 2008, at 6:00 a.m., the client's blood glucose was 137, and it was documented that no units of insulin were given. According to the sliding scale, the client should have received one unit of Novolog insulin. When interviewed, October 7, 2008, the nurse confirmed that incorrect doses of insulin were administered to client C3. The nurse stated he/she did not know why the incorrect doses were given, but that one of the nurses who made one of the errors was a "new nurse."

Client C3's record contained a physician's order dated September 24, 2008, for Puralube to both eyes every fours for a lubricant. The client's medication administration record for September 2008 indicated that the client received the eye ointment only one time a day. When interviewed on October 7, 2008 the nurse stated he/she did not know why the eye ointment was set up to be administered only one time a day on the September 2008 medication administration record. The nurse stated, "I know we have been giving it every four hours. We have to have been giving it."

Client C3 was on a mechanical ventilator for respiration and had his temperature, blood pressure, and pulse monitored every four hours. The client received Metoprolol (an antihypertensive medication) 25 milligrams twice a day. A nursing order was documented on the client's October 2008 medication administration record, to not administer the Metoprolol if the client's systolic blood pressure was less than 100. Documentation indicated that the client's blood pressure on October 1, 2008 at 8:00 p.m. was 99/54, on October 2, 2008 at 8:00 p.m. it was 98/63., and on October 4, 2008 at 8:00 p.m. the client's blood pressure was 88/48. The client's Metoprolol was not administered on October 4, 2008 at 8:00 p.m. When asked, October 8, 2008, as to whether or not the client's physician was notified of the client's low blood pressures at 8:00 p.m., and the need to hold the client's Metoprolol on October 4, 2008, the nurse stated that a physician had not been notified, and that client C3 had not had a primary physician since he was admitted on September 24, 2008, due to an inability to find one for the client.

Client D3 physician's order form dated September 15, 2008, included an order to check the client's blood glucose four times a day, and administer Novolin insulin per a sliding scale based on the client's blood glucose results. The client left the facility Monday, Wednesday and Fridays for dialysis and was gone from the facility from approximately 9:00 a.m. to 3:00 p.m. The client's October 2008 medication administration record indicated that the client's blood glucose was not checked at noon on October 1, 3, 6, and 7, 2008 and no insulin was given. When interviewed October 8, 2008 at 9:30 a.m. the nurse stated that she thought that the client had a physician's order to not check the client's blood glucose and give insulin per the sliding scale on the days he goes to dialysis, because the employees at dialysis would not "have anything to do with his insulin." The nurse was unable to find a physician's order to not check the client's blood glucose and administer insulin per sliding scale.

Client I1 had a physician's order dated September 18, 2008 for Bupropion HCL 75 mg tablet, take two tablets (150) milligrams (mg) per G-tube daily. Client I1's Bupropion HCL 75 mg bubble pack card was noted on the back that the Bupropion expired September of 2008. The client's medication administration record for October 2008 indicated that the client had received the expired medication on October 1 through 7, 2008. When interviewed, the nurse at site D was not aware the medication was expired. The nurse removed the medication from the container, and ordered a new card of Bupropion HCL 75 mg medication from the pharmacy for client I1.

Client G1's service agreement dated September 5, 2008 indicated the client received unlicensed direct caregiver (PCA) services 24 hours a day. The PCA care plan dated September 5, 2008 indicated the PCA was to administer the client's medications. The unlicensed direct caregiver signed her initials for administering medications to the client on October 6 and 7, 2008 on the PCA/home health aide (HHA) weekly charting for client G1. The client's October 2008 medication and treatment records had the initials "CZ" documented as administering all the client's medications until October 15, 2008. When interviewed October 10, 2008 the nurse stated she set-up the client's medications but the unlicensed direct caregivers administered the client's medications.

Client D6 had a diagnosis of muscular dystrophy, vertebral fusion, and was ventilator dependent. Client D6 began receiving services from the licensee September 15, 2008. The client received total care, medication administration, central storage of medications and ventilator monitoring from the licensee. The client had discharge orders from her prior placement dated September 29, 2008 which were used as admission and current orders. The orders included artificial tears 1% two drops in both eyes every two hours as needed. When observed October 8, 2008 the medication in the client's medication box was 1.4% not the 1% as ordered. Client D6's September and October 2008 administration records (MAR) listed the Akwa tears as 1.4%. When interviewed October 7, 2008 the site D nurse stated she thought the 1.4% was the correct strength and indicated she had not noticed the discrepancy or checked the medications against the orders. When interviewed October 7, 2008 the prescribing pharmacist stated "that's a med. error." He confirmed the medication had been dispensed in the wrong strength.

The status of the correction orders issued as a result of a follow-up visit made on August 13, 14, and 15, 2008 is as follows:

1. MN Rule 4668.0150 Subp. 4 Not Corrected $350.00

Based on record review and interview, the licensee failed to have complete medication records for one of two clients' (#D6) records reviewed at site D. The findings include:

Client D6 had a diagnosis of muscular dystrophy, vertebral fusion, and was ventilator dependent. Client D6 began receiving services from the licensee September 15, 2008. The client received total care, medication administration, central storage of medications and ventilator monitoring from the licensee. The client had discharge orders from her prior placement dated September 29, 2008 which were used as admission and current orders. The orders included Klonopin 2 milligrams (mg.) by mouth twice daily as needed (PRN), Acetaminophen 650 mg. by mouth every six hours as needed, Imodium 2 mg. by mouth one time as needed (recurring), Tylenol PM extra strength take 1-2 tablets by mouth at bedtime as needed, artificial tears 1% two drops in both eyes every two hours as needed, Dulcolax suppository 10 mg. rectally daily as needed, Nystatin powder apply to skin twice daily as needed, Zofran ODT 4 mg by mouth three times daily as needed, and Compazine 5 mg. by mouth every six hours as needed. The orders did not contain an indication for use for the as needed medications and the record did not indicate the area(s) Nystatin powder was to be used on. When interviewed October 7, 2008 the site D nurse confirmed that there were no indications for use for the medications.

2. MN Rule 4668.0160 Subp. 2 Not Corrected $100.00

Based on record review and interview, the licensee failed to maintain a secure record for one of two clients' (D2) records reviewed at site D. The findings include:

Client D6 had a diagnosis of muscular dystrophy, vertebral fusion, and was ventilator dependent. Client D6 began receiving services from the licensee September 15, 2008. The client received total care, medication administration, central storage of medications and ventilator monitoring from the licensee. Client #D6's record contained a release of information document dated September 15, 2008 that was signed by the owner/registered nurse. The document had all listed areas for release of records checked as okay to release records. The document, as well as all others in the record, was unsigned by the client. The client record indicated that on October 1, 2008 a massage therapist was contacted by staff and on October 7, 2008 an acupuncturist and a massage therapist were contacted by staff and client information was relayed in an effort to procure massages for the client. The record also contained a note from the owner/RN dated September 15, 2008 which read that the "client refuses to sign states that she will sign at a later date when she has time to read all documents thoroughly." When interviewed October 7, 2008, client D6 stated she had asked several times for the forms to be brought to her for review and that she had questions about "only a few of them." She stated she asked the nurse who completed her admission many times but "she just never brings them or has time to answer my questions." When asked if she had agreed to the areas of release of records marked on her form she said no while shaking her head side to side. She added 'That makes me mad, I'd never agree to all that." When interviewed October 7, 2008 the site D nurse stated she had placed a call to arrange massages and told the masseuse that the massages were for a client with muscular dystrophy. The nurse confirmed the release was unsigned and stated the registered nurse that completed the form would have to answer any further questions about the form.

3. MN Rule 4668.0160 Subp. 6 Not Corrected $100.00

Based on record review and interview, the licensee failed to ensure that the client's records were complete for two of five clients' (C3, and I1) records reviewed. The findings include:

Client C3 began receiving services from the licensee on September 24, 2008. There was no service agreement in the client's record. When interviewed October 7, 2008, the nurse confirmed there was no service agreement in the client's record and stated that he had given the client's service agreement to the client's representative to review and sign, and had not received it back yet. When questioned if he/she retained a copy of the service agreement that he/she had given to the client's representative, the nurse stated that he/she had not.

Physician orders dated July 27, 2008 lacked a client name on the order. When interviewed October 8, 2008 the nurse confirmed the client's name was not on the order and indicated the physician's order was for client I1.

4. MN Rule 4668.0220 Subp. 8 Not Corrected $500.00

Based on record review and interview, the agency failed to provide representatives of the commissioner access to portions of client records for one of two client's (D3) records reviewed at site D. The findings include:

Client D3 had a physician's order form dated September 15, 2008, that included an order to check the client's blood glucose four times a day, and administer Novolin insulin per a sliding scale based on the client's blood glucose results. The client left the facility Monday, Wednesday and Fridays for dialysis and was gone from the facility from approximately 9:00 a.m.-3:00 p.m. Documentation on the client's October 2008 medication administration record indicated that the client's blood glucose was not checked at noon on October 1, 3, 6, and 7, 2008 and no insulin was given. When interviewed October 8, 2008 at 9:30 a.m. the nurse stated that he/she thought that the client had a physician's order to omit checking the client's blood glucose and insulin per the sliding scale on the days he went to dialysis, because the employees at dialysis would not "have anything to do with his insulin." The nurse stated he/she would look for the order. At 10:15 a.m. on October 8, 2008, the nurse was questioned if he/she found the physician's order to omit the client's noon blood glucose check/insulin coverage on days the client went to dialysis. The nurse stated he/she looked at the records that were kept at the facility, and it was not there, but stated he/she had called a nurse at site C, who was checking for the physician's order at another house where they kept more records. At 10:55 a.m. on October 8, 2008, the nurse was questioned if he/she heard from the nurse at site C concerning the client's blood glucose check/insulin order. The nurse stated that he/she was "suppose to get a fax from (the nurse at site C) with the order." There was no physician's order to omit the client's noon blood glucose check/insulin coverage on days he went to dialysis when the reviewer left the facility at 11:30 a.m. The reviewer went back to the facility at 3:30 p.m. October 8, 2008 to pick up requested information for other clients. The nurse stated he/she never received a fax from the nurse at site C concerning an order to omit checking client D3's blood sugar and insulin coverage at noon on the days he went to dialysis.

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 an on-site visit, MDH nurses will interview staff, clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to describe 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 may 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.

Name of Class A Licensee: CAREMAXX HEALTH CARE SYSTEMS

HFID #: 21374

Date(s) of Survey: October 7, 8, 9, 10, and 13, 2008

Project #: QL21374003

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 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 contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 4 _X_ New Correction Order issued _X_ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 4 _X_New Correction Order issued _X_Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 4 _X_New Correction Order issued _X_Education Provided
4. The provider maintains and protects client records. **Focus Survey** • MN Rule 4668.0160 **Expanded Survey** [Note: See Informational Bulletin 99-11 for Class A variance for	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded

Indicators of Compliance	Outcomes Observed	Comments
Electronically Transmitted Orders. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 4 _X_ New Correction Order issued _X_ Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
Services setting with regards to medication administration, storage and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		**Follow-up Survey** # 4 X New Correction Order issued X Education Provided
7. The provider is licensed and provides services in accordance with the license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 Subp. 3 • MN Rule 4668.0012 • MN Rule 4668.0060 Subp. 2 and 6 • MN Rule 4668.0180 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• 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 reflect services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 4 X New Correction Order issued X Education Provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings, of the focused survey may result in an expanded survey.

SURVEY RESULTS: ____ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0016 Subp. 8:
Waiver 99-7: MN Rule 4668.0865 Subp.8 requirement not met

INDICATOR OF COMPLIANCE: # 8
INDICATOR OF COMPLIANCE: 6

Based on observation, interview, the agency failed to follow the conditions of the Class A Variance/Waiver for Central Storage of Medications which was approved by the Minnesota Department of Health in July 1999. The agency is licensed as a Class A Home Care Provider in accordance with the definition of MN rule 4668.0003 Subpart 11 and was granted a waiver under MN Rule 4668.0100 Subp. 3. The agency failed to ensure that the waiver requirements of MN Rule 4668.0865 Subp. 8 were followed in that the agency failed to assure that all medications were stored in a locked compartment in two of three sites (C and H) visited. The findings include:

On October 8, 2008 at 8:00 a.m. at site C, the central storage of refrigerated medications was reviewed. The following medications for client C3 were observed to be stored in the door of an unlocked common use refrigerator along with food items; two bottles of liquid Neurontin, a vial of Lantus insulin, and a vial of Novolog insulin. When interviewed, October 8, 2008, the nurse confirmed that the clients' medications needing refrigeration were kept in the kitchen refrigerator that was unlocked.

On October 8, 2008, at 1:30 p.m. at site H, the central storage of refrigerated medications was reviewed. Client G1's insulin was observed to be stored in a common use refrigerator in a box that was not locked. When interviewed October 8, 2008 an unlicensed staff stated that the box was lockable, and attempted several times with the reviewer present, to lock it with a key. The box would not lock.

2. MN Rule 4668.0016 Subp. 8
Waiver 99-7: MN Rule 4668.0865 Subp. 9

INDICATOR OF COMPLIANCE: # 8
INDICATOR OF COMPLIANCE: 6

Based on observation, and interview, the agency failed to follow the conditions of the Class A Variance/Waiver for Central Storage of Medications which was approved by the Minnesota Department of Health in July 1999. The agency is licensed as a Class A Home Care Provider in accordance with the definition of MN rule 4668.0003 Subpart 11 and was granted a waiver under MN Rule 4668.0100 Subp. 3. The agency failed to ensure that the waiver requirements of MN Rule 4668.0865 Subp. 9 were followed in that the licensee failed to provide locked affixed storage for schedule II drugs in two of two sites (C and D) visited that had Schedule II medications. The findings include:

On October 8, 2008 at 8:15 a.m. the central storage of Schedule II medications were reviewed at site C. Schedule II medications such as Morphine Sulfate and Duragesic patches were stored in a locked safe on a shelf in the medication cabinet. The locked safe was not permanently affixed to the physical plant, and could be removed from the shelf and placed on the kitchen counter. When interviewed on October 8, 2008, the nurse confirmed that this was where Schedule II medications were stored for clients residing at site C.

During a review of medications at site D on October 7, 2008 the central storage of Schedule II medications were observed. They were stored in a closet in locked safe on top of a small refrigerator. The locked safe was not permanently affixed to the physical plant, and could be removed. When interviewed on October 7, 2008, the nurse confirmed that this was where Schedule II medications were stored for clients residing at site D. When interviewed on October 7, 2008, the nurse confirmed that the locked box was not permanently affixed to the physical plant.

3. MN Rule 4668.0030 Subp. 3

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview the licensee failed to ensure that the Minnesota Home Care Bill of Rights was provided to each client prior to services being initiated for one of one client (C3) records reviewed at site C. The findings include:

Client C3 began receiving services from the licensee on September of 2008. There was no evidence in the client's record which was reviewed on October 7, 2008, that the client/client's representative received a copy of the Minnesota Home Care Bill of Rights. When interviewed on October 7, 2008, the nurse confirmed there was no evidence that the client/client's representative received a copy of the bill of rights, but stated that he/she had given the client's representative the admission information, which included a copy of the bill of rights, and had not received it back yet. The client's representative was interviewed on October 7, 2008, and stated she had received a packet of admission information including the bill of rights, but not until Friday October 3, 2008. On October 8, 2008, a nurse gave the reviewer a copy of an acknowledgement that the client's representative received a copy of the bill of rights. This document was dated September 24, 2008, although the client's representative confirmed she did not receive this document until October 3, 2008. When questioned on October 10, 2008, regarding why the date did not reflect when the client's representative received the information, the nurse stated the September 24, 2008 date was written in when the documents were prepared.

4. MN Rule 4668.0060 Subp. 3

INDICATOR OF COMPLIANCE: # 1

Based on observation, record review and interview, the licensee failed to ensure that services required by the client's service agreement were completed for one of two clients' (#D6) records reviewed at site D. The findings include:

Client D6 had a diagnosis of muscular dystrophy, vertebral fusion, and was ventilator dependent. Client D6 began receiving services from the licensee September of 2008. The client received total care, medication administration, central storage of medications and ventilator monitoring from the licensee.

Client D6's record contained a service agreement dated September of 2008. The plan indicated the client received registered nurse (RN) and licensed practical nurse (LPN) "complex" services 12 hours daily for each. On October 7, 2008, an unlicensed caregiver DD accompanied this reviewer into client D6's room. Employee DD stated "I take care of (client D6)." She showed this reviewer the client's room and explained the client cares, preferences, and personality. The employee was detailed indicating the client did not like to be touched much, had pain when s/he attempted range of motion especially to her left knee and right shoulder, and the client liked to read and browse catalogs. S/he stated s/he changed the client's incontinent pads, washed the client, answered the client's calls and a bell the client will occasionally hold and shake to ring. The employee indicated s/he attended to the client's basic care needs on a regular basis when working at site D which was the employee's assigned work site. When interviewed October 7, 2008 the client confirmed employee DD regularly did many cares for her. The client flow sheets and care sheets were all completed and signed by nurses. October 7, 2008 at 4:15 PM employee DD approached this reviewer and stated "I was mistaken. I'm just here to take people to appointments. I was told to tell you that." October 8, 2008 employee DD stated s/he was a cleaner. When asked what was cleaned s/he stated "mopping floors." The nurse was sitting in the area and stated the employee mopped and did transportation only. When asked what product s/h used to mop, as the floors had scuff marks and bits of white dusty debris in the corners, employee DD replied "Tide.' S/he then stated "all purpose cleaner," When asked what kind of all purpose cleaner, the employee was unable to answer. This reviewer asked the employee to "show me" instead. The employee went upstairs to the main floor, checked two sets of cabinets in the laundry room where a mop bucket and Tide detergent was located. Then s/he checked two sets of cabinets in a bathroom. She came into the living room with a puzzled look, scanned the dining room and kitchen, after another hesitation s/he walked to the kitchen and opened the cabinet below the sink that s/he had passed twice before. S/he located a bottle of cleaner and happily said this was the cleaner. When asked how much was needed for the mop large commercial sized bucket in the house she was unable to answer. After some thought s/he said "a little bit."

5. MN Rule 4668.0140 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to enter into a written service agreement with the client/client's responsible person in a timely manner for one of one client's record reviewed who was newly admitted to site C. The findings include:

Client C3 began receiving services from the licensee on September of 2008, which included complex registered nurse care and licensed practical nursing care twenty-four hours a day. There was no written service agreement in the client's record, when the client's record was reviewed on October 7, 2008. When interviewed on October 7, 2008, the nurse confirmed there was no service agreement in the client's record and stated that s/he had given the client's service agreement to the client's representative to review and sign, and had not received it back yet. When questioned if s/he retained a copy of the service agreement that s/he had given to the client's representative, the nurse stated that s/he had not. When interviewed October 7, 2008 the client's representative stated that client C3's service agreement had been given to her for review and signature, but not until October 3, 2008. On October 8, 2008, the nurse gave the reviewer a copy of a form titled "Service Agreement" for client C3. The service agreement was not signed. When interviewed on October 10, 2008, the nurse confirmed that client C3's

service agreement was not signed by the client's representative. The nurse stated "it must have been overlooked."

6. MN Rule 4668.0140 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview, the licensee failed to ensure that service agreements were complete for three of five clients' (C3, G1, and D6) records reviewed. The findings include:

Client C3 began receiving services from the licensee on September of 2008. The client did not have a signed service agreement no later than the second visit in his record when reviewed on October 7, 2008, although on October 8, 2008 a form titled "Service Agreement" for client C3 was provided to the reviewer. This form did not include the fee for the services provided. When interviewed on October 10, 2008, the nurse confirmed that the fees for services were blank on the service agreement, and stated that he/she did not know why they were not listed on the service agreement.

Client G1's service agreement was dated September of 2008. The client's record indicated the nurse was setting up his medications weekly in a weekly medi-set container. Weekly medication set-up by the nurse was not included on the client's service agreement. When interviewed October 10, 2008 the nurse agreed that weekly medication set-up was a service they provided for the client, and that it was not on the client's service agreement.

Client D6 had a diagnosis of muscular dystrophy, vertebral fusion, and was ventilator dependent. Client D6 began receiving services from the licensee September of 2008. The client received total care, medication administration, central storage of medications and ventilator monitoring from the licensee. Client D6's record contained a service agreement dated September of 2008. The plan indicated the client received registered nurse (RN) and licensed practical nurse (LPN) "complex" services 12 hours daily for each. It also read "(see nsg. care plan)" The service agreement did not identify the services to be done or the frequency of services or ,a contingency plan. The care plan had check marks by assist with positioning, dressing and read bed bath and check and change. It did not indicate the frequency of services nor did it include ventilator care and monitoring or other services related to the client's need for total care. When interviewed October 8, 2008 the nurse confirmed the service agreement was incomplete.

7. MN Rule 4668.0160 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name, date and title of the person making the entry in two of two clients' (D2 and I1) records reviewed at site D. The findings include:

Client I1's nursing progress notes dated October 1, 2008 through October 7, 2008 lacked either the employee's full name, title of person making entry or both. When interviewed October 10, 2008 the nurse agreed that they needed to document their full name and title.

Client's D6's record contained documents titled, "Client Flow Sheet." This document described the clients' physical functioning and was blank where it would have been signed by the 7 AM to 7 PM staff member on the sheets dated October 1, 4, 5 and 7, 2008. The October 7, 2008 contained a notation in the 12 midnight hourly time area which read "refused/sleeping." All hourly entry lines from 1 AM through 3 PM on October 7, 2008, when the document was reviewed were blank. Client's #D6's record also contained documents titled, "Ventilator Flow Sheet." This document described the clients' ventilator settings and function and was blank where it would have been signed by the 7 AM to 7 PM staff member on the sheets dated October 1, 2, and 3, 2008. The Ventilator Flow Sheets dated October 1, 2, and 3, 2008 also lacked documentation of any settings or functions for the 8 AM through 6 PM hourly times. When interviewed, October 8, 2008 the nurse confirmed the afore mentioned flow sheets were incomplete

8. MN Statute §626.557 Subd. 14(b)

INDICATOR OF COMPLIANCE: # 3

Based on record review, the licensee failed to develop an individual abuse prevention plan for one of two clients' (D6) records reviewed at site D. The findings include:

Client D6 had a diagnosis of muscular dystrophy, vertebral fusion, and was ventilator dependent. Client D6 began receiving services from the licensee September 15, 2008. The client received total care, medication administration, central storage of medications and ventilator monitoring from the licensee. Client D6's record contained a "Vulnerable Adult Assessment dated September 15, 2008 by the owner/ registered nurse. It identified that the client was non-ambulatory, wheelchair bound, and a paraplegic. It did not indicate the client was ventilator dependent nor did it not contain any plan for the identified areas of vulnerability. Client D6 had an abuse prevention plan that was not dated or signed by the person who prepared it. It read that "Staff involved in plan included three nurses including the owner/registered nurse. It identified Obesity, immobility and depression/anxiety as risks. The plan did not contain an assessment of the physical plant and its factors that may permit abuse or from others. When interviewed September 8, 2008 the site D nurse confirmed there was no individual abuse prevention plan.

A draft copy of this completed form was left with Josephine Gurley, RN/Owner, at an exit conference on October 13, 2008. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. 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 review, this form will be posted on the MDH website. CLASS A Licensed-only Home Care Provider general information is available by going to the following web address and clicking on the Class A Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0001 1713 6536

September 26, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
5701 Shingle Creek Parkway 110
Brooklyn Park, MN 55430

Re: Licensing Follow Up visit

Dear Ms. Gurley:

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 August 13, 14, and 15, 2008.

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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

Division of Compliance Monitoring • Case Mix Review
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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 CLASS A HOME CARE PROVIDERS

September 26, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
5701 Shingle Creek Parkway
Brooklyn Park, MN 55430

RE QL21374003:

Dear Ms. Gurley:

1.On August 13, 14, and 15, 2008, 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 issued as a result of follow up visits to an original survey completed on November 26, 27, 28, 20, 30, 2007, and December 1, 3, 4, 5, 11, 12, 2007, and subsequent follow up visits made on March 17, 18, 19, and 20, 2008, and May 12, 13, and 14, 2008, with correction orders received by you on December 28, 2007, April 24, 2008, and July 12, 2008 and found to be uncorrected during an inspection completed on August 13, 14, and 15, 2008.

As a result of correction orders remaining uncorrected on the May 12, 13, and 14, 2008 re-inspection, a penalty assessment in the amount of **$700.00** was imposed on July 8, 2008.

2. On August 13, 14, and 15, a 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 issued as a result of a survey completed on May 12, 13, and 14, 2008, which were received by you on July 12, 2008.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on August 13, 14, and 15, 2008:

1. MN Rule 4668.0012 Subp. 15 **No Fine**

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Based on interviews and record review, the licensee failed to provide representatives of the commissioner access to portions of client records. The findings include:

Reviewers arrived at site A at 11:30 am on May 12, 2008. At 11:55 am Nurse IE arrived at site A and she informed the reviewers, the owner, sent her to the facility to assist the reviewers. Nurse IE was given the current and discharged client rosters to fill out with specific instructions to list on the discharge and admission rosters; all discharged and admitted clients since the January 2008, including the location the clients had been discharged to, and all deaths that had occurred. The reviewers requested that the client roster list would be received by 2 pm on May 12, 2008. The reviewers also requested the complete client records for the two clients at site A. Clients A6 and I3 residing at site A began receiving services from the agency December 28, 2007 and September 17, 2007, respectively. Nurse IE left site A. At 12:10 pm on May 12, 2008, the reviewers telephoned nurse IE again requesting the client records. She stated the records were at the office because she had been auditing them. The reviewers requested that she bring the client records to site A.

At 12:35 pm on May 12, 2008, the reviewers telephoned nurse IE and informed her that the reviewers would be leaving site A to go to another residence since she had not provided the records as requested for site A. Nurse IE stated said that she was driving and she would be at site A shortly.

At 1:00 pm on May 12, 2008, the reviewer telephone nurse IE requesting the records. Nurse IE informed the reviewer she had been in a car accident and she was finishing up and would be coming to site A.

At 1:20 pm on May 12, 2008, nurse IE arrived at site A with portions of the requested two client records. The client records provided were incomplete and did not contain any supervisory visits. Provided were current documents such as physician orders, medication administration records, and personal care attendant documentation sheets for May, 2008.

At 1:50 pm on May 12, 2008, the reviewers requested the supervisory visits for site A and again the client rosters from nurse IE. Nurse IE stated those documents were at the office and she stated she called the owner inquiring about the requested documents.

At 2:42 pm on May 12, 2008, the reviewers telephoned nurse IE and repeated the request for the rosters and supervisory visits.

At 3:55pm on May 12, 2008, nurse IE returned to site A without the client rosters and supervisory visits. Nurse IE telephoned the owner. At this time the reviewer spoke with the owner and directly requested the rosters and supervisory visits from the owner. The owner told the reviewer if the reviewer would quit talking to her on the phone she could complete the forms. After 4:00 pm on May 12, 2008, employee MF, an unlicensed care staff (PCA), called the reviewers' supervisor and informed the supervisor the rosters were done. The supervisory visits were not provided.

The reviewers arrived at site J at 3:05 pm on May 13, 2008. The reviewers telephoned nurse IE the designated contact person, and requested the supervisory visits for sites A and J and for the client rosters that were said to have been readied the prior afternoon. At 3:35 pm on May 13, 2008, nurse IE arrived at site J with no rosters or supervisory visits. At 4:09 pm on May 13, 2008, twenty-eight hours and thirty

minutes after the initial request, for the client rosters, the client rosters. The supervisory visits for clients at site J were sent to site J via the fax machine. The agency failed to provide documentation of the supervisory visits for site A.

At 8:23 am on May 14, 2008, the reviewer telephoned the owner and requested the complete record for client A5, since admission to the agency on February 11, 2008 to be delivered to site I. The request included nursing notes, supervisory visits, PCA notes, medication sheets, prescriber orders, and service plans. At 11:40 am on May 14, 2008, the reviewers arrived at site I and inquired of nurse IM and PCA (IH), if records for client A5 had been delivered to the house. They both stated no. An attempt was made to contact the owner IE by telephone, but a voice mail message was received and the voice mailbox would not accept any messages.

At 11:45 am on May 14, 2008 the reviewer telephoned the Caremaxx office and spoke with employee MF. The reviewer told employee MF they were looking for the owner FG and the requested records. MF stated she had not seen the owner yet that day, but that she would forward the message to her.

At 11:51am on May 14, 2008, the owner was telephoned. Again a voice mail message was received and the voice mailbox would not accept any messages. At 11:52 am on May 14, 2008, the reviewer telephoned the Caremaxx office to inquire if the driver had the requested records and would deliver the records to site I. At 11:56am on May 14, 2008 the reviewer telephone the Caremaxx office and was informed that the owner FG was gathering client A5's paperwork and she'd drop it off at site I.

At 12:40pm on May 14, 2008 no records had been delivered to site I and the reviewers left the site.

TO COMPLY: The commissioner may deny renewal of a license, or may suspend, revoke, or make conditional a license, if the licensee, or an owner or managerial official of the licensee:

A. is in violation, or during the term of the license has violated, any of the requirements of this chapter or Minnesota Statutes, sections 144A.43 to 144A.47;

B. permits, aids, or abets the commission of any illegal act in the provision of home care;

C. performs any act detrimental to the welfare of a client;

D. obtained the license by fraud or misrepresentation;

E. knowingly made or makes a false statement of a material fact in the application for a license or in any other record or report required by this chapter;

F. denies representatives of the commissioner access to any part of the provider, its books, records, or files, or employees;

G. interferes with or impedes a representative of the commissioner in contacting the provider's clients;

H. interferes with or impedes a representative of the commissioner in the enforcement of this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

I. destroys or makes unavailable any records or other evidence relating to the licensee's compliance with this chapter and Minnesota Statutes, sections 144A.43 to 144A.47;

J. refuses to initiate a background study under Minnesota Statutes, section 144.057 or 245A.04; or

K. has failed to timely pay any fines assessed under part 4668.0230 or 4668.0800, subpart 6

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: No Fine

3. MN Statute 144A.44 Subd. 1 (2) **$250.00**

Based on record review and interview, the licensee failed to ensure medications were received as ordered for one of two clients (I3) reviewed at site A and one of two clients (J3) reviewed at site J. The findings include:

Clients I3's record contained a physician's order dated April 16, 2008 for Darvocet N-50 to be administered four times per day. The May 2008 medication administration record did not contain documentation Darvocet N-50 had been administered from May 1, 2008 through May 12, 2008. The client's medi-set for the week starting of May 9, 2008 was observed and it did not contain any Darvocet N-50. When interviewed on May 12, 2008 nurse IE stated the Darvocet N-50 was intended to be ordered as a PRN (as needed) order and she had contacted the physician "recently," to get the order changed to PRN, but she had not yet received the order change. The nurse also stated she was unable to recall when she had called for the order change.

The medications in client I3's medi set-up for the week starting May 9, 2008, were counted by the reviewer and nurse IE on May 12, 2008. The medi-set contained thirteen pills in the 8am box and eight pills in the 8pm box. According to the document titled, "Number of tablets to be give (sic) to client by PCA" the client's medi-set was to contain twelve tablets in the 8am box and seven pills in the 8pm box. According to policy and interview, the medications in each client's medi-set box were counted at the start and end of each care attendant's shift. If there was a discrepancy in the count of the medications between the medi-set and the number of medications recorded on the document titled "Number of tablets to be give (sic) to client by PCA," the nurse was to be notified. When interviewed on May 14, 2008, unlicensed care giver (PCA) AH stated he had counted the medications according to policy, but he had not called any nurse with the discrepancy in the number of the medications, since the owner of the agency, had been in the facility on May 12, 2008 and had changed the number of the medications listed on the aforementioned document. The document was reviewed and it was noted for the week of May 9, 2008, the number of medications entered on the document was thirteen and there was a slash mark through the number thirteen and the number twelve had been written for 8am time slot. The number of medications entered on the document for 8pm was eight and there was a slash mark through that number and the number seven had been written in the 8pm time slot on the document. The client's

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current physician orders dated April 19, 2008 were reviewed and the correct numbers of medications to be administered at 8am were fourteen pills and nine pills at 8pm.

The reviewer and nurse IE counted the contents of client J3's medi-set on May 13, 2008. The client's medi-set contained Metoprolol ER 100 mg for May 13 and May 14, 2008. Documentation on the May medication administration record completed by the owner of the agency indicated no Metoprolol ER 100 mg had been put into the client's medi-set for May 13 and 14, 2008. On the May 2008 medication administration record, the client's Metoprolol ER 100mg. was circled for May 12, 13 and 14, 2008, indicating the medication had not been set up in the medi-set. The medi-set contained the correct number of medications according to the current physician orders.

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 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $250.00

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **$250.00**. 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 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 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, 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 651-201-4301.

September 26, 2008

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: August 13, 14 and 15, 2008

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:
Josephine Gurley, RN, Owner
Connie Ziralyo, LPN
Rebecca Kassera, PCA
Theresa Tay, PCA

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: # 3 ___

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 survey conducted on November 26, 27, 28, 29, 30, 2007 and December 1, 3, 4, 5, 11, 12, 2007 and not corrected at subsequent follow up visits conducted on March 17, 18, 19, 20, 2008 and May 12, 13, and 14, 2008. 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 orders issued as a result of a visit made on November 26, 27, 28, 29, 30, 2007 and December 1, 3, 4, 5, 11, 12, 2007 and not corrected at subsequent follow up visits conducted on March 17, 18, 19, 20, 2008 and May 12, 13, and 14, 2008, is as follows:

1. MN Rule 4668.0060 Subp. 3 Corrected

The status of the correction orders issued as a result of a follow up visit made on May 12, 13, and 14, 2008 is as follows:

1. MN Rule 4668.0012 Subp. 15 **Not Corrected** **No Fine**

Based on interviews and record review, the licensee failed to provide representatives of the commissioner access to portions of client records for one of three (H1) records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008 after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. The client's May medication administration records noted that numerous medications had been changed on May 1, 2008. The medication changes noted on the May medication administration record dated May 1, 2008 were for Protonix, Clozapine, Akwa tears, Certagen, Glucosamine & Chondroitin, Mag-Ox, and Ditropan. When the client's record was reviewed on August 13, 2008 a medication error was noted by this reviewer. The May 2008 physician orders were requested from the agency owner on August 14, 2008 at 3:30 pm so the order changes could be verified. It was requested that the May 2008 orders be available for review, in addition to other requested documents no later than the following day by 11:00 am. On August 15 around 2:00 pm, the requested documents were said to have been provided but did not contain any May 1, 2008 physician orders for client H1. Also there were no original documents provided from the hospital, nursing home or physician, only documents from Caremaxx. When interviewed on August 15, 2008 at approximately 1:20 pm, licensed nurse IE stated she thought the physician orders were at another office. No information was available at 3:00pm when the reviewers left the facility.

2. MN Rule 4668.0100 Subp. 9 **Corrected**

3. MN Statute 144A.44 Subd. 1 (2) **Not Corrected** **$250.00**

Based on record review and interview, the licensee failed to ensure medications and treatments were received as ordered for one of one clients (H1) medication records reviewed at site H. The findings include:

Client H1's record contained a physician order dated June 23, 2008, for Mag-Ox (Magnesium Oxide) 400 mg., one tablet to be administered daily. August medication administration records had documentation that 400 mg. of Mag-Ox had been set up in the client's medi-set container twice per day at 8am and 8pm for August 1 through August 16, 2008 for administration by the unlicensed care staff. The client's medi-set container was checked on August 13, 2008, and it contained 400 mg. of Mag-Ox in the 8am and 8 pm time slot for August 14, 2008. There was no evidence any dose of this medication had been given on August 14, 2008. When interviewed on August 14, 2008, licensed nurse IE, stated at the time the order for the once daily Mag-Ox was received, there was an order for Mag-Ox in the computer for twice per day. She said the twice per day order was written on the medication administration records by the pharmacy that prints the licensee's medication administration records for the August administration record. Licensed nurse IE verified that the current physician order was for Mag-Ox to be administered once per day and that medication errors had occurred from August 1 to August 14, 2008.

Client H1 had physician's orders dated May 5, 2008 and June 23, 2008 for lung sounds to be checked every shift. Treatment records for June and July 2008 and the vital signs/communication form for August 2008 documented lung sounds were obtained once daily and the client's lungs were "clear." None of the entries documenting the clear lung sounds had a signature or initials indicating which staff member had assessed the client's lungs. The documentation indicating "clear" for all dates in June, July and August, 2008, appeared to be entered by the same person. When interviewed on August 15, 2008, licensed nurse IE stated she had made the notation "clear" on all of the dates. She stated she worked the day shift twelve out of every fourteen days. She stated that after she had her two days off, when she returned to work, she contacted the nurse that worked her two days off and asked the nurse the results of the client's lung sounds for each day. She then entered the results for those days that she had been off duty. The June and July 2008 treatment record and the August vital signs/communication form, noted the lung sounds were taken once per day rather than the every shift as ordered by the physician.

When interviewed on August 15, 2008, licensed nurse IE stated she worked the day shift and another nurse worked the evening shift. On August 19, 2008, the owner stated there are two shifts with on duty nurses and the third shift is covered by an on-call nurse. Neither the owner nor nurse IE could provide evidence that the lung sounds were done as ordered.

Client H1 also had a current "PCA CARE PLAN" dated February 21, 2008 which indicated the client received total help from unlicensed staff (PCA) for medication assistance and medication administration.. It stated "PCA to administer all medications." In the "CARE RELATED NEEDS" section it read "Apply Metrogel 0.75% to rash around eyes daily." Client H1's record also contained instructions for unlicensed staff written by the owner/registered nurse, dated May 5, 2008 which read "She gets a cream called Metrogel 0.75% apply this cream around eyes daily-make sure you do not touch her eyes while doing this. Go around the eyes. Make sure you apply this after you wash her face as indicated above." A document titled ADMISSION ORDERS ADDITIONS AND CLARIFICATIONS" which was written by the owner/RN dated May 5, 2008 and provided to the reviewers as orders, listed "Akwa Tears-OK to continue? Yes" There was no dosage, frequency route or indication for use of the Akwa tears nor was Metrogel listed on the sheet. The document also contained the listing of eleven other medications that lacked the complete dosage instruction of strength, amount, frequency and/ or indication for use. Client H1's May 2008 medication administration record indicated Akwa tears 1.4% drops instill 1 drop into both eyes twice daily. It was listed for administration at 8 am and 8pm. The entry on the MAR indicated the medication was discontinued May 1, 2008. There was a new entry made on the MAR dated May 5, 2008 for Akwa tears 1.4% one drop in both eyes BID for 8am and 8 pm. The MAR was signed with an "S" at 8 am on May 9, 10, 11, 12 and 13, 2008 and the "S" was lined out. All other times and dates were blank. The May MAR listed "Metrogel 0.75% apply to rash around eyes daily." This was initialed on May 8 and 9, 2008 and then circled as not given. There was no other evidence in the record that the treatment was administered nor was there documentation as to why it was not. The same was so for the Akwa tears.

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 an on-site visit, MDH nurses will interview staff, clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to describe 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 may 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.

Name of Class A Licensee: CAREMAXX HEALTH CARE SYSTEMS

HFID #: 21374

Dates of Survey: August 13, 14 and 15, 2008

Project #: QL21374003

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 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 contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
4. The provider maintains and protects client records. **Focus Survey** • MN Rule 4668.0160 **Expanded Survey** [Note: See Informational Bulletin 99-11 for Class A variance for	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded

Indicators of Compliance	Outcomes Observed	Comments
Electronically Transmitted Orders. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 3 _X_ New Correction Order issued _X_ Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
Services setting with regards to medication administration, storage and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		**Follow-up Survey** # 3 X New Correction Order issued ___Education Provided
7. The provider is licensed and provides services in accordance with the license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 Subp. 3 • MN Rule 4668.0012 • MN Rule 4668.0060 Subp. 2 and 6 • MN Rule 4668.0180 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• 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 reflect services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	**Focus Survey** ___Met ___Correction Order(s) issued ___Education Provided **Expanded Survey** ___Survey not Expanded ___Met ___Correction Order(s) issued ___Education Provided **Follow-up Survey** #___ ___New Correction Order issued ___Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ___Survey not Expanded ___Met ___Correction Order(s) issued ___Education Provided **Follow-up Survey** #___ ___New Correction Order issued ___Education Provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings, of the focused survey may result in an expanded survey.

SURVEY RESULTS: ___ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0150 Subp 4

INDICATOR OF COMPLIANCE # 6

Based on record review and interview, the agency failed to assure medication orders were complete for one of one clients' (H1) medication records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008 after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. A document titled ADMISSION ORDERS ADDITIONS AND CLARIFICATIONS" which was written by the owner/RN dated May 5, 2008 and provided to the reviewers as orders, listed: "Antacid liquid PRN (as needed), Disposable enema Fleet PRN, Ibuprofen 600 mg PRN, Lunesta 2mg. PRN, Milk of Magnesia PRN, Akwa tears, Certagen tab,, Glucosamine & Condrotin, Oxybutin 5mg tab, Zyprexa SD 10 mg vial Inject 10 mg IM if she refuses Clozaril, Proctofoam Hcl-1% foam PRN, APAP 325 mg tabs PRN" and an unreadable reference to "Tylenol." There were no further dosages, names of drug, frequency of administration, or indications for use on the document. When interviewed August 15, 2008, the owner stated these were the medication orders used for client H1 upon return to the agency.

2. MN. Rule 4668.0160 Subp. 2

INDICATOR OF COMPLIANCE # 4

Based on record review and interview, the licensee failed to retain records for portions of client records for one of three (H1) medication records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008 after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. The client's May medication administration records (MAR) noted that numerous medications had been changed on May 1, 2008. The medication changes noted on the May medication administration record dated May 1, 2008 were for Protonix, Clozapine, Akwa tears, Certagen, Glucosamine & Chondroitin, Mag-Ox, and Ditropan. When the client's record was reviewed on August 13, 2008 a medication error was noted by this reviewer. The original May 2008 physician orders were requested from the agency owner on August 14, 2008 at 3:30 pm so the order changes could be verified. It was requested that the May 2008 orders be available for review, in addition to other requested documents no later than the following day by 11:00 am. On August 15 around 2:00 pm, the requested documents were said to have been provided but did not contain any May 1, 2008 physician orders for client H1. Also there were no original documents provided from the hospital, nursing home or physician, only documents from Caremaxx. When interviewed on August 15, 2008 at approximately 1:20 pm, licensed nurse IE stated she thought the physician orders were at another office. No information was available at 3:00pm when the reviewers left the facility.

3. MN Rule 4668.0160 Subp. 6

INDICATOR OF COMPLIANCE # 4

Based on record review and interview, the licensee failed to ensure the licensee failed to ensure services provided to the client were documented in the client's record and that notes summarizing contact with the client were signed by each individual providing the service no later than two weeks after the contact in one of three client records (H1) reviewed at site H. The findings include:

Client H1 had physician's orders dated May 5, 2008 and again on June 23, 2008, indicating the client's lung sounds were to be checked every shift. Treatment records for June and July 2008 and the vital signs/communication form for August 2008 documented lung sounds were obtained once daily and the client's lungs were "clear." None of the entries documenting the clear lung sounds had a signature or initials indicating which staff member had assessed the client's lungs. The documentation indicating "clear" for all dates in June, July and August, 2008, appeared to be entered by the same person. When interviewed on August 15, 2008, licensed nurse IE stated she had made the notation "clear" on all of the dates. She stated she worked the day shift twelve out of every fourteen days. She stated that after she had her two days off, when she returned to work, she contacted the nurse that worked her two days off and asked them the results of the client's lung sounds for each day. She then entered the results for those days that she had been off duty. When interviewed on August 15, 2008, the owner stated she had done the weekend lung sounds. There was no explanation given as to why one nurse would routinely need to call another to document her findings from the weekends.

4. MN Rule 4668.0220 Subp. 8

AREA OF COMPLIANCE: # 7

Based on interviews and record review, the licensee failed to provide representatives of the commissioner access to portions of client records for one of three (H1) records reviewed at site H. The findings include:

Documentation in the progress notes for client H1 indicated the client resumed care from the licensee on May 1, 2008 after the client had been hospitalized and had a short term stay in a nursing home following a hospitalization. The client's May medication administration records noted that numerous medications had been changed on May 1, 2008. The medication changes noted on the May medication administration record dated May 1, 2008 were for Protonix, Clozapine, Akwa tears, Certagen, Glucosamine & Chondroitin, Mag-Ox, and Ditropan. When the client's record was reviewed on August 13, 2008 a medication error was noted by this reviewer. The May 2008 physician orders were requested from the agency owner on August 14, 2008 at 3:30 pm so the order changes could be verified. It was requested that the May 2008 orders be available for review, in addition to other requested documents no later than the following day by 11:00 am. On August 15 around 2:00 pm, the requested documents were said to have been provided but did not contain any May 1, 2008 physician orders for client H1. Also there were no original documents provided from the hospital, nursing home or physician, only documents from Caremaxx. When interviewed on August 15, 2008 at approximately 1:20 pm, licensed nurse IE stated she thought the physician orders were at another office. No information was available at 3:00pm when the reviewers left the facility.

A draft copy of this completed form was faxed to Josephine Gurley, Owner, prior to a telephone exit conference on August 19, 2008. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. 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 review, this form will be posted on the MDH website. CLASS A Licensed-only Home Care Provider general information is available by going to the following web address and clicking on the Class A Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 2203

July 8, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
5701 Shingle Creek Parkway 110
Brooklyn Park, MN 55430

Re: Licensing Follow Up visit

Dear Ms. Gurley:

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 May 12, 13, and 14, 2008.

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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 2203

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

July 8, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
5701 Shingle Creek Parkway 110
Brooklyn Park, MN 55430

RE:QL21374003_2

Dear Ms. Gurley:

1.On May 12, 13, and 14, 2008, 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 issued as a result of a survey completed on November 26, 27, 28, 29, and 30, 2007 and December 1, 3, 4, 5, 11, and 12, 2007, with correction orders received by you on December 28, 2007 and found to be uncorrected during an inspection completed on March 17, 18, and 19, 2008.

As a result of correction orders remaining uncorrected on the March 17, 18, and 19, 2008, re-inspection, a penalty assessment in the amount of **$450.00** was imposed on April 22, 2008.

The following correction orders remained uncorrected at the time of the subsequent re-inspection on May 12, 13, and 14, 2008.

1. MN Rule 4668.0060 Subp. 3 **$700.00**

Based on observations, record review and interviews, the licensee failed to ensure that clients received services agreed to in the service agreement in one of three current clients' records (A3) reviewed at site A, four of five records (D1, D3, D4, and D5) reviewed at site D, one of five records reviewed (F4) at site F, one of four current clients (I4) at site I, and one of four records reviewed (M3) at site M. The findings include:

July 8, 2008

Client A3 began receiving services on March 16, 2007. His service agreement dated March 16, 2007, indicated he was to receive two hours per day of registered nurse (RN) services. The client record for November 2007, lacked documentation to support that an RN provided services two hours per day. When interviewed on November 26, 2007, the RN/owner stated that client A3 received his medications and wound care from RN's or Licensed Practical Nurse's (LPN). The RN/owner stated an LPN was scheduled in the A site daily from 8:00 a.m. to 2:00 p.m. and 5:00 p.m. to 11:00 p.m. When interviewed on November 27, 2007, LPN IE stated that she frequently gets calls to go to site A because a licensed nurse is not available to give client A3 an insulin injection.

Client D1's service agreement dated June 16, 2005, indicated client D1 would be provided with thirteen hours per day of RN services. When interviewed on November 27, 2007, RN DA indicated RN's work twelve hour shifts Monday through Friday with LPN coverage on the weekends. RN DA also indicated client D1 receives unlicensed nursing services daily, which was not identified on the service agreement.

Client D3's service agreement dated May 16, 2006, indicated the licensee would provide three hours per day of RN and LPN services with eighteen hours of unlicensed staff services daily. On November 27, 2007, RN DA reported that RN's work twelve hour shifts Monday through Friday with LPN coverage on the weekends. The licensee was not providing daily RN services on the weekends.

Client D4's service agreement dated October 31, 2007, indicated RN services were to be provided eight hours per day. Client D5's service agreement dated June 7, 2007, indicated RN services were to be provided twelve hours per day. When interviewed on November 27, 2007, RN DA indicated she and another RN shared a twelve hour shift three days a week, another registered nurse worked two days a week and an LPN worked the weekend. The licensee was not providing eight hours of RN services on the weekend for clients D4 and D5.

Client I4 began receiving services on November 18, 2004. The client's service agreement dated November 18, 2004, indicated the client received RN skilled visits two hours a day. There was no evidence in the client's record that a RN had visited the client two hours every day. The client's nursing progress notes dated October 5, 2007 through November 11, 2007, contained one entry by an RN. When interviewed on November 27, 2007, LPN IE, stated that the client received weekly medication set-up by an LPN. LPN IE was unsure what the RN skilled visits for two hours a day were.

Client F4's service agreement, dated November 24, 2006, stated he was to receive RN services four hours per week. The RN did a supervisory visit every one to two months on December 9 and 18, 2006, January 11, 2007, March 6, 2007, April 4, 2007, May 29, 2007, July 16, 2007, September 9, 2007 and October 18, 2007. The record lacked evidence of any other RN services provided to the client. When interviewed on November 29, 2007, the RN/owner did not know what RN services were to be provided or why the services were not provided. The RN/owner thought it must have been an omission.

Client M3's service agreement dated October 5, 2007, stated client M3 was to receive "RN Supervision Visit" one hour per day. Client M3's record lacked documentation of the daily RN visits from October 5, 2007 through November 29, 2007. When interviewed on November 29, 2007, the RN/owner stated an RN visited the client daily. The RN/owner confirmed there was no evidence of RN documentation in the client's record.

July 8, 2008

TO COMPLY: The licensee shall provide all services required by the client's service agreement, required by part 4668.0140.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4**), the** total amount you are assessed is: **$700.00**. 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 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 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, 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 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: May 12, 13, 14, 2008

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:
Josephine Gurley, RN/Owner
Connie, Ziralyo, LPN
Sumo Gbamonquillia, PCA
Alexandra Afdour, PCA
Josiah Marucha, PCA
Larry Opoku-Agyemang, PCA
Churi Nwanasi, LPN
Zelda Smith. Lead PCA
Saheed Alabi, PCA
Frederick Freeman, PCA

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 November 26, 27, 28, 29, 30, 2007 and December 1, 3, 4, 5, 11, 12, 2007 and a subsequent follow up visit made on March 17, 18, 19, and 20, 2008. The results of the survey were delineated during a telephone exit conference. Refer to telephone Exit Conference Attendance Sheet for the names of individuals attending the exit conference.

   The status of the correction orders issued as a result of a visit made on November 26, 27, 28, 29, 30, 2007 and December 1, 3, 4, 5, 11, 12, 2007 and not corrected at subsequent follow up visit conducted on March 17, 18, 19, 20, 2008, is as follows:

1. MN Rule 4668.0060 Subp. 3 Not Corrected $700.00

Based on record review and interview, the licensee failed to ensure clients received services as contracted in the service agreement for one of two clients (A6) reviewed at site A and one of two clients (J3) reviewed at site J. The findings include:

Client A6 began receiving services on December 28, 2007. His service agreement dated February 1, 2008, indicated the client was to be walked three times per day with assistance from the unlicensed care attendant. The unlicensed care giver was also to ensure the client completed his range of motion exercises twice daily, apply Metrogel ointment twice daily to the client's face, apply TMC cream to the client's arms daily and check the client's blood sugar level daily at alternating times. There was no documentation in the client record from April 30, 2008 to May 12, 2008 indicating the walking, range of motion, or the ointment and cream had done. The blood sugar documentation sheet indicated that the client's blood sugar had been checked daily from April 30, 2008 to May 12, 2008 however it was done every day at 8am and not at alternating times as required in the service agreement. When interviewed May 12, 2008, the licensed practical nurse (IE) stated that she didn't think the unlicensed care givers had to document each day for the walking and range of motion programs. She also stated that she didn't think the unlicensed care givers had to document each instance of the application of topical creams or ointments. She reviewed the blood sugar documentation sheet and confirmed that monitoring had not been done correctly.

Client J3 began receiving services on March 19, 2008. The client had been diagnosed with renal failure and was starting dialysis in May 2008. The client's service agreement dated March 19, 2008, indicated the care givers were to monitor what the client consumed and that the client needed to eat foods that were low in potassium and low in sodium. There was a menu plan titled "Caremaxx Healthcare Systems Weekly Menu" posted in the client's residence at site J. The menu included polish sausages, cup of noodles, Hamburger Helper and fish sticks. When interviewed on May 14, 2008, the client stated staff added too much salt to the food, so he watered his food down so there was less of a concentration of salt in the food. The client gave an example of staff adding two tablespoons of salt to Hamburger Helper when they made the entrée. He stated for the evening meal on May 14, 2008, he would have a polish sausage. Staff showed the reviewer the polish sasuage they would be serving and the label noted that one sausage contained 990 mg. of sodium. The client stated he does not like chicken so staff purchased beef noodles for him to eat when he didn't like what was being served on the menu. The beef noodles container, Maruchan Instant Lunch, listed 1,180 mg. of sodium in each serving. The client's service agreement indicated the client's vital signs were to be monitored daily. It was noted in the service agreement when the client's blood pressure was higher than 140 for the upper number or 90 for the lower number the elevated blood pressure was to be reported to the nurse by phone. The client's blood pressure was elevated above the parameters noted in the service agreement on seven days between May 1 and May 13, 2008. There was no evidence in the client record from May 1 through May 13, 2008 indicating the nurse had been informed of the elevated blood pressures.

When interviewed, May 13, 2008, the nurse (IE) stated it was the procedure for the unlicensed care giver (PCA) to contact the nurse and document on the back of the PCA daily sheet that the nurse had been contacted.

12. MN Rule 4668.0140 Subp. 2 **Corrected**

16. MN Rule 4668.0160 Subp. 5 **Corrected**

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

Cc: Attorney General's Office

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 an on-site visit, MDH nurses will interview staff, clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to describe 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 may 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.

Name of Class A Licensee: CAREMAXX HEALTH CARE SYSTEMS

HFID #: 21374

Dates of Survey: May 12, 13, 14, 2008

Project #: QL21374003

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 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 contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 2 _X_ New Correction Order issued _X_ Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 2 _X_ New Correction Order issued _X_ Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
4. The provider maintains and protects client records. **Focus Survey** • MN Rule 4668.0160 **Expanded Survey** [Note: See Informational Bulletin 99-11 for Class A variance for	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded

Indicators of Compliance	Outcomes Observed	Comments
Electronically Transmitted Orders. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
Services setting with regards to medication administration, storage and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		**Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
7. The provider is licensed and provides services in accordance with the license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 Subp. 3 • MN Rule 4668.0012 • MN Rule 4668.0060 Subp. 2 and 6 • MN Rule 4668.0180 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• 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 reflect services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** # 2 __X__New Correction Order issued ____Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ____Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings, of the focused survey may result in an expanded survey.

SURVEY RESULTS: ___ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0012 Subp. 15

INDICATOR OF COMPLIANCE: # 7

Based on interviews and record review, the licensee failed to provide representatives of the commissioner access to portions of client records. The findings include:

Reviewers arrived at site A at 11:30 am on May 12, 2008. At 11:55 am Nurse IE arrived at site A and she informed the reviewers, the owner, sent her to the facility to assist the reviewers. Nurse IE was given the current and discharged client rosters to fill out with specific instructions to list on the discharge and admission rosters; all discharged and admitted clients since the January 2008, including the location the clients had been discharged to, and all deaths that had occurred. The reviewers requested that the client roster list would be received by 2 pm on May 12, 2008. The reviewers also requested the complete client records for the two clients at site A. Clients A6 and I3 residing at site A began receiving services from the agency December 28, 2007 and September 17, 2007, respectively. Nurse IE left site A. At 12:10 pm on May 12, 2008, the reviewers telephoned nurse IE again requesting the client records. She stated the records were at the office because she had been auditing them. The reviewers requested that she bring the client records to site A.

At 12:35 pm on May 12, 2008, the reviewers telephoned nurse IE and informed her that the reviewers would be leaving site A to go to another residence since she had not provided the records as requested for site A. Nurse IE stated said that she was driving and she would be at site A shortly.

At 1:00 pm on May 12, 2008, the reviewer telephone nurse IE requesting the records. Nurse IE informed the reviewer she had been in a car accident and she was finishing up and would be coming to site A.

At 1:20 pm on May 12, 2008, nurse IE arrived at site A with portions of the requested two client records. The client records provided were incomplete and did not contain any supervisory visits. Provided were current documents such as physician orders, medication administration records, and personal care attendant documentation sheets for May, 2008.

At 1:50 pm on May 12, 2008, the reviewers requested the supervisory visits for site A and again the client rosters from nurse IE. Nurse IE stated those documents were at the office and she stated she called the owner inquiring about the requested documents.

At 2:42 pm on May 12, 2008, the reviewers telephoned nurse IE and repeated the request for the rosters and supervisory visits.

At 3:55pm on May 12, 2008, nurse IE returned to site A without the client rosters and supervisory visits. Nurse IE telephoned the owner. At this time the reviewer spoke with the owner and directly requested the rosters and supervisory visits from the owner. The owner told the reviewer if the reviewer would quit talking to her on the phone she could complete the forms. After 4:00 pm on May 12, 2008, employee

MF, an unlicensed care staff (PCA), called the reviewers' supervisor and informed the supervisor the rosters were done. The supervisory visits were not provided.

The reviewers arrived at site J at 3:05 pm on May 13, 2008. The reviewers telephoned nurse IE the designated contact person, and requested the supervisory visits for sites A and J and for the client rosters that were said to have been readied the prior afternoon. At 3:35 pm on May 13, 2008, nurse IE arrived at site J with no rosters or supervisory visits. At 4:09 pm on May 13, 2008, twenty-eight hours and thirty minutes after the initial request, for the client rosters, the client rosters. The supervisory visits for clients at site J were sent to site J via the fax machine. The agency failed to provide documentation of the supervisory visits for site A.

At 8:23 am on May 14, 2008, the reviewer telephoned the owner and requested the complete record for client A5, since admission to the agency on February 11, 2008 to be delivered to site I. The request included nursing notes, supervisory visits, PCA notes, medication sheets, prescriber orders, and service plans. At 11:40 am on May 14, 2008, the reviewers arrived at site I and inquired of nurse IM and PCA (IH), if records for client A5 had been delivered to the house. They both stated no. An attempt was made to contact the owner IE by telephone, but a voice mail message was received and the voice mailbox would not accept any messages.

At 11:45 am on May 14, 2008 the reviewer telephoned the Caremaxx office and spoke with employee MF. The reviewer told employee MF they were looking for the owner FG and the requested records. MF stated she had not seen the owner yet that day, but that she would forward the message to her.

At 11:51am on May 14, 2008, the owner was telephoned. Again a voice mail message was received and the voice mailbox would not accept any messages. At 11:52 am on May 14, 2008, the reviewer telephoned the Caremaxx office to inquire if the driver had the requested records and would deliver the records to site I. At 11:56am on May 14, 2008 the reviewer telephone the Caremaxx office and was informed that the owner FG was gathering client A5's paperwork and she'd drop it off at site I.

At 12:40pm on May 14, 2008 no records had been delivered to site I and the reviewers left the site.

2. MN Rule 4668.0100 Subp. 9

INDICATOR OF COMPLIANCE: # 1

Based on record review and interviews the licensee failed to ensure supervisory visits were completed for two of two clients' records (A6 and I3) at site A; one of one client record (A5) at site I; and two of two clients' records (M1 and J3) at site J.

Client A6 and client I3 began receiving services from unlicensed staff, including medication administration on December 28, 2007 and September 17, 2007 respectively. The service agreements for each client indicated the frequency of supervision of the unlicensed care giver would be every two weeks. No supervisory visits were in the client records when the records were reviewed at site A on May 12, 2008. The reviewer requested documentation of the supervisory visits at 1:50 pm, 2:42 pm, and 3:55 pm on May 12, 2008, and again at 3:05 pm and 3:35 pm on May 13, 2008 from nurse. At 4:10 pm on May 13, 2008, the owner faxed supervisory visits to site J for clients residing at site J, but no supervisory visits for client A6 or client I3. Supervisory visits for these two clients and client A5 were

again requested from the owner on May 14, 2008 at 8:23 am. Supervisory visits of the unlicensed staff could not be determined since the owner failed to provide documentation of the supervisory visits during the course of the site visit which ended at 12:40 pm on May 14, 2008.

Client M1 began receiving services March 28, 2007. His service agreement dated February 1, 2008 indicated the frequency of supervision of the personal care attendants would be every two weeks. During record review it was noted that supervisory visits had been done by the registered nurse on April 7, 2008, and April 21, 2008. The most recent supervisory visit had been done one week late on May 12, 2008.

Client J3 began receiving services on March 19, 2008. His service agreement dated March 19, 2008 indicated the frequency of supervision of the unlicensed care giver would be every two weeks. Documentation of supervisory visits provided by the owner of the agency indicated visits occurred on April 2, 2008, April 21, 2008 (nineteen days later) and May 9, 2008 (eighteen days later).

3. MN Statute 144A.44 Subd. 1 (2)

INDICATOR OF COMPLIANCE: # 2

Based on record review and interview, the licensee failed to ensure medications were received as ordered for one of two clients (I3) reviewed at site A and one of two clients (J3) reviewed at site J. The findings include:

Clients I3's record contained a physician's order dated April 16, 2008 for Darvocet N-50 to be administered four times per day. The May 2008 medication administration record did not contain documentation Darvocet N-50 had been administered from May 1, 2008 through May 12, 2008. The client's medi-set for the week starting of May 9, 2008 was observed and it did not contain any Darvocet N-50. When interviewed on May 12, 2008 nurse IE stated the Darvocet N-50 was intended to be ordered as a PRN (as needed) order and she had contacted the physician "recently," to get the order changed to PRN, but she had not yet received the order change. The nurse also stated she was unable to recall when she had called for the order change.

The medications in client I3's medi set-up for the week starting May 9, 2008, were counted by the reviewer and nurse IE on May 12, 2008. The medi-set contained thirteen pills in the 8am box and eight pills in the 8pm box. According to the document titled, "Number of tablets to be give (sic) to client by PCA" the client's medi-set was to contain twelve tablets in the 8am box and seven pills in the 8pm box. According to policy and interview, the medications in each client's medi-set box were counted at the start and end of each care attendant's shift. If there was a discrepancy in the count of the medications between the medi-set and the number of medications recorded on the document titled "Number of tablets to be give (sic) to client by PCA," the nurse was to be notified. When interviewed on May 14, 2008, unlicensed care giver (PCA) AH stated he had counted the medications according to policy, but he had not called any nurse with the discrepancy in the number of the medications, since the owner of the agency, had been in the facility on May 12, 2008 and had changed the number of the medications listed on the aforementioned document. The document was reviewed and it was noted for the week of May 9, 2008, the number of medications entered on the document was thirteen and there was a slash mark through the number thirteen and the number twelve had been written for 8am time slot. The number of medications entered on the document for 8pm was eight and there was a slash mark through

that number and the number seven had been written in the 8pm time slot on the document. The client's current physician orders dated April 19, 2008 were reviewed and the correct numbers of medications to be administered at 8am were fourteen pills and nine pills at 8pm.

The reviewer and nurse IE counted the contents of client J3's medi-set on May 13, 2008. The client's medi-set contained Metoprolol ER 100 mg for May 13 and May 14, 2008. Documentation on the May medication administration record completed by the owner of the agency indicated no Metoprolol ER 100 mg had been put into the client's medi-set for May 13 and 14, 2008. On the May 2008 medication administration record, the client's Metoprolol ER 100mg. was circled for May 12, 13 and 14, 2008, indicating the medication had not been set up in the medi-set. The medi-set contained the correct number of medications according to the current physician orders.

A draft copy of this completed form was faxed to the owner, Josephine Gurley on May 15, 2008 to the fax number 763-566-4341. A telephone exit conference was conducted with Josephine Gurley on May 16, 2008. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. 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 review, this form will be posted on the MDH website. CLASS A Licensed-only Home Care Provider general information is available by going to the following web address and clicking on the Class A Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 1671

April 22, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurley:

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 March 17, 18, 19, and 20, 2008.

The documents checked below are enclosed.

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

_____ 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

01/07 CMR1000

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 1671

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

April 22, 2008

Josephine Gurley, Administrator
Caremaxx Health Care Systems
7700 Shingle Creek Drive
Brooklyn Center, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On March 17, 18, 19, and 20, 2008, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007, with correction orders received by you on December 28, 2007.

The following correction orders were not corrected in the time period allowed for correction:

1. MN Rule 4668.0060 Subp. 3 **$350.00**

Based on observations, record review and interviews, the licensee failed to ensure that clients received services agreed to in the service agreement in one of three current clients' records (A3) reviewed at site A, four of five records (D1, D3, D4, and D5) reviewed at site D, one of five records reviewed (F4) at site F, one of four current clients (I4) at site I, and one of four records reviewed (M3) at site M. The findings include:

Client A3 began receiving services on March 16, 2007. His service agreement dated March 16, 2007, indicated he was to receive two hours per day of registered nurse (RN) services. The client record for November 2007, lacked documentation to support that an RN provided services two hours per day. When interviewed on November 26, 2007, the RN/owner stated that client A3 received his medications and wound care from RN's or Licensed Practical Nurse's (LPN). The RN/owner stated an LPN was scheduled in the A site daily from 8:00 a.m. to 2:00 p.m. and 5:00 p.m. to 11:00 p.m. When interviewed

on November 27, 2007, LPN IE stated that she frequently gets calls to go to site A because a licensed nurse is not available to give client A3 an insulin injection.

Client D1's service agreement dated June 16, 2005, indicated client D1 would be provided with thirteen hours per day of RN services. When interviewed on November 27, 2007, RN DA indicated RN's work twelve hour shifts Monday through Friday with LPN coverage on the weekends. RN DA also indicated client D1 receives unlicensed nursing services daily, which was not identified on the service agreement.

Client D3's service agreement dated May 16, 2006, indicated the licensee would provide three hours per day of RN and LPN services with eighteen hours of unlicensed staff services daily. On November 27, 2007, RN DA reported that RN's work twelve hour shifts Monday through Friday with LPN coverage on the weekends. The licensee was not providing daily RN services on the weekends.

Client D4's service agreement dated October 31, 2007, indicated RN services were to be provided eight hours per day. Client D5's service agreement dated June 7, 2007, indicated RN services were to be provided twelve hours per day. When interviewed on November 27, 2007, RN DA indicated she and another RN shared a twelve hour shift three days a week, another registered nurse worked two days a week and an LPN worked the weekend. The licensee was not providing eight hours of RN services on the weekend for clients D4 and D5.

Client I4 began receiving services on November 18, 2004. The client's service agreement dated November 18, 2004, indicated the client received RN skilled visits two hours a day. There was no evidence in the client's record that a RN had visited the client two hours every day. The client's nursing progress notes dated October 5, 2007 through November 11, 2007, contained one entry by an RN. When interviewed on November 27, 2007, LPN IE, stated that the client received weekly medication set-up by an LPN. LPN IE was unsure what the RN skilled visits for two hours a day were.

Client F4's service agreement, dated November 24, 2006, stated he was to receive RN services four hours per week. The RN did a supervisory visit every one to two months on December 9 and 18, 2006, January 11, 2007, March 6, 2007, April 4, 2007, May 29, 2007, July 16, 2007, September 9, 2007 and October 18, 2007. The record lacked evidence of any other RN services provided to the client. When interviewed on November 29, 2007, the RN/owner did not know what RN services were to be provided or why the services were not provided. The RN/owner thought it must have been an omission.

Client M3's service agreement dated October 5, 2007, stated client M3 was to receive "RN Supervision Visit" one hour per day. Client M3's record lacked documentation of the daily RN visits from October 5, 2007 through November 29, 2007. When interviewed on November 29, 2007, the RN/owner stated an RN visited the client daily. The RN/owner confirmed there was no evidence of RN documentation in the client's record.

TO COMPLY: The licensee shall provide all services required by the client's service agreement, required by part 4668.0140.

April 22, 2008

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

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

Based on observation, record review and interview, the licensee failed to provide a complete service agreement for three of three current clients' records (A1, A2 and A3) reviewed at site A; four of four clients' records (B1, B2, B3 and B4) reviewed at site B; one of one client record (C1) reviewed at site C; five of five clients' records (D1, D2, D3, D4 and D5) reviewed at site D; four of five clients' records (F1, F2, F3 and F4) reviewed at site F; four of four current clients' records (I1, I2, I3 and I4) reviewed at site I; and three of three current clients' records (M1, M2 and M3) reviewed at site M. The findings include:

Clients A1, A2 and A3, began receiving services on July 19, 2006, July 18, 2005, and March 16, 2007, respectively. The service agreements for clients A1, A2 and A3, were signed and dated by the client or their representative on the date services began. The service agreements did not contain descriptions, the frequency of the services to be provided, or a schedule of the sessions of supervision. When interviewed on November 26, 2007, LPN (licensed practical nurse) AB stated she was a new employee and did not know why the service agreements lacked the specific services and the schedule of supervisory visits. LPN AB indicated each client had a care plan that listed what cares and services were to be provided. The service agreements did not indicate that the care plan was part of each client's service agreement.

Clients B1, B2, B3 and B4's service plans dated June 6, 2007, August 22, 2003, May 17, 2006, and September 24, 2007, respectively, lacked a description of the services to be provided; which included central storage of medications, medication administration, tube feeding, ventilator and trachea care, dressing, grooming, bathing, transferring and range of motion. The service agreements also lacked the name of the person to contact in case of an emergency or a significant adverse change in the client's condition and the method for the licensee to contact the person. When interviewed on November 28, 2007, RN (registered nurse) BA and LPN BB were unable to provide the reviewer with information for reaching client B1's emergency contact. When interviewed on November 27, 2007, RN BA and LPN BB confirmed the service agreements were incomplete.

Client C1's service agreement dated, October 16, 2007, did not list the services the client received which included: suctioning, tracheostomy, ventilator, gastro–jejunostomy feedings, water orally only to wet the mouth, splinting of left humerus, transportation to dialysis three times per week, dressing, grooming, bathing, mobility, toileting and restraints. There was no fee schedule listed. The contingency plan did not address the method for the licensee to contact the responsible person for client C1.

Client D1's service agreement dated June 16, 2005, included thirteen hours per day of RN services. When interviewed, November 27**,** 2007, RN DA stated RN's worked twelve hour shifts Monday through Friday with LPN coverage on the weekends. RN DA also stated client D1 received daily unlicensed staff services, which were not identified on the service agreement. The service agreement lacked a description of the services to be provided and the frequency of sessions of supervision or monitoring for

services provided by unlicensed staff. On November 29, 2007, RN FH verified the service agreements should be more complete.

Client D3's service agreement dated May 16, 2006, included three hours per day RN and LPN services with eighteen hours of unlicensed services per day. When interviewed November 27, 2007, RN DA stated RNs worked twelve hour shifts Monday through Friday with LPN coverage on the weekends. The service agreement lacked a description of services to be provided and the frequency of sessions of supervision or monitoring for services provided by unlicensed staff. When interviewed, November 29, 2007, RN FH indicated the service agreement should be more complete.

Client D2, D4, and D5 received services including central storage of medications, medication administration, tube feeding, suctioning, nebulizer treatment, trachea care, wound care, catheter care, dressing, grooming, bathing, feeding, turning and positioning. Client D2, D4, and D5's, service agreements dated May 3, 2007, October 31, 2007, and June 7, 2007, respectively, lacked a description of the services to be provided, and did not identify the name and phone number of the person to contact in case of an emergency or a significant adverse change in the client's condition and the method for the licensee to contact the person. When interviewed on November 26, 2007, RN DA indicated that she was not aware of a service agreement because the office did it. When interviewed on November 29, 2007, the RN FH agreed the service agreement for each client was not complete.

Client F1's service agreement, dated November 2, 2006, stated he was to receive one to one unlicensed staff services for twelve hours per day and one to two unlicensed staff services for twelve hours per day. The service agreement failed to provide a description of the services to be provided, the schedule or frequency of supervision or monitoring required, and a complete plan for contingency action.

Clients F2 and F3's service agreements were dated September 6, 2005, and June 4, 2007, respectively. Both clients F2 and F3 received medication administration and assistance with activities of daily living. The service agreements did not include the services to be provided, the frequency of the services and the fees for the services. The service agreements also did not identify the categories of persons to provide the services, or the frequency of supervision or monitoring of delegated nursing tasks.

Client F4's service agreement, dated November 24, 2006, stated he was to receive RN services four hours per week, unlicensed staff services one to one for twelve hours per day and shared unlicensed staff services for twelve hours per day. The service agreement failed to include the services to be provided, the schedule or frequency of supervision or monitoring required, and a complete plan for contingency action.

Client I1's record indicated client I1 received medication administration, tube feedings, and nebulizer treatments. Client I1's service agreement, dated August 13, 2007, did not include these services.

Client I2's record indicated client I2 was receiving medication set up, medication administration, and blood glucose monitoring. Client I2's service agreement dated May 25, 2007, did not include these services.

Client I4 began receiving services on November 18, 2004. A service agreement dated November 18, 2004, indicated Client I4 was to receive RN skilled visits/two hours a day, and unlicensed staff services twelve hours a day. There was no description of the services that the RN and unlicensed staff provided on the service agreement or the frequency of supervision or monitoring of the unlicensed staff. Observations on November 26, 27, and 28, 2007, revealed that the LPN, set-up the client's medications in a weekly medi-set on a weekly basis. The unlicensed staff were observed to administer the medications to the client and assist the client with her dressing, bathing, grooming, and ambulation.

Client I3 began receiving services on September 17, 2007. Client I3's service agreement which was not dated, indicated that client I3 was to receive one to one unlicensed staff services twelve hours a day, and one to two unlicensed staff services twelve hours a day. There was no description of the services that the unlicensed staff provided on the service agreement or the frequency of supervision or monitoring of the unlicensed staff. Observations on November 26, 27, and 28, 2007, revealed that the licensed practical nurse, set-up the client's medications in a weekly medi-set on a weekly basis. The unlicensed staff were observed to administer medications to the client, assist the client with his activities of daily living, prepare his meals, and assist the client with range of motion exercises. When interviewed, on November 27, 2007, LPN IE confirmed the lack of information on clients I4 and I3s' service agreements.

Client M1 began receiving services on March 28, 2007. Client M1's service agreement indicated that client M1 was to receive one to one unlicensed staff services twelve hours a day, and one to two unlicensed staff services twelve hours a day. The service agreement did not include a description of the services that the unlicensed staff provided. The service agreement did not indicate that client M1 was receiving RN or LPN services or supervisory visits. An interview with LPN IE on November 26, 2007, and observations on November 26, 27, and 28, 2007, revealed that an LPN, set up the client's medications in a weekly medi-set on a weekly basis. The unlicensed staff were observed administering medications to the client, providing supervision of daily living activities, preparing his meals, and transporting him to outside activities.

A service agreement dated September 5, 2007, indicated client M2 received assistance with medications, had insulin and other medications set up by a licensed nurse and blood glucose monitoring done by unlicensed staff. The service plan did not address who was to provide the services, the type of services, the frequency of services or the fees for the services.

Client M3's service agreement dated October 5, 2007, indicated client M3 was to receive "RN supervision Visit 1hr/day" and "PCA 12 hr/day." Client M3's record indicated an LPN set up medications and the medications were stored in central storage at site M. The service agreement did not include the services the client received. When interviewed on November 29, 2007, the RN/owner stated she thought the service agreements were correct because a consultant's recommended form was used

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 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 50.00.

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

Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name, date and title of the person making the entry for four of four client records (B1, B2, B3 and B4) reviewed at site B; three of four current clients' records (D1, D2 and D4) reviewed at site D; two of four current clients' records (I3 and I4) reviewed at site I; and two of four records reviewed (M1 and M3) at site M . The findings include:

Client B1 began receiving services on June 6, 2007. Progress notes lacked employee signatures, titles and dates on nine different entries between November 13, 2007, and November 25, 2007.

Client B2 began receiving services on August 22, 2003. Progress notes lacked employee's signatures on November 18, 21, 24 and 26, 2007. Progress notes lacked employee's titles on October 23, 24, and 31, 2007, and November 7, 8, 14, 19, 20 and 23, 2007. Progress notes lacked both employee's last name and title on November 6, 14, 16 and 17, 2007. Ventilator flow sheets and client flow sheets lacked the

employee's last name and title on November 26, 2007. Flow sheets lacked employees' last name on October 16 and 17, 2007.

Client B3 received services between May 17, 2006, and November 20, 2007. Between November 16, 2007 and November 20, 2007, there were three nurses' notes which did not contain an employees' signature and title.

Client B4's progress notes lacked an employee's last name on November 18 and 21, 2007. Progress notes lacked an employee's title on November 15 and 16, 2007. When interviewed November 26, 2007, registered nurse (RN) BA agreed that entries should be signed with the title of the employee.

Client D1 began receiving services on May 7, 2004. Clients care forms were not dated. When interviewed on November 29, 2007, RN FH, stated the documents should have been dated.

Client D2 began receiving services on May 3, 2007. A progress note dated November 02, 2007, was not signed by the employee providing care.

Client D4 began receiving services on October 31, 2007. A Nursing Health Monitoring Visit note dated, November 28, 2007, was not signed by the employee documenting the note. When interviewed, November 29, 2007, RN FH indicated that the documentation should have been signed.

Client I4 had a form titled "PCA Medication Assistance Form" for the month of November 2007. This form contained initials of employees who administered client I4's medications on a daily basis. The form did not contain the names and titles of the persons making the entries. Client I4 also had a form titled "Client Care Form" which included the amount of assistance the client required with her activities of daily living, and special instructions for her care. This form did not include the name and title of the person completing the form.

Client I3 had a form titled, "PCA medication Assistance Form" for the month of November 2007. This form contained initials of employees who administered client I3's medications on a daily basis. The form did not contain the names and titles of the persons making the entries. A form titled "PCA Care Plan" dated September 17, 2007, included the amount of assistance the client required with his activities of daily living, and special instructions for his care. This form did not include the name and title of the employee completing the form. Client I3 had a form titled "Capillary Blood Glucose/Insulin Flow sheet" dated November 17, 2007, though November 21, 2007, and November 22, 2007, through November 26, 2007. This form contained initials of employees that performed blood glucose monitoring at 8:00 a.m., 12:00 noon, and 5:00 p.m. and at bedtime. The form did not contain the names and titles of the employees documenting the blood glucose.

Client M1 had a form titled, "PCA medication Assistance Form" for the month of November 2007. This form contained initials of employees who administered client M1's medications on a daily basis. The form did not contain the names of the persons making the entries, only initials.

April 22, 2008

Client M3's record contained a vulnerable adult assessment that was signed by an RN, but was not dated.

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 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 50.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$450.00**. 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800Subp. 6, the (correction order has/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 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Jocelyn Olson, Office of the Attorney General
Mary Henderson, Program Assurance

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: March 17, 18, 19, and 20, 2008

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 _____

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Josephine Gurley RN/Owner
Connie Ziralyo- LPN
George Safo- RN educator
Alexander Afodour- PCA
Thomas Ajayi- PCA
Rand Elabed- PCA
Charles Monger- PCA
Abraham Massaley- PCA

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 November 26, 27, 28, 29, and 30, 2007 and December 1, 3, 4, 5, 11, and 12, 2007. 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 orders issued as a result of a visit made on November 26, 27, 28, 29, and 30, 2007 and December 1, 3, 4, 5, 11, and 12, 2007 and not corrected at the subsequent follow up visit conducted on March 17, 18, 19, and 20, 2008 is as follows:

1. MN Rule 4668.0060 Subp.3 **Not Corrected** **$350.00**

Based on observation, record review and interviews, the licensee failed to ensure that clients received services as contracted in the service agreement for one of one client (A5) record reviewed at site A and one of one client (E1) record reviewed at site E. The findings include:

Client A5 began receiving services on February 11, 2008. His service agreement dated February 11, 2008 indicated he was to receive PCA (patient care attendant) services 24/hours a day. The PCA/HHA (home health aide) weekly charting 7pm-7am for March 15, 2008 was not documented. When interviewed March 18, 2008 the LPN stated he had received PCA services and she made a late entry for March 15, 2008 on the PCA /HHA weekly charting 7pm-7am sheet.

Client E1 began receiving services on September 1, 2005. Her service agreement dated February 1, 2008 indicated she was to receive four visits a week of RN/LPN services but there was no description of what services they were to provide The client record March 17, 2008, lacked evidence that an RN/LPN provided services four visits a week. Supervisory visits were done on February 11, 25 and March 11, 2008. When interviewed on March 20, 2008 the LPN stated they should be more specific as to what service they provided and document the visit.

2. MN Rule 4668.0065 Subp. 1 **Corrected**

3. MN Rule 4668.0065 Subp. 3 **Corrected**

4. MN Rule 4668.0070 Subp. 3 **Corrected**

5. MN Rule 4668.0100 Subp. 2 **Corrected**

6. MN Rule 4668.0100 Subp. 3 **Corrected**

7. MN Rule 4668.0100 Subp. 4 **Corrected**

8. MN Rule 4668.0100 Subp. 8 **Corrected**

9. MN Rule 4668.0100 Subp 9 **Corrected**

10. MN Rule 4668.0130 Subp. 1 **Corrected**

11. MN Rule 4668.0140 Subp. 1 **Corrected**

12. MN Rule 4668.0140 Subp. 2 **Not Corrected** **$50.00**

Based on observation, record review and interview, the licensee failed to provide a complete service agreement for one of one current client (A5) record reviewed at site A and one of one client (E1) record reviewed at site E. The findings include:

Client A5 began receiving services on February 11, 2008. The service plan dated February 11, 2008 indicated the client would receive RN/LPN service one hour per day and PCA services 24 hours a day.

The service plan the lacked the description of the services to be provided, the fees for the service, and frequency of supervision or monitoring required. When interviewed March 18, 2008 the LPN confirmed the service agreement was not complete.

Client E1 began receiving services on September 1, 2005. The service plan dated February 1, 2008 indicated the client would receive RN/LPN services four visits a week. The service plan lacked the description of the service to be provided. When interviewed March 20, 2008 the LPN confirmed the service agreement was not complete.

13. MN Rule 4668.0150 Subp. 3 **Corrected**

14. MN Rule 4668 0150 Subp. 5 **Corrected**

15. MN Rule 4668.0150 Subp. 6 **Corrected**

16. MN Rule 4668.0160 Subp. 5 **Not Corrected** **$50.00**

Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name, date, title of the person making the entry for one of one client (A5) record reviewed at site A, one of one client (M2) record reviewed at site M, and one of one client (E1) record reviewed at site E The findings include:

Client A5 began receiving services on February 11, 2008. Client A5's progress notes lacked employee titles on entries made March 11, 12, and 16, 2008. The unlicensed care staff weekly comment sheet charting for 7am to 7pm lacked the date of entry and full name and title of person making the entry.
Client M2 began receiving services on September 7, 2005. Client M2's progress note lacked employee titles on entries made March 12, 2008. The unlicensed care staff weekly comment sheet charting for 7am to 7pm lacked the full name and title of person making the entry.
Client E1 began receiving services on September 1, 2005. Client E1's progress notes lacked employee titles on entries made February 15, 18, 19, and 2008. The unlicensed care staff weekly comment sheet charting for 7am to 7pm lacked the full name and title of person making the entry. When interviewed March 20, 2008 the licensed practical nurse confirmed the entries were not complete.

17. MN Rule 4668.0160 Subp. 6 **Corrected**

18. MN Statute 144A.44 Subd.1 (2) **Corrected**

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 0926

December 21, 2007

Josephine Gurley, Administrator
Caremaxx Health Care Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Results of State Licensing Survey

Dear Ms. Gurley:

The above agency was surveyed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007, for the purpose of assessing compliance with state licensing regulations. State licensing deficiencies, if 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. If further clarification is necessary, I can arrange for an informal conference at which time your questions relating to the order(s) can be discussed.

A final version of the Licensing Survey Form is enclosed. This document will be posted on the MDH website.

Also attached is an optional Provider questionnaire, which is a self-mailer, which affords the provider with an opportunity to give feedback on the survey experience.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call our office with any questions at (651) 201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosures

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR3199

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 an on-site visit, MDH nurses will interview staff, clients and/or their representatives, make observations and review documentation. The survey is an opportunity for the licensee to describe 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 may 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.

Name of Class A Licensee: CAREMAXX HEALTH CARE SYSTEMS

HFID #: 21374

Date(s) of Survey: November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007

Project #: QL21374003

Indicators of Compliance	Outcomes Observed	Comments
1. The provider accepts and retains clients for whom it can meet the needs. **Focus Survey** • MN Rule 4668.0140 **Expanded Survey** • MN Rule 4668.0050 • MN Rule 4668.0060 Subp. 3, 4 and 5 • MN Rule 4668.0180 Subp. 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 contain all the required information. • Services agreed to are provided Clients are provided referral assistance.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided

Indicators of Compliance	Outcomes Observed	Comments
2. The provider promotes client rights. **Focus Survey** • MN Rule 4668.0030 • MN Statute §144A.44 **Expanded Survey** • MN Rule 4668.0040 • MN Rule 4668.0170	• Clients' are aware of and have their rights honored. • Clients' are informed of and afforded the right to file a complaint.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** _#__ ____New Correction Order issued ____Education Provided
3. The provider promotes and protects each client's safety, property, and well-being. **Focus Survey** • MN Statutes §144A.46 Subd. 5(b) • MN Statute §626.556 • MN Statutes §626.557 **Expanded Survey** • MN Rule 4668.0035	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded _X_Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** _#__ ____New Correction Order issued ____Education Provided
4. The provider maintains and protects client records. **Focus Survey** • MN Rule 4668.0160 **Expanded Survey** [Note: See Informational Bulletin 99-11 for Class A variance for	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded

Indicators of Compliance	Outcomes Observed	Comments
Electronically Transmitted Orders. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
5. The provider employs and/or contracts with qualified and trained staff. **Focus Survey** • MN Rule 4668.0100 • [Except Subp. 2] • MN Rule 4668.0065 **Expanded Survey** • MN Rule 4668.0060 Subp. 1 • MN Rule 4668.0070 • MN Rule 4668.0075 • MN Rule 4668.0080 • MN Rule 4668.0130 • MN Statute §144A.45 Subd. 5 [Note: See Informational Bulletin 99-7 for Class A variance in a Housing With Services Setting. Non-compliance with this variance will result in a correction order issued under 4668.0016.]	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) issued _X_Education Provided **Follow-up Survey** #___ ____New Correction Order issued ____Education Provided
6. The provider obtains and keeps current all medication and treatment orders [if applicable]. **Focus Survey** • MN Rule 4668.0150 **Expanded Survey** • MN Rule 4668.0100 Subp. 2 [Note: See Informational Bulletin 99-7 and 04-12 for Class A variance in a Housing With	• 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.	**Focus Survey** ____Met ____Correction Order(s) issued ____Education Provided **Expanded Survey** ____Survey not Expanded ____Met _X_Correction Order(s) Issued _X_Education Provided

Indicators of Compliance	Outcomes Observed	Comments
Services setting with regards to medication administration, storage and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		**Follow-up Survey** # 1 X New Correction Order issued 12/11/07 X Education Provided
7. The provider is licensed and provides services in accordance with the license. **Focus Survey** • MN Rule 4668.0019 **Expanded Survey** • MN Rule 4668.0008 Subp. 3 • MN Rule 4668.0012 • MN Rule 4668.0060 Subp. 2 and 6 • MN Rule 4668.0180 • MN Rule 4668.0220 Note: MDH will make referrals to the Attorney General's office for violations of MN Statutes 144D or 325F.72; and make other referrals, as needed.	• 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 reflect services available. • Licensee provides services within the scope of the license. • Licensee has a contact person available when a para-professional is working.	**Focus Survey** ___Met ___Correction Order(s) issued ___Education Provided **Expanded Survey** ___Survey not Expanded X Met ___Correction Order(s) issued X Education Provided **Follow-up Survey** #___ ___New Correction Order issued ___Education Provided
8. The provider is in compliance with MDH waivers and variances. **Expanded Survey** • MN Rule 4668.0016	• Licensee provides services within the scope of applicable MDH waivers and variances	*This area does not apply to a Focus Survey.* **Expanded Survey** ___Survey not Expanded X Met ___Correction Order(s) issued ___Education Provided **Follow-up Survey** #___ ___New Correction Order issued ___Education Provided

Please note: Although the focus of the licensing survey is the regulations listed in the Indicators of Compliance boxes above, other rules and statutes may be cited depending on what system a provider has or fails to have in place and/or the severity of a violation. The findings, of the focused survey may result in an expanded survey.

SURVEY RESULTS: ___ All Indicators of Compliance listed above were met.

For Indicators of Compliance not met, the rule or statute numbers and the findings of deficient practice are noted below.

1. MN Rule 4668.0060 Subp. 3

INDICATOR OF COMPLIANCE: # 1

Based on observations, record review and interviews, the licensee failed to ensure that clients received services agreed to in the service agreement in one of three current clients' records (A3) reviewed at site A, four of five records (D1, D3, D4, and D5) reviewed at site D, one of five records reviewed (F4) at site F, one of four current clients (I4) at site I, and one of four records reviewed (M3) at site M. The findings include:

Client A3 began receiving services on March 16, 2007. His service agreement dated March 16, 2007, indicated he was to receive two hours per day of registered nurse (RN) services. The client record for November 2007, lacked documentation to support that an RN provided services two hours per day. When interviewed on November 26, 2007, the RN/owner stated that client A3 received his medications and wound care from RN's or Licensed Practical Nurse's (LPN's). The RN/owner stated an LPN was scheduled in the A site daily from 8:00 a.m. to 2:00 p.m. and 5:00 p.m. to 11:00 p.m. When interviewed on November 27, 2007, LPN IE stated that she frequently gets calls to go to site A because a licensed nurse is not available to give client A3 an insulin injection.

Client D1's service agreement dated June 16, 2005, indicated client D1 would be provided with thirteen hours per day of RN services. When interviewed on November 27, 2007, RN DA indicated RN's work twelve hour shifts Monday through Friday with LPN coverage on the weekends. RN DA also indicated client D1 receives unlicensed nursing services daily, which was not identified on the service agreement.

Client D3's service agreement dated May 16, 2006, indicated the licensee would provide three hours per day of RN and LPN services with eighteen hours of unlicensed staff services daily. On November 27, 2007, RN DA reported that RN's work twelve hour shifts Monday through Friday with LPN coverage on the weekends. The licensee was not providing daily RN services on the weekends.

Client D4's service agreement dated October 31, 2007, indicated RN services were to be provided eight hours per day. Client D5's service agreement dated June 7, 2007, indicated RN services were to be provided twelve hours per day. When interviewed on November 27, 2007, RN DA indicated she and another RN shared a twelve hour shift three days a week, another registered nurse worked two days a week and an LPN worked the weekend. The licensee was not providing eight hours of RN services on the weekend for clients D4 and D5.

Client I4 began receiving services on November 18, 2004. The client's service agreement dated November 18, 2004, indicated the client received RN skilled visits two hours a day. There was no evidence in the client's record that a RN had visited the client two hours every day. The client's nursing progress notes dated October 5, 2007 through November 11, 2007, contained one entry by an RN. When interviewed on November 27, 2007, LPN IE, stated that the client received weekly

medication set-up by an LPN. LPN IE was unsure what the RN skilled visits for two hours a day were.

Client F4's service agreement, dated November 24, 2006, stated he was to receive RN services four hours per week. The RN did a supervisory visit every one to two months on December 9 and 18, 2006, January 11, 2007, March 6, 2007, April 4, 2007, May 29, 2007, July 16, 2007, September 9, 2007 and October 18, 2007. The record lacked evidence of any other RN services provided to the client. When interviewed on November 29, 2007, the RN/owner did not know what RN services were to be provided or why the services were not provided. The RN/owner thought it must have been an omission.

Client M3's service agreement dated October 5, 2007, stated client M3 was to receive "RN Supervision Visit" one hour per day. Client M3's record lacked documentation of the daily RN visits from October 5, 2007 through November 29, 2007. When interviewed on November 29, 2007, the RN/owner stated an RN visited the client daily. The RN/owner confirmed there was no evidence of RN documentation in the client's record.

2. MN Rule 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that tuberculosis screening was completed for three of seven employee's (FC, FD and FH) records reviewed at site F; one of one licensed employee (II) records reviewed at site I; and one of one licensed employee (MA) record reviewed at site M. The findings include:

Employee FC was hired and began working with clients on August 8, 2007. Documentation dated March 12, 2004; indicated employee FC had a positive Mantoux test. A chest x-ray dated March 12, 2004, stated, "consistent with previous granulomatous infection. Activity is indeterminate on a single examination." There was no evidence of subsequent tuberculosis screening.

Employee FD was hired on April 25, 2006, and began providing care for clients on April 26, 2006. There was no evidence of tuberculosis screening until February 23, 2007.

Employee FH was hired on October 9, 2004. A tuberculosis screening was completed on July 20, 2005. The agency was unable to provide a more current tuberculosis screening.

Employee II was hired on January 5, 2007, and had a positive Mantoux prior to employment with the licensee. Employee II had a negative chest x-ray dated October 5, 2001. There was no evidence of subsequent tuberculosis screening.

Employee MA was hired on April 11, 2007, and had a positive Mantoux prior to employment with the licensee. Employee MA's record contained a negative chest x-ray dated October 26, 2007. There was no evidence of chest x- ray prior to direct client contact.

When interviewed on November 29, 2007, the RN/Owner indicated she was unaware a negative chest x-ray was to be obtained within the previous twelve months of employment under certain circumstances.

3. MN Rule 4668.0065 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interviews, the licensee failed to ensure that for each twelve months of employment, employees completed in-service training related to infection control techniques in three of five registered nurse (FG, CC and FH) records reviewed. The findings include:

RN CC was hired on September 28, 2006. There was no documented evidence that RN CC had completed infection control in-service training since September 28, 2006.

RN FG had been providing care to clients since at least November 2, 2001, and RN FH since November 10, 2004. RN FG and RN FH's records each contained an undated document titled "Infection Control Doc. Txt." There was no documented evidence that RN FG or RN FH had completed yearly in-service training related to infection control.

When interviewed on November 29, 2007, RN/owner stated all employees, including herself, attended annual infection control training sessions. However, the RN/owner was unable to provide any verification that these training sessions had occurred.

4. MN Rule 4668.0070 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on observations, record review and interview, the licensee failed to have current job descriptions for one of two unlicensed employee (AC) records reviewed at site A, one of three (FD) unlicensed employee's records reviewed at site F, three of three (IB, IC and ID) unlicensed employee's records reviewed at site I and two of two unlicensed employee's records reviewed at site M. The findings include:

On November 26, 2007, at 12:50 p.m., employee IC, an unlicensed employee, was observed to administer medication to client I3. Employee IC removed the client's medication from the medi-set container, crushed the pills, and then placed the pills in the client's food, as the client fed himself.

On November 27, 2007, unlicensed employees, ID, FD, MC and MB, were observed administering medications to clients I4, F4, M1 and M2, respectively.

On November 28, 2007, unlicensed employees, IB and MC, were observed administering medications to clients I1 and M1, respectively.

A November medication assistance form indicated employee AC, an unlicensed employee, administered client A3's medications on November 19, 20, 21, 26 and 27, 2007.

The job descriptions for unlicensed employees performing home health aide tasks, read that unlicensed staff performed medication reminders. The job descriptions did not include assistance with medication administration or medication administration.
When interviewed on November 26, 2007, the RN/owner stated that unlicensed employees provide medication administration after a licensed nurse has set-up the medications in a medi-set pill box for each client.

5. MN Rule 4668.0100 Subp. 2

INDICATOR OF COMPLIANCE: # 6

Based on observations, record review and interviews, the licensee failed to ensure unlicensed personnel received medication administration training and instructions from an registered nurse (RN), including as needed (PRN) medication administration, for two of two unlicensed employees reviewed (AA and AC) at site A; three of three unlicensed personnel (IB, IC, and ID) reviewed at site I; and two of two unlicensed personnel (MB and MC) at site M. The findings include:

Unlicensed employees AA and AC were hired on October 7, 2005, and November 15, 2006, respectively. Client A1 and A3's records indicated employees AA and AC assisted them with medication administration. The "PCA Orientation/Competency Checklist" in employee AA and AC's records was a photocopy form. The photocopy form was pre filled out and indicated medication administration was taught by an RN and was checked under "sign-off." The forms were generic and were used for other unlicensed employees. The forms also had a photocopied signature of the RN/owner with the date area next to the RN signature left blank. The forms were signed and dated by the employees on the day of hire. The forms did not note the dates of the training and lacked evidence of a competency evaluation. When interviewed on November 28, 2007, employee AA stated that the unlicensed employees were trained to perform home health aide tasks, including medication administration by the lead unlicensed employee, employee IG and not by the nurse.

Employee IB was observed on November 28, 2007, to administer a Flonase inhaler to client I1. A competency evaluation dated June 15, 2007, indicated employee IB was trained in medication administration by a written test. The personnel record lacked evidence the employee had demonstrated competency prior to administering medication

Client I4's record indicates employee IC administered medications to client I4 in November 2007. Employee ID was observed on November 28, 2007, administering medications to client I4.
There was no evidence that employees' IC or ID received medication administration training by an RN.

Clients I3 and I4 were observed receiving medication administration from the unlicensed employees during the survey. Although clients I3 and I4 had handwritten procedures on how to administer the client's medications in their charts, the procedures were documented by a licensed practical nurse (LPN), not a registered nurse (RN) as required.

Client M3's record contained prescriber orders dated November 10, 2007 for Vicodin 5/500 one to two tablets by mouth as needed (PRN) and Ibuprofen 600 mg. four times daily PRN. The PRN medication assistance form indicated the PRN medications were given on November 10, 12, 13, 14,

15, 16, 17, 18, 19, and 20, 2007. The bottom of the PRN medication assistance form indicated unlicensed staff must call the nurse before assisting clients with PRN medication administration. Client M3's record lacked evidence the RN had been contacted.

Client M4's record contained a prescriber's order dated November 8, 2007 for Lorazepam one milligram (mg.) by mouth every six hours PRN for anxiety. The PRN medication assistance form for November 2007 indicated PRN medications were given on November 12 and 13, 2007. Client M4's record lacked evidence the RN had been contacted. When interviewed on November 27, 2007, unlicensed employees MB and MC stated an LPN was contacted prior to giving a PRN medication.

6. MN Rule 4668.0100 Subp. 3

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that only licensed nurses injected insulin for one of one client record (I3) reviewed who received insulin administration. The findings include:

Client #I3 received Lantus insulin injections six units subcutaneously every bedtime, in addition to Novolog Insulin injections four to twelve units subcutaneously four times a day per a sliding scale as needed. When interviewed on November 27, 2007, LPN IE indicated that a nurse drew up client I3's insulin for one week and the unlicensed staff administered the insulin on a daily basis. Documentation on November 12, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, and 26, 2007, reflected that unlicensed employees administered client I3's insulin.

7. MN Rule 4668.0100 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on observations, record reviews and interviews, the licensee failed to ensure a registered nurse (RN) had instructed unlicensed personnel prior to performing delegated nursing procedures and specified in writing, specific instructions for performing the procedures for two of two unlicensed employees' records (AA and AC) reviewed at site A; one of one unlicensed employee record (DC) reviewed at site D; three of three unlicensed employees' records (IB, IC, and ID) reviewed at site I; one of two unlicensed employees' records (MC) reviewed at site M. The findings include:

Employees AA and AC were hired to perform home health aide tasks on October 7, 2005, and November 15, 2006, respectively. Records from November 2007 for clients A1 and A3 indicate that employees AA and AC performed blood sugar monitoring. There was no evidence in the records indicating employees AA and AC had been instructed by an RN or had demonstrated to an RN the ability to competently perform blood sugar monitoring. When interviewed on November 28, 2007, employee AA stated that all the unlicensed personnel were trained by the lead unlicensed employee, employee (IG), for all the home health aide tasks, including blood sugar monitoring. In addition, a written procedure for performing blood sugar monitoring was not in each client's record or available at site A.

Documentation on November 26, 2007, 7:00 p.m. to 7:00 a.m., indicated employee DC provided client D2's bed bath, repositioning, vital signs and other health related cares. Client D2 had a tracheostomy and received tube feedings. A Client Care Form dated May 3, 2007, indicated client D2 required total care for dressing, grooming, bathing, Hoyer lift transfers and a Foley catheter. There were no documented instructions for the cares to be provided. When interviewed on November 28, 2007, RN FH indicated she was in the process of developing a procedure book for site D.

On November 28, 2007, employee IB, an unlicensed employee, was observed performing a nebulizer treatment and administering a tube feeding to client I1. There was no evidence indicating employee IB was trained by an RN prior to performing the nebulizer treatment and the tube feeding. When interviewed on November 28, 2007, employee IB reported an LPN had trained her to perform the procedures.

Client I4's record indicated employee IC had performed blood sugar monitoring for client I4 during November 2007. Employee IC's personnel record lacked evidence of training by an RN on how to perform blood sugar monitoring.

Client I3's record indicated employee ID performed range of motion on client I3 during November 2007. Employee ID's record lacked evidence that employee ID had been trained by an RN or therapist to perform range of motion.

When interviewed on November 28, 2007, employee IG, an unlicensed employee, indicated she had been trained by an RN, and she (employee IG) trained the other unlicensed personnel at site I.

Client M1's medical record indicated the portable oxygen needed to accompany client M1 when he left his home. The portable oxygen tank was to be filled from the "Big" oxygen tank. On November 27 and 28, 2007, written instructions for filling the portable oxygen tank were not located. On November 27, 2007, employee MC reported that he filled the portable oxygen tank at least daily. Employee MC reported that another unlicensed employee trained him on how to fill the portable oxygen tank. However, on another occasion, a licensed nurse did a skills check. Employee MC's personnel record did not contain evidence of training or competency related to the operation of the oxygen tanks. On November 28, 2007, RN FH confirmed there were no policies or procedures for operating the oxygen tanks and she had not provided training to the unlicensed employees. On November 29, 2007, the RN/owner confirmed another unlicensed employee trained employee MC on how to fill and operate the oxygen tanks.

8. MN Rule 4668.0100 Subp. 8

INDICATOR OF COMPLIANCE: # 5

Based on record review, the licensee failed to ensure that a registered nurse (RN) oriented each unlicensed person who performed home health aide tasks to each client prior to providing services for one of two clients' records (I1) reviewed at site I. The findings include:

Client I1's record contained "PCA Daily Charting: 7PM – 7AM" dated November 24, 2007, which indicated employee IA, an unlicensed staff, "trained" employee IL, who was also an unlicensed staff, to work with client I1. The "PCA Daily Charting: 7AM-7PM" indicated employee IL provided care

for client I1 on November 25, 2007. Client I1's MAR for November 2007, indicated client I1 was to receive Peptamen two cans at 8:00 a.m., 12 noon, 5:00 p.m., and one can at 8:00 p.m., and flush j-tube with 100 ml. water before feeding and then follow up with 200 ml. water flush after feeding. Employee IL documented on the "PCA Daily charting: 7AM-7PM"dated November 25, 2007, that she had given two cans of tube feeding at breakfast, lunch, and dinner, but did not document the 100 ml of water that was to be given before the tube feeding or the water that is to be given after the tube feeding. There was no evidence that a registered nurse had oriented employee IL to client I1's cares.

9. MN Rule 4668.0100 Subp. 9

INDICATOR OF COMPLIANCE: # 5

Based on record review and interviews the licensee failed to ensure that supervisory visits were completed for four of four clients' records (A1, A2, A3 and A4) reviewed at site A; three of four current clients' records (D1, D2 and D3) reviewed at site D; four of four current clients' records (F1, F2, F3 and F4) reviewed at site F; three of four current clients' records (I1, I2 and I4) reviewed at site I; and three of three current clients' records (M1, M2 and M3) reviewed at site M. The findings include:

Client A1 began receiving services on July 19, 2006. Client A1 received blood sugar monitoring and medication administration from unlicensed staff performing home health aide tasks. Client A2 began receiving numerous services on July 18, 2005, including medication administration from the unlicensed staff. Client A3 began receiving services on March 16, 2007. Client A3 received assistance with numerous home health aide tasks from the unlicensed personnel. Client A4 began receiving services February 1, 2007, and was discharged to the hospital on October 23, 2007. Client A4 received assistance with numerous home health aide tasks from the unlicensed staff. Client A1, A2, A3 and A4's records did not contain evidence that supervisory visits were completed. When interviewed on November 26, 2007, the RN/owner stated that RN FH performed the supervisory visits. Copies of the supervisory visits were requested on November 27 and 28, 2007, but were not provided.

Client D1's service agreement dated June 16, 2005, indicated he received 13 hours per day of RN services, however, an interview with an RN on November 26, 2007, indicated unlicensed staff provided care. Documentation indicated client D1 received dressing, hygiene, washing, positioning and Hoyer lift transferring assistance from unlicensed staff. There was no evidence of supervisory visits.

Client D2's service agreement dated May 3, 2007, indicated that unlicensed staff were to provide home health aide tasks sixteen hours per day. Documentation on November 26, 2007, indicated that employee DC provided a bath, repositioning, vital signs, light house keeping and other health related cares. There were no supervisory visits in client D2's record and none were provided during the course of the survey. When interviewed on November 27, 2007, RN DA indicated that she was unaware of the need to do supervisory visits.

Client D3's service agreement dated May 16, 2006, indicated RN, LPN and unlicensed home health aide tasks were provided. Documentation dated May 2, 2006, indicated client D3 was totally dressed, groomed and washed. There were no supervisory visits documented in the record or provided during the on-site visit.

Client F1 began receiving services November 2, 2006, and received medication assistance from unlicensed staff performing home health aide tasks. The last supervisory visit documented was dated October 18, 2007.

Client F2 began receiving services on July 21, 2003, including medication administration from unlicensed personnel. Documentation indicated supervisory visits occurred on May 29, 2007, July 16, 2007, August 9, 2007, and October 24, 2007, and November 27, 2007. There was no evidence additional supervisory or monitoring visits occurred.

Client F3 began receiving services on June 4, 2007, which included unlicensed staff providing medication administration and catheter care. Supervisory visits occurred on July 16, 2007, August 9, 2007, October 18, 2007 October 24 and November 27, 2007. There was no evidence additional supervisory or monitoring visits occurred.

Client F4 began receiving services on November 22, 2006, including medication assistance and supervision with transfers, dressing, eating, grooming, and bathing. The last supervisory visit documented was on October 18, 2007.

Client's I1 and I2 began receiving services August 13, 2007, and May 25, 2007, respectively. Client I1 received medication administration, tube feedings, and nebulizer treatments. Client I1's record contained one supervisory visit dated October 7, 2007. Client I2 received medication administration and blood glucose monitoring. Client I2's record contained one supervisory visit on July 2, 2007. When interviewed dated November 27, 2007, employee IG indicated there were no other supervisory visits found for the clients.

Client I4 began receiving services on November 18, 2004, including medication administration by unlicensed staff, in addition to assistance with her activities of daily living. Supervisory visits of the unlicensed personnel were not conducted every fourteen days as required. A supervisory visit by an RN was documented on May 2, 2007, but not again until June 13, 2007. A supervisory visit by an RN was documented on August 7, 2007, and not again until October 24, 2007. There were no documented supervisory visits after October 31, 2007.

Client M1 began receiving services from unlicensed staff, including medication administration, on March 28, 2007. Supervisory visit were conducted on October 17, 2007, and November 14, 2007. No evidence of additional supervisory visits was provided during the on-site visit.

Client M2 began receiving services on September 5, 2007, including medication administration and blood glucose monitoring. There was evidence of only one supervisory visit which was documented on October 17, 2007.

Client M3 began receiving services on September 5, 2007, including medication administration by unlicensed personnel. Client M3's record contained evidence of supervisory visits by an RN on October 17, 2007, and November 14, 2007. There was no evidence additional supervisory or monitoring visits occurred.

When interviewed on November 29, 2007, the RN/owner indicated she was unaware that the supervisory visits needed to be completed every fourteen days for clients who were receiving medication administration.

10. MN Rule 4668.0130 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record reviews and interviews, the licensee failed to ensure that unlicensed staff were trained and competency tested by a registered nurse (RN) for two of two unlicensed employee's records (AA and AC) reviewed at site A; one of one unlicensed employee's records (DC) reviewed at site D; and three of five unlicensed employees' records (ID, IC and IL) reviewed at site I. The findings include:

Unlicensed employees AA and AC were hired on October 7, 2005, and November 15, 2006, respectively. Client A1 and A3's records indicated employees AA and AC assisted them with medication administration. The "PCA Orientation/Competency Checklist" in employee AA and AC's records was a photocopy form. The photocopy form was pre filled out and indicated medication administration was taught by an RN and was checked under "sign-off." The forms were generic and were used for other unlicensed employees. The forms also had a photocopied signature of the RN/owner with the date area next to the RN signature left blank. The forms were signed and dated by the employees on the day of hire. The forms did not note the dates of the training and lacked evidence of a competency evaluation. When interviewed on November 28, 2007, employee AA stated that the unlicensed employees were trained to perform home health aide tasks, including medication administration by the lead unlicensed employee, employee IG and not by the nurse.

Employee DC was hired on May 15, 2007, as an unlicensed employee, to perform home health aide tasks. Records lacked evidence that employee DC demonstrated competency to an RN for dressing, grooming, bathing, and transferring. When interviewed on November 27, 2007, employee DC indicated he was a home health aide in another state before moving to Minnesota, and he was trained by an RN at that agency.

There was evidence that employee ID, an unlicensed employee, received written training related to medication administration. There was no evidence that employee ID had a competency evaluation for medication administration. When interviewed on November 26, 2007, employee ID, stated that she had been employed for approximately two months to perform home health aide tasks. When questioned regarding her training, employee ID stated that the two lead unlicensed employees on the day shift and night shift had trained her on how to administer medications, how to bathe the clients, how to assist them with brushing their teeth, how to prepare the food, how to communicate with the clients, and how to take a blood pressure and temperature. Employee ID stated that employee IB, the unlicensed employee on the day shift trained her on how to administer client I1's gastrostomy tube feedings.

Personnel records indicated employee IC, an unlicensed employee received written training related to medication administration. There was no evidence that employee ID had a competency evaluation for medication administration. When interviewed on November 26, 2007, employee IC, stated that she had been employed for four days. When questioned regarding her training, employee IC stated that this was her second day working at site I, and that she had been working with client I3. She stated that

employee IA, a lead unlicensed employee, trained her on how to administer client I3's medications, how to give him his bath, and how to take his blood pressure and pulse.

When interviewed on November 26, 2007, LPN IE stated that the unlicensed staff start at the main office and watch some videos regarding care and services. Then the unlicensed staff members go to the home and train with the lead unlicensed employee. Approximately two to three weeks later, RN FH comes to the home and reviews the care plan with the unlicensed employee to make sure they are providing the services correctly.

Client I1's records contained "PCA Daily Charting: 7PM – 7AM" dated November 24, 2007, which indicated employee IA , an unlicensed employee, "trained" employee IL, who was also an unlicensed employee, to work with client I1. Client I1's medication administration record for November 2007, indicated client I1 was to receive Peptamen two cans at 8:00 a.m., 12 noon, 5:00 p.m. and one can at 8:00 p.m., and flush j-tube with 100 ml. water before feeding and then follow up with 200 ml. water flush after feeding. On November 25, 2007, employee IL documented she had given client I1 two cans of tube feeding at breakfast, lunch, and dinner. There was no evidence that employee IL had been trained by an RN.

11. MN Rule 4668.0140 Subp. 1

INDICATOR OF COMPLIANCE: # 1

Based on record review and interview the licensee failed to ensure a service agreement was completed no later than the second visit to a client for one of one discharge client records (A4) reviewed at site A; and one of one discharge client record (M4) reviewed at site M; and failed to ensure that a service agreement modification was agreed to in writing for one of three current clients' records (B2) reviewed at site B. The findings include:

Client A4 began receiving services on February 1, 2007, and was discharged to the hospital on October 23, 2007. A service agreement was not found in client A4's record.

Client M4 began receiving services on November 8, 2007. Client M4's record lacked evidence that a service agreement had been completed. When interviewed on November 29, 2007, the registered nurse (RN)/owner confirmed there was not a service agreement in client M4's record.

A service agreement indicated client B2 began receiving unlicensed staff services for two hours per day on August 22, 2003. On November 27, 2007, the RN/owner, RN BA and licensed practical nurse (LPN) BB, reported that client B2 had not received unlicensed staff services for a long time. The RN/owner reported that the insurance company had dropped the coverage for unlicensed services. The RN/owner stated it was an oversight not to have modified client B2's service agreement.

12. MN Rule 4668.0140 Subp. 2

INDICATOR OF COMPLIANCE: # 1

Based on observation, record review and interview, the licensee failed to provide a complete service agreement for three of three current clients' records (A1, A2 and A3) reviewed at site A; four of four

clients' records (B1, B2, B3 and B4) reviewed at site B; one of one client record (C1) reviewed at site C; five of five clients' records (D1, D2, D3, D4 and D5) reviewed at site D; four of five clients'records (F1, F2, F3 and F4) reviewed at site F; four of four current clients' records (I1, I2, I3 and I4) reviewed at site I; and three of three current clients' records (M1, M2 and M3) reviewed at site M. The findings include:

Clients A1, A2 and A3, began receiving services on July 19, 2006, July 18, 2005, and March 16, 2007, respectively. The service agreements for clients A1, A2 and A3, were signed and dated by the client or their representative on the date services began. The service agreements did not contain descriptions, the frequency of the services to be provided, or a schedule of the sessions of supervision. When interviewed on November 26, 2007, LPN (licensed practical nurse) AB stated she was a new employee and did not know why the service agreements lacked the specific services and the schedule of supervisory visits. LPN AB indicated each client had a care plan that listed what cares and services were to be provided. The service agreements did not indicate that the care plan was part of each client's service agreement.

Clients B1, B2, B3 and B4's service plans dated June 6, 2007, August 22, 2003, May 17, 2006, and September 24, 2007, respectively, lacked a description of the services to be provided; which included central storage of medications, medication administration, tube feeding, ventilator and trachea care, dressing, grooming, bathing, transferring and range of motion. The service agreements also lacked the name of the person to contact in case of an emergency or a significant adverse change in the client's condition and the method for the licensee to contact the person. When interviewed on November 28, 2007, RN (registered nurse) BA and LPN BB were unable to provide the reviewer with information for reaching client B1's emergency contact. When interviewed on November 27, 2007, RN BA and LPN BB confirmed the service agreements were incomplete.

Client C1's service agreement dated, October 16, 2007, did not list the services the client received which included: suctioning, tracheostomy, ventilator, gastro–jejunostomy feedings, water orally only to wet the mouth, splinting of left humerus, transportation to dialysis three times per week, dressing, grooming, bathing, mobility, toileting and restraints. There was no fee schedule listed. The contingency plan did not address the method for the licensee to contact the responsible person for client C1.

Client D1's service agreement dated June 16, 2005, included thirteen hours per day of RN services. When interviewed, November 27**,** 2007, RN DA stated RN's worked twelve hour shifts Monday through Friday with LPN coverage on the weekends. RN DA also stated client D1 received daily unlicensed staff services, which were not identified on the service agreement. The service agreement lacked a description of the services to be provided and the frequency of sessions of supervision or monitoring for services provided by unlicensed staff. On November 29, 2007, RN FH verified the service agreements should be more complete.

Client D3's service agreement dated May 16, 2006, included three hours per day RN and LPN services with eighteen hours of unlicensed services per day. When interviewed November 27, 2007, RN DA stated RNs worked twelve hour shifts Monday through Friday with LPN coverage on the weekends. The service agreement lacked a description of services to be provided and the frequency of sessions of supervision or monitoring for services provided by unlicensed staff. When interviewed, November 29, 2007, RN FH indicated the service agreement should be more complete.

Client D2, D4, and D5 received services including central storage of medications, medication administration, tube feeding, suctioning, nebulizer treatment, trachea care, wound care, catheter care, dressing, grooming, bathing, feeding, turning and positioning. Client D2, D4, and D5's, service agreements dated May 3, 2007, October 31, 2007, and June 7, 2007, respectively, lacked a description of the services to be provided, and did not identify the name and phone number of the person to contact in case of an emergency or a significant adverse change in the client's condition and the method for the licensee to contact the person. When interviewed on November 26, 2007, RN DA indicated that she was not aware of a service agreement because the office did it. When interviewed on November 29, 2007, the RN FH agreed the service agreement for each client was not complete.

Client F1's service agreement, dated November 2, 2006, stated he was to receive one to one unlicensed staff services for twelve hours per day and one to two unlicensed staff for twelve hours per day. The service agreement failed to provide a description of the services to be provided, the schedule or frequency of supervision or monitoring required, and a complete plan for contingency action.

Clients F2 and F3's service agreements were dated September 6, 2005, and June 4, 2007, respectively. Both clients F2 and F3 received medication administration and assistance with activities of daily living. The service agreements did not include the services to be provided, the frequency of the services and the fees for the services. The service agreements also did not identify the categories of persons to provide the services, or the frequency of supervision or monitoring of delegated nursing tasks.

Client F4's service agreement, dated November 24, 2006, stated he was to receive RN services four hours per week, unlicensed staff services one to one for twelve hours per day and shared unlicensed staff services for twelve hours per day. The service agreement failed to include the services to be provided, the schedule or frequency of supervision or monitoring required, and a complete plan for contingency action.

Client I1's record indicated client I1 received medication administration, tube feedings, and nebulizer treatments. Client I1's service agreement, dated August 13, 2007, did not include these services.

Client I2's record indicated client I2 was receiving medication set up, medication administration, and blood glucose monitoring. Client I2's service agreement dated May 25, 2007, did not include these services.

Client I4 began receiving services on November 18, 2004. A service agreement dated November 18, 2004, indicated Client I4 was to receive RN skilled visits/two hours a day, and unlicensed staff services twelve hours a day. There was no description of the services that the RN and unlicensed staff provided on the service agreement or the frequency of supervision or monitoring of the unlicensed staff. Observations on November 26, 27, and 28, 2007, revealed that the nurse, who was an LPN, set-up the client's medications in a weekly medi-set on a weekly basis. The unlicensed staff were observed to administer the medications to the client and assist the client with her dressing, bathing, grooming, and ambulation.

Client I3 began receiving services on September 17, 2007. Client I3's service agreement which was not dated, indicated that client I3 was to receive one to one unlicensed staff services twelve hours a

day, and one to two unlicensed staff services twelve hours a day. There was no description of the services that the unlicensed staff provided on the service agreement or the frequency of supervision or monitoring of the unlicensed staff. Observations on November 26, 27, and 28, 2007, revealed that the licensed practical nurse, set-up the client's medications in a weekly medi-set on a weekly basis. The unlicensed staff were observed to administer medications to the client, assist the client with his activities of daily living, prepare his meals, and assist the client with range of motion exercises. When interviewed, on November 27, 2007, LPN IE confirmed the lack of information on clients I4 and I3s' service agreements.

Client M1 began receiving services on March 28, 2007. Client M1's service agreement indicated that client M1 was to receive one to one unlicensed staff services twelve hours a day, and one to two unlicensed staff services twelve hours a day. The service agreement did not include a description of the services that the unlicensed staff provided. The service agreement did not indicate that client M1 was receiving RN or LPN services or supervisory visits. An interview with LPN IE on November 26, 2007, and observations on November 26, 27, and 28, 2007, revealed that an LPN, set up the client's medications in a weekly medi-set on a weekly basis. The unlicensed staff were observed administering medications to the client, providing supervision of daily living activities, preparing his meals, and transporting him to outside activities.

A service agreement dated September 5, 2007, indicated client M2 received assistance with medications, had insulin and other medications set up by a licensed nurse and blood glucose monitoring done by unlicensed staff. The service plan did not address who was to provide the services, the type of services, the frequency of services or the fees for the services.

Client M3's service agreement dated October 5, 2007, indicated client M3 was to receive "RN supervision Visit 1hr/day" and "PCA 12 hr/day." Client M3's record indicated an LPN set up medications and the medications were stored in central storage at site M. The service agreement did not include the services the client received. When interviewed on November 29, 2007, the RN/owner stated she thought the service agreements were correct because a consultant's recommended form was used.

13. MN Rule 4668.0150 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to have a current prescriber's order for a medication for one of two current clients' records reviewed (B1) at site B. The findings include:

Client B1's medication administration record indicated Nystop (nystatin topical powder) 15 gram powder was to be applied topically on inguinal skin folds twice daily. There was no evidence of a physician order for this medication. When interviewed on November 27, 2007, registered nurse (RN) FH stated there was not an order for the Nystop.

Client B1 had physician orders dated, September 12, 2007, which indicated that Theragen Liquid and Certagen (both vitamins) were to be administered once daily. The November 2007 medication administration record indicated that only "multivitamin liquid" was given one time per day, and Certagen had "D/C" (discontinue) written across the spaces of the calendar days. When interviewed

on November 27, 2007, a licensed practical nurse indicated the physician had discontinued the Certagen, but s/he could not find the order.

14. MN Rule 4668.0150 Subp. 5

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview the licensee failed to have prescriber orders recorded and forwarded to the prescriber for the prescriber's signature for two of three current client records (A1 and A3) reviewed at site A. The findings include:

Client A1 began receiving services, including assistance with medication administration, on July 19, 2006. A progress note, dated November 21, 2007, stated the on call doctor was called after client A1 complained of an upset stomach; the progress notes indicated the doctor ordered a blood sugar check, four times a day, for two days, and Maalox four times a day for two days. There was no evidence these orders had been transferred to a physician order form and forwarded to the physician for signature. The progress note also stated that "Tylenol prn" was given. The record lacked evidence of a physician order for Tylenol. When interviewed on November 26, 2007, the RN/owner verified there was no order for Tylenol. On November 26, 2007, licensed practical nurse (LPN) AB stated the protocol for a verbal order was to write the order on a piece of paper, sign the order, and fax the order to the prescriber for signature. She stated she did not know where the order was for November 21, 2007.

Client A3 began receiving services, including assistance with medication administration on March 16, 2007. On November 13, 2007, the Medication Administration Record (MAR) read, "continue insulin sliding scale as previously ordered; Note: client received scheduled 10 units NovoLog before each meal along with sliding scale." The record did not contain a prescriber's order to resume the "sliding scale" NovoLog insulin. The MAR also indicated on November 13, 2007, that there were new orders for aspirin 81 mg. every day; ibuprofen 800 mg. two times a day; and ranitidine 150mg. two times a day. Records lacked prescriber's orders for the identified medications. When interviewed, November 28, 2007, LPN AE, stated she did not know where the orders were for the medication changes

15. MN Rule 4668.0150 Subp. 6

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that medication and treatment orders were renewed at least every three months for one of three current client records (A1) reviewed at site A; one of three current client records (B2) reviewed at site B; one of four current clients' records (I4) reviewed at site I; and two of three current client records (M1 and M2) reviewed at site M. The findings include:

Client A1 began receiving services on July 19, 2006. The November 2007 medication administration record (MAR) indicated client A1 received omeprazole, Risperdal, simvastatin, Actos, aspirin, Depakote, diphenhydramine, fluvoxamine, metformin, and regular insulin with sliding scale coverage. The most recent physician order for fluvoxamine was August 23, 2007; the most recent physician order for Actos, metformin, Novolin R, for sliding scale; omeprazole, aspirin, and simvastatin was November 1, 2006. The most recent physician order for Risperdal and Depakote was July 18, 2006.

The record lacked a physician order for diphenhydramine. When interviewed, November 27, 2007, the RN (registered nurse)/owner stated that orders were renewed at the main office. No additional prescriber's orders were provided as of November 29, 2007.

Client B2 began receiving services on August 22, 2003. Client B2's most recent prescriber orders for medications were dated July 1, 2007. When interviewed on November 26, 2007, RN BA stated she was unaware that medication orders had to be renewed at least every three months.

Client I4 started receiving services on November 18, 2004. Documentation indicated that the client's medication and treatment orders were renewed by a physician on March 9, 2007. There were no further renewals of the client's medications. When interviewed on November 27, 2007, LPN (licensed practical nurse) IE, confirmed that March 9, 2007, was the last time client I4's medications and treatments were renewed by a prescriber.

Client M1's medications including Prevacid, Genebs, Milk of Magnesia, Aspirin, Cozaar, Docusate Sodium, Lactulose, and Tylenol PM were most recently renewed on August 6, 2007. When interviewed on November 29, 2007, the RN/owner reported that the documentation to renew the client's medications had not been submitted to the prescriber because the pharmacy had not provided the agency with the renewal of medication documentation.

Client M2 began receiving services on September 5, 2007. On August 31, 2007, a prescriber ordered NovoLog insulin with sliding scale dosage times up to four times per day for thirty days and Pepcid 20 milligrams two times a day for thirty days, both with no refills. There were no subsequent prescriber's orders. The medication record and the capillary blood glucose insulin flow sheet documentation indicated insulin was administered to client M2 on November 14 and 21, 2007. Pepcid was administered two times per day during November 2007. When interviewed on November 27, 2007, LPN IE, indicated she stated she was unaware orders needed to be renewed after 30 days and confirmed the insulin and Pecid orders were not renewed after thirty days.

16. MN Rule 4668.0160 Subp. 5

INDICATOR OF COMPLIANCE: # 4

Based on record review and interview, the licensee failed to ensure that entries in the client record were authenticated with the name, date and title of the person making the entry for four of four client records (B1, B2, B3 and B4) reviewed at site B; three of four current clients' records (D1, D2 and D4) reviewed at site D; two of four current clients' records (I3 and I4) reviewed at site I; and two of four records reviewed (M1 and M3) at site M . The findings include:

Client B1 began receiving services on June 6, 2007. Progress notes lacked employee signatures, titles and dates on nine different entries between November 13, 2007, and November 25, 2007.

Client B2 began receiving services on August 22, 2003. Progress notes lacked employee's signatures on November 18, 21, 24 and 26, 2007. Progress notes lacked employee's titles on October 23, 24, and 31, 2007, and November 7, 8, 14, 19, 20 and 23, 2007. Progress notes lacked both employee's last name and title on November 6, 14, 16 and 17, 2007. Ventilator flow sheets and client flow sheets

lacked the employee's last name and title on November 26, 2007. Flow sheets lacked employees' last name on October 16 and 17, 2007.

Client B3 received services between May 17, 2006, and November 20, 2007. Between November 16, 2007 and November 20, 2007, there were three nurses' notes which did not contain an employees' signature and title.

Client B4's progress notes lacked an employee's last name on November 18 and 21, 2007. Progress notes lacked an employee's title on November 15 and 16, 2007. When interviewed November 26, 2007, registered nurse (RN) BA agreed that entries should be signed with the title of the employee.

Client D1 began receiving services on May 7, 2004. Clients care forms were not dated. When interviewed on November 29, 2007, RN FH, stated the documents should have been dated.

Client D2 began receiving services on May 3, 2007. A progress note dated November 02, 2007, was not signed by the employee providing care.

Client D4 began receiving services on October 31, 2007. A Nursing Health Monitoring Visit note dated, November 28, 2007, was not signed by the employee documenting the note. When interviewed, November 29, 2007, RN FH indicated that the documentation should have been signed.

Client I4 had a form titled "PCA Medication Assistance Form" for the month of November 2007. This form contained initials of employees who administered client I4's medications on a daily basis. The form did not contain the names and titles of the persons making the entries. Client I4 also had a form titled "Client Care Form" which included the amount of assistance the client required with her activities of daily living, and special instructions for her care. This form did not include the name and title of the person completing the form.

Client I3 had a form titled, "PCA medication Assistance Form" for the month of November 2007. This form contained initials of employees who administered client I3's medications on a daily basis. The form did not contain the names and titles of the persons making the entries. A form titled "PCA Care Plan" dated September 17, 2007, included the amount of assistance the client required with his activities of daily living, and special instructions for his care. This form did not include the name and title of the employee completing the form. Client I3 had a form titled "Capillary Blood Glucose/Insulin Flow sheet" dated November 17, 2007, though November 21, 2007, and November 22, 2007, through November 26, 2007. This form contained initials of employees that performed blood glucose monitoring at 8:00 a.m., 12:00 noon, and 5:00 p.m. and at bedtime. The form did not contain the names and titles of the employees documenting the blood glucose.

Client M1 had a form titled, "PCA medication Assistance Form" for the month of November 2007. This form contained initials of employees who administered client M1's medications on a daily basis. The form did not contain the names of the persons making the entries, only initials.

Client M3's record contained a vulnerable adult assessment that was signed by an RN, but was not dated.

17. MN Rule 4668.0160 Subp. 6

INDICATOR OF COMPLIANCE: # 4

Based on record review and interviews, the licensee failed to ensure that client records were complete for one of three current records reviewed (A3) at site A; two of three current clients' records (B1 and B2) reviewed at site B; one of four current clients' records (D4) reviewed at site D; three of four current clients; records (I1, I3 and I4) reviewed at site I; and one of three current clients' records (M2) reviewed at site M. The findings include:

Client A3 began receiving services on March 16, 2007. Three pages of progress notes and two pages of blood glucose flow sheets in client A3's file lacked client A3's name. When interviewed on November 26, 2007, licensed practical nurse (LPN) AB confirmed the records belonged in client A3's record and indicated that sometimes the staff failed to fill in the client's name.

Client B1's record had one of six pages that were not labeled with the client's name from November 13, 2007, through November 25, 2007.

The client name was absent on progress note pages dated October 23 and 30, 2007, and November 5 and 7, 2007, found in Client B2's record. When interviewed on November 27, 2007, registered nurse (RN) BA acknowledged that the client names were absent from the progress notes.

Progress notes dated November 21, 2007, through November 23, 2007, were not labeled with client D4's name. When interviewed on November 27, 2007, RN DA, stated the pages should have been labeled with client D4's name.

Client I1's record contained Personal Care Attendant (PCA) Daily Charting 7PM – 7AM forms dated, November 12, 17, 18, and 21, 2007. The forms were not signed and did not indicate the services that were provided

A progress note indicated client I3 returned from the hospital at 6:00 p.m., on October 10, 2007, and the documentation commented on client I3's vital signs, skin condition, appetite, comfort and medication orders. The employee who wrote the note did not sign the note or the medication orders on October 10, 2007.

Weekly medication set-ups were not documented on the client I4's November 2007 Medication Administration Record (MAR). When interviewed on November 27, 2007, LPN IE confirmed that she set up client I4's morning medications weekly and usually documented the set up on the MAR. LPN IE stated that LPN MA set up the client's evening medications and was to have documented the set up on the MAR. Employee IE confirmed client I4's November 2007 medication administration record did not contain evidence of any medication set ups. When questioned as to why client I4's November 2007 MAR was blank, LPN IE stated that she was "behind" in her documentation.

Client M2's record had capillary blood glucose/insulin flow sheets without the client's name or identifier. There were a total of four flow sheets without client M2's name, dated, October 29, 2007 through November 2, 2007; November 3, 2007 through November 7, 2007; November 8, 2007

through November 12, 2007; and November 13, 2007 through November 17, 2007. On November 28, 2007, RN/owner stated client M2's documentation was not complete.

Client M2's record had capillary blood glucose/insulin flow sheets without documentation of the blood glucose reading, type of insulin, and the number of units received on October 30, 2007, and November 5, 6, and 7, 2007. In addition, Novolog insulin, scheduled at 5:00 p.m., was not documented on October 30, 2007, and November 5, 6, 7, 25 and 27, 2007. On November 27, 2007, the 9:00 p.m. scheduled insulin and blood glucose readings were blank. Daily charting and nursing progress notes did not address the reason blood glucose monitoring and insulin administration had not been provided. When interviewed on November 27, 2007, the RN/owner indicated the blank spaces on the blood glucose/insulin flow sheets were errors.

18. MN Statute §144A.44 Subd. 1(2)

INDICATOR OF COMPLIANCE: # 2

Based on observations, record reviews and interviews, the licensee failed to provide nursing care and services according to accepted medical or nursing standards for two of three clients' records (B1 and B2) reviewed at site B; one of one client record (C1) reviewed at site C; and two of four current clients' records (F2 and F3) reviewed at site F. The findings include:

On November 26, 2007, a tracheostomy suctioning procedure for client B1 was observed. Registered nurse (RN) BA was observed holding and speaking on the phone several times and then was observed to suction client B1 without washing her hands. When interviewed, November 26, 2007, employee BA stated she had washed her hands before she took the phone calls, but not before she started the suctioning.

Client B2's medication administration record (MAR) stated "chart on skin condition every Wednesday after morning bath, closely examine posterior neck, coccyx, and peri-area. Call MD for treatment order if any open areas are noted." The MAR's for October and November 2007, had weekly signatures suggesting that the charting was done. However, weekly skin charting, including the status of a coccyx wound, was not found as indicated on October 10, 17, 24, and 31, 2007, and November 7, 14, 21, 2007. The coccyx wound was observed by the reviewer during repositioning on November 27, 2007. The coccyx wound was approximately 1.0 centimeter long by 0.5 centimeter wide. RN (registered nurse) BA and licensed practical nurse (LPN) BB stated the wound was smaller than it had been. When interviewed, November 27, 2007, RN BA and LPN BB stated they were unaware the condition of the coccyx open area had not been documented.

Client C1 had multiple medical problems and began receiving services on October 16, 2007. Client C1 had a fracture of the left humerus, which was splinted on October 16, 2007. Client C1 was hospitalized from October 31, 2007 through November 17, 2007, and November 26, 2007 through November 28, 2007. Documentation for client C1 dated October 30, 2007, stated, "L (left) humerus splint & dresg (dressing) sleeve & gauze had constricted ____ inner inside of L arm. Area cleansed with sterile H_20 (water). Betadine; covered with gauze. Noted that o/a (open area) was 4 inches long 1 inch deep; can visible tissue." The RN was notified and client C1 was sent to the hospital emergency room. On November 1, 2007, documentation stated, "informed that blood work done & eval (evaluation) of o/a was + staph (staphylococcus), is septic. M.D.'s (medical doctor) to meet this

afternoon will call later with current info (information)." Client C1's left arm was observed on November 29, 2007. Client C1's left antecubital space was almost healed, but not completely closed. The left humerus splint was not padded. The splint was over a gauze sleeve, but the splint still extended into the antecubital space. When interviewed on November 29, 2007, LPN FJ indicated the open area was caused by the splint, and she believed a physician's order was needed to pad the splint, but a physician had not been contacted. There was no charting regarding skin inspections and the splint pressure points.

Client F3, a paraplegic, began receiving services on June 4, 2007. Documentation and an interview with the RN/owner on November 29, 2007, indicated client F3 had a history of non-compliance and refusing care. Staff were instructed via a memo in the PCA assignment book to complete a "tracking sheet for target behaviors" with directions that client F3's behaviors, including refusing medications and cares were to be monitored and documented every hour. The last notation entered on the behavior tracking sheet was on October 29, 2007, but that notation was unrelated to client F3 refusing care or medications.

Wound assessments for client F3 were completed by a clinic wound nurse on August 14, 28, October 11 and November 6, 2007. Prescriber orders from a clinic wound nurse dated August 28, 2007, indicated wound treatments were to be provided to client F3 once per day. Documentation on November 6, 2007, indicated client F3 had numerous pressure ulcers (the sites were not identified) and stated that the "wound has increased in size dramatically." The clinic wound nurse documentation dated November 6, 2007, stated the nurse had checked the alternating pressure mattress on client F3's bed and noted that the static button for the bed was in the "on" position and "no one was aware of this and it is questionable how long it has been like this." (When the static button is on the alternating pressure mattress is in the "on" position, the pressure in the mattress is constant and does not alternate the pressure points on the client's body while in the bed). The clinic wound nurse also noted, "The house is presently out of AMD Fluffs and are waiting for more." The clinic wound nurse indicated s/he could not determine how long the agency did not have the proper wound treatment supplies to complete the wound treatments. The clinic wound nurse wrote an order to "get the AMD Fluffs ASAP and use to pack dry into the sacral wound BID (twice per day)." Client F3's sacral wound measured 5.8 cm x 3 cm x 0.7 cm deep. The clinic wound nurse checked "pts shoe and found a wadded up piece of paper towel in shoe. Pt and staff unaware of why it would be there." Client F3 was a paraplegic and had no sensation in his lower extremities. Client F3 had a pressure ulcer on the right heel and on the outside of his left foot by the little toe. Staff assisted with applying the shoe.

During the course of the on-site visit on November 26, 27, 28 and 29, 2007, the RN/owner was only able to provide client F3's treatment records for November 2007. The November 2007 treatment record was blank, indicating the wound treatments were not completed. There were no documented assessments of client F3's wounds by the home care provider's licensed nurses.

Client F3 had a suprapubic catheter. Care instructions indicated the catheter was to be changed by the nurse every three weeks starting on June 18, 2007. Client F3 was seen by a urologist for leakage around the suprapubic tube on August 13, 2007. The urology note stated, "Catheter changed late May?? Had been at (a nursing home) and believes that was the last time it was changed." Client F3's record at site F, indicated catheter changes were done twice since services were initiated on June 4, 2007.

Client F3 was hospitalized from November 12, 2007, until November 21, 2007, for infected decubitus ulcers and a urinary tract infection. The hospital discharge note on November 21, 2007, indicated client F3 had large, stage IV ulcers over bilateral ischial tuberosities and his sacrum. When interviewed on November 29, 2007, the RN/owner stated client F3 was non-compliant and refused the wound treatments. It was the policy of the agency to document each time a treatment was refused or completed. When interviewed on November 28, 2007, client F3 stated his wound treatments were sometimes done once per day, but then sometimes not for two days in a row. The RN/owner reported it was the policy of the agency to complete a wound assessment weekly for any client with a wound and to document each time a suprapubic catheter was changed.

Client F2 had a left heel pressure ulcer that was 2.1 cm. x 0.7 cm. in size on October 18, 2007. There was an order for wound treatment to the heel every other day. The November 2007 treatment records were blank with no indication treatment had been provided for the left heel wound. Client F2's treatment records for the previous ten months were not located or provided for review. When interviewed on November 27, 2007, client F2 stated a nurse provided wound treatments to the left heel wound every other day.

A draft copy of this completed form was left with Josephine Gurley, RN/Owner, at an exit conference on December 12, 2007. Any correction order(s) issued as a result of the on-site visit and the final Licensing Survey Form will be sent to the licensee. 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 review, this form will be posted on the MDH website. CLASS A Licensed-only Home Care Provider general information is available by going to the following web address and clicking on the Class A Home Care Provider link:

http://www.health.state.mn.us/divs/fpc/profinfo/cms/casemix.html

Regulations can be viewed on the Internet: http://www.revisor.leg.state.mn.us/stats (for MN statutes) http://www.revisor.leg.state.mn.us/arule/ (for MN Rules).

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7005 0390 0006 1222 2245

January 18, 2008

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
770 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurley:

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 December 21, 2007.

The documents checked below are enclosed.

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

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

_____ 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 21, 2007

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Lynn Eddy, LPN
Joseph Dillon, LPN
Josephine Gurley, RN/Owner

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #7

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visits made on December 5, 14, 17, 18, 19, 20, and 21, 2007.

The status of the correction orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 is as follows:

1. MN Rule 4668.0150 Subp. 2 **Corrected**

2. The following referral is being made:
i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 20, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurely:

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 December 20, 2007.

The documents checked below are enclosed.

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

_____ 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 20, 2007

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Marie Robinson, PCA
Youder Soror, PCA
Connia Zirayo, LPN
Emmanuel Ngarma, PCA
Bernice Bettie, PCA

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #6

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 November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visits made on December 5, 14, 17, 18, 19, and 20, 2007.

The status of the correction orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 is as follows:

1. MN Rule 4668.0150 Subp. 2 **Not corrected** **$11,200.00**

Based on observations, interview and record review, the licensee failed to ensure medications were administered as ordered for two of two clients' (I2 and I4) records reviewed at site I. The findings include:

Client I2's medi-set container was observed on the morning of December 20, 2007 with licensed practical nurse (LPN) IE. Amlodipine 10 milligrams (mg.) was set up in the 4:00 p.m. and 8:00 p.m. slot for the entire week, even though there was no physician's order to administer this medication. When interviewed on December 20, 2007, LPN IE confirmed that there was not a physician's order for the

Amlodipine on the most recent physician's order sheet signed by the physician on December 7, 2007. LPN IE stated that she did not know why the medication was not on the physician's order sheet.

Client I2 had a physician's order dated December 7, 2007 for Metoclopramide 5 mg. to be administered three times a day before meals. According to the Nursing 2008 Drug Handbook, this medication was to be administered thirty minutes before meals. Although client I2's medication administration record (MAR) dated December 2007 indicated the medication was to be administered at 7:00 a.m., 11:00 a.m. and 4:00 p.m., an interview with LPN IE on December 20, 2007 revealed that LPN IE set up all of the client's a.m. medications and placed them all in the 8:00 a.m. medication slot in the client's medi-set, including the Metoclopramide. LPN IE stated that the client usually received his a.m. medications while he was eating, and noted that she would need to removed the Metoclopramide and have the staff give it before the client eats. On December 20, 2007, client I2 was observed to receive all of his a.m. medications at 8:00 a.m. The client was observed to eat his breakfast at 8:15 a.m.

Client I4 was to receive three and one half pills at 8:00 p.m. The client's personal care attendant (PCA) medication assistance form for December 17, 2007 at 8:00 p.m. had a blackened out area where staff were to initial that medications had been administered. There were no initials of staff indicating that the client's medications were administered. There was no other evidence or documentation that the client's 8:00 p.m. medications had been administered on December 17, 2007. When interviewed on December 20, 2007, LPN IE stated she did not know why the area was blackened out, or why there was no documentation that the client received her 8:00 p.m. medications on December 17, 2007.

2) The following referral is being made:
i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

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

December 20, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On December 20, 2007 a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007 with correction orders received by you on December 3, 2007.

The following correction orders were not corrected in the time period allowed for correction:

MN Rule 4668.0150 Subp. 2 **$11,200.00**

Based on records review and interviews the licensee failed to ensure medications were received as ordered for three of four clients reviewed (A1, A2 and A3) at site A, for two of four clients reviewed (B1, and B2) at site B, for four of four clients reviewed (D1, D2, D3 and D4) at site D, for two of three clients reviewed (I3 and I4) at site I, and for two of four clients reviewed (M1 and M2) in house M. The findings include:

Client A1's record contained physician orders for diphenhydramine 25milligrams one to two capsules every six hours; and blood sugar checks with sliding scale coverage with regular insulin, four times daily. During observation of the set-up medications for client A1 on November 26, 2007, it was noted that the containers contained 25 milligrams of diphenhydramine that were being administered at 8AM, 5PM and 8PM; the November, 2007 medication administration record (MAR) also indicated that the client was having blood sugar checks done periodically. On interview, November 26, 2007, the personal care attendant (employee AA) stated that the client only had blood sugar checks done one time per day around 4PM. On interview, November 28, 2007, the LPN stated she did not know why the blood sugar checks were only being done one time per day; she could not find a physician order for this and she stated she would verify with the physician what the order should be.

Client A2 began receiving services July 18, 2005. He had a diagnosis of traumatic brain injury with left hemiplegia and received total assistance with all activities of daily living. The medication administration record and pharmacy printout for November 2007, indicated the client received Baclofen 5mg. TID, Colace 100 mg. BID, Effexor XR 150 mg. QD, Keppra 1000 mg. BID, Seroquel 50 mg. BID, and Trazadone 50 mg. QD. The November 2007, medication administration record was blank from November 1st to the 6th and from November 18th to the 21st. There was no indication that the medications were set up or given.

When interviewed on November 26, 2007, the LPN stated that a nurse would have set up the medications in a medi-set weekly and the unlicensed staff would have given them.
Client A2 had a physicians order dated November 6, 2007, for Vitamin B12 1000 mcg sublingual daily. The November 2007, medication administration record indicated it was first given on November 18, 2007. The Vitamin B12 was observed, November 28, 2007, to be supplied from an over the counter bottle labeled 1000 mcg tablets for oral use. When interviewed November 28, 2007, Unlicensed staff AA verified that this vitamin pill was set up daily in each medi-set and that the client swallowed the pill whole with the rest of his pills. She verified this was not the ordered liquid consistency as ordered by the physician for this medication. She stated that this is what the clients' wife brought in.
The nurse who set up the meds wasn't available to interview and the LPN on duty November 28, 2007 did not normally work at this site and did not know anything about it.

On November 28, 2007, during the 8 am observation of the medication pass, client A3 requested to see the medications, before the licensed practical nurse (LPN) administered them. Client A3 noted that there was a medication missing. All of the medications were then inspected against the medication administration record. During the inspection the LPN stated that client A3's Metformin 1000 milligrams was not in the client's medication container, so he had not set this medication up, however, he had initialed the Metformin for November 28, 2007, at 8am on the medication administration record (MAR) as given. During the inspection it was also noted that the Omeprazole had not be set up for the 8 am medications. The LPN stated that he had missed setting this medication up and he had not documented the medication as given. Before the administration of the medications the LPN found the Metformin for client A3 and the medication was administered. The November, 2007 medication administration record also indicated that aspirin, ibuprofen, ranitidine and Novolog insulin, being used for sliding scale, were being administered to client A3 on November 28, 2007, however, the record lacked physician orders for these medications. When interviewed, November 28, 2007, the LPN stated she did not know where the physician order for these medications was and she would check with the registered nurse/owner.

Client B1 had a physician order dated, September 12, 2007, for Certagen vitamins to be administered once daily. The November 2007, medication chart had "D/C" (discontinue) written across the spaces of calendar days for the Certagen. When interviewed November 27, 2007, the licensed practical nurse stated the physician had discontinued the Certagen but could not find the order.

Client B2 was ventilator dependent (mechanical ventilation of the lungs). The client had orders for Albuterol 0.083% nebulizer one vial every 4-6 hours as needed for wheezing and Albuterol 90 mcg. (micrograms) inhaler two puffs as needed. The medications were not available for administration when the reviewer observed the client's medications on November 27, 2007. The reviewer noted these medications were still not available when the reviewer returned to the facility at 7:14 am on November 29, 2007. Licensed staff person BB stated the medications were

reordered on November 27, 2007, but licensed staff person BA called the pharmacy at 8:30 am on November 29, 2007, and requested refills. This reviewer contacted the pharmacy on November 29, 2007, and was informed that staff had initially reordered the medications on November 28, 2007, not on November 27, 2007, as was reported on interview.

Client D1's November 2007, medication administration record (MAR) indicated the Keppra 100 mg/ml 5 ml per G-tube twice daily was not administered on November 3 and 9, 2007, Ketoconazole 2% cream apply twice daily to face was not administered on November 1, 2, 3, 4, 5 and 18, 2007, Levothyroxine 75 mcg one tablet per G-tube every morning was not administered on November 3 and 13, 2007. Metoprolol 50 mg tablet take 1/1/2 tablets per g-tube twice daily was not administered on November 4, 2007, Mupirocin 2% ointment apply to G-tube site twice daily was not administered on November 2, 4, 6, 9, and 22, 2007, Prochlorperazine 5mg one tablet per feeding tube was not administered on November 1, 2, 3, 4 and 18, 2007. Spiriva 18 mcg one capsule inhaled daily for bronchospasm was not administered on November 1, 4, 17, 18 and 21, 2007. Amlodipine 2.5mg tablet one per g-tube every morning was not administered on November 3, 2007. C- Prevacid 10 ml per g-tube once daily was not administered on November 3, 2007. Cerovite liquid 15 ml per g-tube once daily was not administered on November 3 and 18 2007. Clotrimazole 1% cream apply to trach twice daily was not administered on November 3, 17, 18, 19 and 23, 2007. Combivent inhalation aerosol four puffs, four times daily, were not administered on November 5, 7, 11, 12, 18 and 19, 2007. Guaifenesin Syrup 10 ml per feeding tube twice daily for cough was not administered on November 2, 3, 6 and 22, 2007. Hydrocortisone 1.5% cream to face twice daily was not administered on November 2, 3, 4, 7, 16, 17 and 22, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.

Client D2's November 2007, MAR indicated the Bacitracin applied twice a day to G-tube site was not administered on November 19 and 20, 2007, A dressing change twice daily to the right lower extremity was not administered on November 19, 2007, Pummel and Phlegm fighter twice daily was not administered on November 18, 2007. Bisacodyl 10 mg suppository once daily was not administered on November 20, 2007. Milk of Magnesia 30 cc per feeding tube once daily was not administered on November 18, 2007. Albuterol nebulizer treatment 3cc four times daily was not administered on November 18 and 20, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 27, 2007, the registered nurse, employee DA, stated that the staff must have forgotten to document the medications as given.

Client D2 had an order for Prevacid suspension 2mg/ml 30 ml per feeding tube once daily since November 16, 2007. During observation on November 28, 2007, it was noted that the currently used Prevacid had expired on November 4, 2007. The November 2007 MAR indicated that the client had received it on November 17, 18, 19, 20 and 21, 2007.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that she was unaware that the bottle of Prevacid was expired.

Client D3's November 2007, MAR indicated the NPH insulin 12 units at 7:30 am was not administered on November 6 and 21, 2007. NPH insulin 7 units at 4:30 pm were not administered on November 10, 2007. Septra DS one tablet twice daily for 7 days was not administered on November 6 and 7, 2007. Renegal 800 mg three tablets three times daily with meals was not administered on November 15 and 21, 2007. Blood sugar checks with sliding

scale insulin were not administered on November 9 and 18, 2007. Seroquel 100 mg two tablets at bedtime were not administered on November 7, 2007. Sodium Bicarbonate 325 mg two tablets twice daily were not administered on November 4, 2007.

There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. Client D3 had a physician order dated August 2, 2007, for Novo Human insulin 8 units every morning and 5 units in the evening. The previous order dated July 11, 2007, was for Insulin Human NPH 12 units at 7:30 am and 7 units at 4:30 pm. Upon interview November 27, 2007 the registered nurse, employee DA stated she thought the orders from July 11, 2007, were the current orders.

Client D3 received dialysis three times weekly on Monday, Wednesday and Friday. The record indicated on November 5 and 7, 2007, the resident was at dialysis but documentation indicated he received sliding scale insulin on both days at 12 noon. When interviewed, November 28, 2007, the registered nurse, employee DA stated he received his 12 noon blood sugar check and sliding scale insulin at dialysis and not by the licensees' staff.

Client D4's November 2007, MAR indicated Protonix 40 mg one tablet daily was not administered on November 4, 2007. Accuzyme spray twice daily to right and left heels was not administered on November 14, 15, and 18, 2007. Vitamin C 500 mg twice a daily was not administered on November 7, 2007. Dressing change twice a daily to the feet was not administered on November 5, 2007. Flush PICC line twice daily with 5 cc of Normal Saline then 5 cc Heparin was not administered on November 5, 6 and 21, 2007. Tracheostomy care was not documented as being done on November 26, 2007, and change wound-vac dressing every Monday, Wednesday and Friday was not documented as done on November 7, 9, 16, 20 and 24, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 28, 2007, the registered nurse, employee DA indicated that the client would at times refuse treatments and medications.

During observation of a medication pass on Monday, November 26, 2007, at 12:50 p.m. employee IC, an unlicensed staff was observed to administer medication to client I3. During the medication pass it was noted that the client's prior Sunday evening pill was still in the medi-set. The medication was identified as Ferrous Sulfate 324 milligrams. Employee IC stated that if the client refused the medication it would be logged in the personal care attendant notes, the PCA would have contacted the nurse, and the nurse would have logged it in her notes. No notation was made regarding the client refusing his evening medication on November 26, 2007. It could not be determined why the medication was not administered.

Client I3 received six units of Lantus insulin at bedtime, and had Novolog insulin coverage by sliding scale at 8:00 a.m., 12:00 noon, 5:00 p.m. and bedtime. Unlicensed personnel documented that they administered the insulin that had been pre-set up by the nurse to client I3. When interviewed November 27, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's record indicated unlicensed staff had administered insulin.

Client I3 began receiving services from the home care provider on September 17, 2007. The client's services included one–to-one client to staff care ratio, medication administration and central storage of medication from the licensee. The client had physician's orders for Haldol .4 milliliters intramuscularly every eight hours as needed for agitation. In addition the client

received Ativan 1 milligrams four times a day, Risperdal .5 milligrams twice a day, Celexa forty milligrams every, and Ambien ten milligrams at bedtime. Nurses' notes dated September 17, 2007, read that client I3 was "very agitated, crying and yelling…refuses to stay seated. Was given Ativan upon arrival. No relief and about 1 hour later he was given Haldol IM." On September 18, 2007, "Very agitated up and about….given Haldol at 8:00 a.m." On September 19, 2007, "Up and about. Given Haldol at 8:00 a.m." On September 20, 2007, "Continues to be very restless, crying and moving from one position to another. Very unsteady…..Haldol IM given. Continues to receive Ativan as ordered." On September 23, 2007, "Increased agitation. Continues to receive Ativan and Haldol as ordered." A notation dated September 24, 2007 indicated the client was very lethargic, sleepy, hard to arouse from sleep. The client was then transported by ambulance to the hospital and admitted with a diagnosis of "Altered mental state." Hospital records indicated the client needed to be intubated upon admission. In addition, a hospital physician's note dated September 26, 2007, indicated the following, "It is possible that the patient may have overdosed on one or several of his psych meds as he takes several. This could cause a gradual change in mental status." A hospital physician's note dated October 3, 2007, read the licensee "was called and RN informed us that pt received several injections of Haldol the day of admission. This may explain his altered mental status." There was no further documentation in the client's record concerning the times/frequency he received the Haldol injections. Numerous requests were made by the reviewer to obtain the client's September 2007 medication administration record. The licensee did not provide the requested documentation.

The client returned from the hospital to the facility on October 5, 2007, and was readmitted to the hospital on October 8, 2007, because of increased edema in both legs. When discharged from the hospital October 10, 2007, the client's discharge orders included Norvasc ten milligrams daily. Client I3's October 2007, medication administration record indicated that on October 11, 2007, Norvasc five milligrams was set up in the client's medi-set instead of the ten milligrams as ordered.

Client I3 was readmitted to the hospital again on October 30, 2007, due to being "very lethargic, and stuperous." The client's admission diagnosis was "altered mental status." The hospital history and physical dated October 30, 2007, read, "The nursing home staff states that he has been receiving his medications although he could have access to them and could have overdosed." A notation by a hospital physician dated October 31, 2007, indicated the following, "Unfortunately I cannot tell from the notes available to what extent he (the client) was receiving any of his PRN. medications in the nursing home." The client was readmitted to the facility on November 1, 2007.

On November 6, 2007, client I3 readmitted to the hospital because of episodes of jerky movements. The client was discharged back to the facility on November 8, 2007. Cogentin one milligram twice a day was ordered upon discharge however Cogentin 0.5 milligrams was documented as having been set-up to be administered

The following medication discrepancies were noted from what the physician ordered for client I3 upon discharge, and what was documented as being set-up in the medi-set containers to be administered. Cogentin one milligram twice a day was ordered upon discharge, but when the client's November 2007, medication administration record was reviewed, Cogentin .5 milligrams was documented as having been set-up to be administered. Celexa 10 milligrams daily were ordered upon discharge however the November 2007, medication administration record indicated that Celexa 20 milligrams were set-up and administered. Prilosec 10 milligrams daily were ordered to be given upon discharge however the November 2007 medication administration

record indicated that Prilosec 20 milligrams (two capsules) were set-up and administered. Risperdal .5 milligrams daily at bedtime was ordered upon discharge however the November 2007, medication administration record indicated that Risperdol .5 milligrams twice a day was set-up and administered. When interviewed, November 28, 2007, employee IE, a licensed practical nurse could not explain why the medications were not instituted as ordered upon discharge.

During observation at housing site I on Tuesday November 27, 2007, unlicensed employee ID was observed to administer client I4's 8:00 a.m. medications. Employee ID counted eleven and one half pills that were preset-up in client I4's medi-set slot for Tuesday at 8:00 a.m., and administered the pills to the client. The client's record was reviewed and it was noted that the client was to receive twelve and one half pills at 8:00 a.m. every morning instead of eleven and a half as observed.

When questioned about the discrepancy, employee IE, the licensed practical nurse (LPN) checked the client's medi-set, and noted a half of a pill was stuck to the bottom of the medi-set in the Tuesday 8:00 a.m. slot. Employee IE stated she was unsure why there would be an additional half of a tablet of medication in the slot, when the client had already received a half of a tablet that morning. The LPN identified the half of a tablet as Baclofen 5 milligrams. The LPN stated she spoke with employee ID regarding the medication pass. The LPN reported that employee ID stated that the morning of November 27, 2007, employee ID had noted there were no pills in client I4' s medi-set slot for Tuesday, November 27, 2007. Employee ID then asked nurse MA, a licensed practical nurse if she could move the pills that were pre set up in Friday's slot to Tuesday's slot. According to employee ID, nurse MA stated she could, so employee ID moved the client's pills from the Friday slot to the Tuesday slot. Nurse IE stated that maybe when employee ID moved the pills employee ID inadvertently dropped a pill on the floor. Nurse IE stated that there had not been pills in the Tuesday 8:00 a.m. slot because she had not had the time to fill the weekly medi-set for client I4 on Monday, November 26, 2007. When the medication discrepancy was noted, the reviewer requested nurse IE to assist in checking the accuracy of the amount of pills that were in the Wednesday 8:00 a.m. slot. There were twelve pills in the Wednesday 8:00 a.m. slot, when there should have been twelve and one half pills. Nurse IE could not explain why the half of a tablet of Baclofen was not in the Wednesday slot, nor why there would have been two half tablets in Tuesday's slot. In addition, it could not be determined what medication client I4 did not receive Tuesday morning at 8:00 a.m.

Client I4 had an order for Docusate Sodium 100 milligrams twice a day. The medications set up by the licensee's nurse in the medi-set revealed that the Docusate Sodium was only set up for one time daily at bedtime. When interviewed, November 28, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's Docusate Sodium was not set up twice a day as ordered.

Client I4's medications, that the nurses used to fill the client's weekly medi-set container, contained numerous expired medications. Twenty-seven bubble pack cards of client I4's regularly scheduled medications including Prilosec, Docusate Sodium, Toprol, Detrol, Baclofen, and Gabapenten were noted to have expiration dates ranging from June 5, 2007 to November 1, 2007. When interviewed, November 28, 2007, employee IE, a licensed practical nurse confirmed that there were expired medications. She stated she tried to check the expiration dates when dispensing the medications in the medi-sets.

Physician orders on August 10, 2007, indicate client M1 was prescribed a transdermal patch, Androderm (testosterone) 5 mg. every day. The November MAR indicated the transdermal patch was not applied during November 2007. It was observed the medication cupboard did not contain the Androderm transdermal patches at 8:00 a.m., on November 28, 2007. Client M1 stated that he had not worn the Androderm patch for a long time. During an interview on November 29, 2007, the RN/owner reported that the transdermal patch had not been ordered from the pharmacy due to payment issues and therefore had not been administered to the client. She stated that staff failed to contact the physician regarding another order for the patch.

Progress notes on October 26, 2007, indicated client M1 had complained that he had not received his prescribed Coumadin, a blood thinner, for the past week. The physician's office was contacted and client M1 was transported to a clinic for an INR blood test. The INR was 1.7 (desired range was indicated as 2-3). The physician reordered the Coumadin 8 mg. every day. During an interview on November 29, the RN/owner indicated that it was believed the client had received the Coumadin. The client was sent to the clinic as a precautionary measure to have his INR checked. The owner stated that situation was not investigated to determine if a medication error had occurred.

Physician documentation on October 10, 2007, indicated client M1's laboratory results were abnormal and the physician ordered a hold on Zaroxalyn 5 mg., a diuretic, which was ordered as needed every day for weight gain over two pounds. On October 16, 2007, the physician ordered the hold continued. The MAR indicates Zaroxalyn was administered at 8:00 p.m., on November 11, 2007. A physician order to resume the use of the Zaroxalyn was not found in the medical record. During an interview on November 29, 2007, the RN/owner stated it appeared that the LPN had administered the medication on November 11, 2007, however she was unable to verify if an error had occurred as she was unfamiliar with the client's orders.

Client M2 received medication administration and blood glucose monitoring four times daily with sliding scale Novolog insulin coverage by unlicensed personnel. The November 2007, blood glucose/insulin flow sheet indicated client was scheduled for Novolog insulin 5 units subcutaneously at 5 pm and Lantus insulin 20 units subcutaneously at 9 pm. The November blood glucose/insulin flow sheet indicated the insulin and blood sugar checks were not administered on November 5 and 6, 2007, for the 5 pm insulin and blood sugar, November 15, 2007, for the 5pm and 9 pm insulin, November 25, 2007, for the 5 pm insulin, and November 27, 2007, for the 9 pm insulin. There was no documentation as to why the insulin was not administered and no evidence a registered nurse was contacted. When interviewed November 28, 2007, the owner/registered nurse indicated the personal care attendants should be charting insulin on the blood glucose/insulin flow sheets.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $11,200.00

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$11,200.00**. 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/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 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 19, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurely:

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 December 18, 2007.

The documents checked below are enclosed.

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

_____ 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 19, 2007

BEDS LICENSED:
HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Mulbah Bursune, PCA
Comfort Kular, PCA
Flora McArthur, PCA
Sumo Gbamonquillie, PCA
Vickie Briggs, LPN

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #5

ITEMS NOTED AND DISCUSSED:
An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visits made on December 5, 14, 17, 18, and 19, 2007. 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 orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 is as follows:

1. MN Rule 4668.0150 Subp.2 **Not corrected** **$5600.00**

Based on observations, interview and record review, the licensee failed to ensure medications were administered as ordered for three of three clients' (F2, F3, and F4) records reviewed at site F. The findings include:

Client F3 had a physician's order dated December 14, 2007 for Baclofen 5 milligrams (mg.) three times a day. The client's medication administration record (MAR), dated December 2007, which was used by the nurse to set up the client's medications in the medi-set read that Baclofen was to be administered only as needed instead of three times daily as ordered. Client F3 was observed to receive his a.m.

medications on December 19, 2007 at 7:30 a.m. The client did not receive Baclofen 5 milligrams, although it was ordered to be administered three times a day. The client's medi-set container was observed on the morning of December 19, 2007 with LPN FN, and did not contain Baclofen in the a.m., noon, evening, or bedtime slots for the entire week even though the physician ordered the medication to be administered three times a day.

Client F3 had a physician's order dated December 14, 2007 for Detrol LA 4 mg. twice a day. The client's MAR dated December 2007 read that Detrol was to be administered every a.m instead of twice daily as ordered. The the client's medi-set container was observed on the morning of December 19, 2007 with LPN FN, and Detrol was set-up only in the a.m. slot for the entire week, even though the physician's order was for Detrol to be administered twice a day.
Client F3 had a physician's order dated December 14, 2007 for Oxybutynin 5 mg. to be administered at bedtime as needed. The client's MAR dated December 2007 read Oxybutynin 5 mg. to be administered every bedtime instead only set up as needed per the order. The client's medi-set container was observed on the morning of December 19, 2007 with LPN FN, and Oxybutynin was set-up in the client's medi-set in the bedtime slot for the entire week, even though the physician's order was for the medication to be given as needed. When interviewed on December 19, 2007, LPN FN confirmed the discrepancies in client F3's physician's orders and what was being set-up in the medi-set container and being administered. She stated that she was not aware there was a medication listing that was signed by the physician December 14, 2007 and in the client's record.

Client F2's personal care attendant (PCA) medication assistance form for December 14, 17, and 18, 2007 for 8:00 p.m. was blank. There were no initials of staff indicating that the client's medications were administered. There was no other evidence or documentation that the medications had been administered. The client was to receive twelve pills at 8:00 p.m., including Amitriptyline, Baclofen, Docusate Sodium, Gabapentin, Naproxen, Risperdal, Mirtazapine, and Tizanidine. When interviewed on December 19, 2007, LPN FN stated she was sure the client's medications were administered, and that the PCAs forgot to sign that they administered them.

The client's physician's orders, medication administration record for December 2007, and the form that included the number of tablets to be given to the client at specific times, indicated that the client was not to receive any medications from 4:00 p.m. to 6::00 p.m. Client F4's PCA medication assistance form dated December 17, 2007was signed that he received medications at 8:00 a.m., 12:00 noon, 4:00-6:00 p.m., and 8:00 p.m. When interviewed on December 19, 2007, LPN FN stated that the PCA must have made a mistake. She stated that the client F4 only got medications three times a day at 8:00 a.m. 12:00 noon and 8:00 p.m.

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

3) The following referral/s is/are being made: [select from below, delete those not applicable and renumber]
   i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 20, 2008

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Amended Licensing Follow Up visit

Dear Ms. Gurley:

On December 19, 2007, you were hand delivered a Notice of Assessment for Noncompliance letters as the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. Subsequent to that delivery, an error was noted in the information on the letter that was delivered to you. **Please disregard the information on the first page of the original letter that was delivered to you.**

Attached is the corrected Notice of Assessment for Noncompliance letter. The amended information that has been corrected is underscored and the stricken [~~stricken~~] information has been removed.

The documents checked below are enclosed.

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

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

__X__ Notice of Assessment for Noncompliance with Correction Orders 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR1000AMMENDED

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

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

December 19, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On December ~~18,~~ 19, 2007, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007 with a correction order received by you on December 3, 2007.

The following correction orders were not corrected in the time period allowed for correction:

MN Rule 4668.0150 Subp. 2 **$5600.00**

Based on records review and interviews the licensee failed to ensure medications were received as ordered for three of four clients reviewed (A1, A2 and A3) at site A, for two of four clients reviewed (B1, and B2) at site B, for four of four clients reviewed (D1, D2, D3 and D4) at site D, for two of three clients reviewed (I3 and I4) at site I, and for two of four clients reviewed (M1 and M2) in house M. The findings include:

Client A1's record contained physician orders for diphenhydramine 25milligrams one to two capsules every six hours; and blood sugar checks with sliding scale coverage with regular insulin, four times daily. During observation of the set-up medications for client A1 on November 26, 2007, it was noted that the containers contained 25 milligrams of diphenhydramine that were being administered at 8AM, 5PM and 8PM; the November, 2007 medication administration record (MAR) also indicated that the client was having blood sugar checks done periodically. On interview, November 26, 2007, the personal care attendant (employee AA) stated that the client only had blood sugar checks done one time per day around 4PM. On interview, November 28, 2007, the LPN stated she did not know why the blood sugar checks were only being done one time per day; she could not find a physician order for this and she stated she would verify with the physician what the order should be.

Client A2 began receiving services July 18, 2005. He had a diagnosis of traumatic brain injury with left hemiplegia and received total assistance with all activities of daily living. The medication administration record and pharmacy printout for November 2007, indicated the client received Baclofen 5mg. TID, Colace 100 mg. BID, Effexor XR 150 mg. QD, Keppra 1000 mg. BID, Seroquel 50 mg. BID, and Trazadone 50 mg. QD. The November 2007, medication administration record was blank from November 1st to the 6th and from November 18th to the 21st. There was no indication that the medications were set up or given.

When interviewed on November 26, 2007, the LPN stated that a nurse would have set up the medications in a medi-set weekly and the unlicensed staff would have given them.
Client A2 had a physicians order dated November 6, 2007, for Vitamin B12 1000 mcg sublingual daily. The November 2007, medication administration record indicated it was first given on November 18, 2007. The Vitamin B12 was observed, November 28, 2007, to be supplied from an over the counter bottle labeled 1000 mcg tablets for oral use. When interviewed November 28, 2007, Unlicensed staff AA verified that this vitamin pill was set up daily in each medi-set and that the client swallowed the pill whole with the rest of his pills. She verified this was not the ordered liquid consistency as ordered by the physician for this medication. She stated that this is what the clients' wife brought in.
The nurse who set up the meds wasn't available to interview and the LPN on duty November 28, 2007 did not normally work at this site and did not know anything about it.

On November 28, 2007, during the 8 am observation of the medication pass, client A3 requested to see the medications, before the licensed practical nurse (LPN) administered them. Client A3 noted that there was a medication missing. All of the medications were then inspected against the medication administration record. During the inspection the LPN stated that client A3's Metformin 1000 milligrams was not in the client's medication container, so he had not set this medication up, however, he had initialed the Metformin for November 28, 2007, at 8am on the medication administration record (MAR) as given. During the inspection it was also noted that the Omeprazole had not be set up for the 8 am medications. The LPN stated that he had missed setting this medication up and he had not documented the medication as given. Before the administration of the medications the LPN found the Metformin for client A3 and the medication was administered. The November, 2007 medication administration record also indicated that aspirin, ibuprofen, ranitidine and Novolog insulin, being used for sliding scale, were being administered to client A3 on November 28, 2007, however, the record lacked physician orders for these medications. When interviewed, November 28, 2007, the LPN stated she did not know where the physician order for these medications was and she would check with the registered nurse/owner.

Client B1 had a physician order dated, September 12, 2007, for Certagen vitamins to be administered once daily. The November 2007, medication chart had "D/C" (discontinue) written across the spaces of calendar days for the Certagen. When interviewed November 27, 2007, the licensed practical nurse stated the physician had discontinued the Certagen but could not find the order.

Client B2 was ventilator dependent (mechanical ventilation of the lungs). The client had orders for Albuterol 0.083% nebulizer one vial every 4-6 hours as needed for wheezing and Albuterol 90 mcg. (micrograms) inhaler two puffs as needed. The medications were not available for administration when the reviewer observed the client's medications on November 27, 2007. The reviewer noted these medications were still not available when the reviewer returned to the

facility at 7:14 am on November 29, 2007. Licensed staff person BB stated the medications were reordered on November 27, 2007, but licensed staff person BA called the pharmacy at 8:30 am on November 29, 2007, and requested refills. This reviewer contacted the pharmacy on November 29, 2007, and was informed that staff had initially reordered the medications on November 28, 2007, not on November 27, 2007, as was reported on interview.

Client D1's November 2007, medication administration record (MAR) indicated the Keppra 100 mg/ml 5 ml per G-tube twice daily was not administered on November 3 and 9, 2007, Ketoconazole 2% cream apply twice daily to face was not administered on November 1, 2, 3, 4, 5 and 18, 2007, Levothyroxine 75 mcg one tablet per G-tube every morning was not administered on November 3 and 13, 2007. Metoprolol 50 mg tablet take 1/1/2 tablets per g-tube twice daily was not administered on November 4, 2007, Mupirocin 2% ointment apply to G-tube site twice daily was not administered on November 2, 4, 6, 9, and 22, 2007, Prochlorperazine 5mg one tablet per feeding tube was not administered on November 1, 2, 3, 4 and 18, 2007. Spiriva 18 mcg one capsule inhaled daily for bronchospasm was not administered on November 1, 4, 17, 18 and 21, 2007. Amlodipine 2.5mg tablet one per g-tube every morning was not administered on November 3, 2007. C- Prevacid 10 ml per g-tube once daily was not administered on November 3, 2007. Cerovite liquid 15 ml per g-tube once daily was not administered on November 3 and 18 2007. Clotrimazole 1% cream apply to trach twice daily was not administered on November 3, 17, 18, 19 and 23, 2007. Combivent inhalation aerosol four puffs, four times daily, were not administered on November 5, 7, 11, 12, 18 and 19, 2007. Guaifenesin Syrup 10 ml per feeding tube twice daily for cough was not administered on November 2, 3, 6 and 22, 2007. Hydrocortisone 1.5% cream to face twice daily was not administered on November 2, 3, 4, 7, 16, 17 and 22, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.

Client D2's November 2007, MAR indicated the Bacitracin applied twice a day to G-tube site was not administered on November 19 and 20, 2007, A dressing change twice daily to the right lower extremity was not administered on November 19, 2007, Pummel and Phlegm fighter twice daily was not administered on November 18, 2007. Bisacodyl 10 mg suppository once daily was not administered on November 20, 2007. Milk of Magnesia 30 cc per feeding tube once daily was not administered on November 18, 2007. Albuterol nebulizer treatment 3cc four times daily was not administered on November 18 and 20, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 27, 2007, the registered nurse, employee DA, stated that the staff must have forgotten to document the medications as given.

Client D2 had an order for Prevacid suspension 2mg/ml 30 ml per feeding tube once daily since November 16, 2007. During observation on November 28, 2007, it was noted that the currently used Prevacid had expired on November 4, 2007. The November 2007 MAR indicated that the client had received it on November 17, 18, 19, 20 and 21, 2007.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that she was unaware that the bottle of Prevacid was expired.
Client D3's November 2007, MAR indicated the NPH insulin 12 units at 7:30 am was not administered on November 6 and 21, 2007. NPH insulin 7 units at 4:30 pm were not administered on November 10, 2007. Septra DS one tablet twice daily for 7 days was not administered on November 6 and 7, 2007. Renegal 800 mg three tablets three times daily with

meals was not administered on November 15 and 21, 2007. Blood sugar checks with sliding scale insulin were not administered on November 9 and 18, 2007. Seroquel 100 mg two tablets at bedtime were not administered on November 7, 2007. Sodium Bicarbonate 325 mg two tablets twice daily were not administered on November 4, 2007.
There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. Client D3 had a physician order dated August 2, 2007, for Novo Human insulin 8 units every morning and 5 units in the evening. The previous order dated July 11, 2007, was for Insulin Human NPH 12 units at 7:30 am and 7 units at 4:30 pm. Upon interview November 27, 2007 the registered nurse, employee DA stated she thought the orders from July 11, 2007, were the current orders.

Client D3 received dialysis three times weekly on Monday, Wednesday and Friday. The record indicated on November 5 and 7, 2007, the resident was at dialysis but documentation indicated he received sliding scale insulin on both days at 12 noon. When interviewed, November 28, 2007, the registered nurse, employee DA stated he received his 12 noon blood sugar check and sliding scale insulin at dialysis and not by the licensees' staff.

Client D4's November 2007, MAR indicated Protonix 40 mg one tablet daily was not administered on November 4, 2007. Accuzyme spray twice daily to right and left heels was not administered on November 14, 15, and 18, 2007. Vitamin C 500 mg twice a daily was not administered on November 7, 2007. Dressing change twice a daily to the feet was not administered on November 5, 2007. Flush PICC line twice daily with 5 cc of Normal Saline then 5 cc Heparin was not administered on November 5, 6 and 21, 2007. Tracheostomy care was not documented as being done on November 26, 2007, and change wound-vac dressing every Monday, Wednesday and Friday was not documented as done on November 7, 9, 16, 20 and 24, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 28, 2007, the registered nurse, employee DA indicated that the client would at times refuse treatments and medications.

During observation of a medication pass on Monday, November 26, 2007, at 12:50 p.m. employee IC, an unlicensed staff was observed to administer medication to client I3. During the medication pass it was noted that the client's prior Sunday evening pill was still in the medi-set. The medication was identified as Ferrous Sulfate 324 milligrams. Employee IC stated that if the client refused the medication it would be logged in the personal care attendant notes, the PCA would have contacted the nurse, and the nurse would have logged it in her notes. No notation was made regarding the client refusing his evening medication on November 26, 2007. It could not be determined why the medication was not administered.

Client I3 received six units of Lantus insulin at bedtime, and had Novolog insulin coverage by sliding scale at 8:00 a.m., 12:00 noon, 5:00 p.m. and bedtime. Unlicensed personnel documented that they administered the insulin that had been pre-set up by the nurse to client I3. When interviewed November 27, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's record indicated unlicensed staff had administered insulin.

Client I3 began receiving services from the home care provider on September 17, 2007. The client's services included one–to-one client to staff care ratio, medication administration and central storage of medication from the licensee. The client had physician's orders for Haldol .4

milliliters intramuscularly every eight hours as needed for agitation. In addition the client received Ativan 1 milligrams four times a day, Risperdal .5 milligrams twice a day, Celexa forty milligrams every, and Ambien ten milligrams at bedtime. Nurses' notes dated September 17, 2007, read that client I3 was "very agitated, crying and yelling…refuses to stay seated. Was given Ativan upon arrival. No relief and about 1 hour later he was given Haldol IM." On September 18, 2007, "Very agitated up and about….given Haldol at 8:00 a.m." On September 19, 2007, "Up and about. Given Haldol at 8:00 a.m." On September 20, 2007, "Continues to be very restless, crying and moving from one position to another. Very unsteady…..Haldol IM given. Continues to receive Ativan as ordered." On September 23, 2007, "Increased agitation. Continues to receive Ativan and Haldol as ordered." A notation dated September 24, 2007 indicated the client was very lethargic, sleepy, hard to arouse from sleep. The client was then transported by ambulance to the hospital and admitted with a diagnosis of "Altered mental state." Hospital records indicated the client needed to be intubated upon admission. In addition, a hospital physician's note dated September 26, 2007, indicated the following, "It is possible that the patient may have overdosed on one or several of his psych meds as he takes several. This could cause a gradual change in mental status." A hospital physician's note dated October 3, 2007, read the licensee "was called and RN informed us that pt received several injections of Haldol the day of admission. This may explain his altered mental status." There was no further documentation in the client's record concerning the times/frequency he received the Haldol injections. Numerous requests were made by the reviewer to obtain the client's September 2007 medication administration record. The licensee did not provide the requested documentation.

The client returned from the hospital to the facility on October 5, 2007, and was readmitted to the hospital on October 8, 2007, because of increased edema in both legs. When discharged from the hospital October 10, 2007, the client's discharge orders included Norvasc ten milligrams daily. Client I3's October 2007, medication administration record indicated that on October 11, 2007, Norvasc five milligrams was set up in the client's medi-set instead of the ten milligrams as ordered.

Client I3 was readmitted to the hospital again on October 30, 2007, due to being "very lethargic, and stuperous." The client's admission diagnosis was "altered mental status." The hospital history and physical dated October 30, 2007, read, "The nursing home staff states that he has been receiving his medications although he could have access to them and could have overdosed." A notation by a hospital physician dated October 31, 2007, indicated the following, "Unfortunately I cannot tell from the notes available to what extent he (the client) was receiving any of his PRN. medications in the nursing home." The client was readmitted to the facility on November 1, 2007.

On November 6, 2007, client I3 readmitted to the hospital because of episodes of jerky movements. The client was discharged back to the facility on November 8, 2007. Cogentin one milligram twice a day was ordered upon discharge however Cogentin 0.5 milligrams was documented as having been set-up to be administered

The following medication discrepancies were noted from what the physician ordered for client I3 upon discharge, and what was documented as being set-up in the medi-set containers to be administered. Cogentin one milligram twice a day was ordered upon discharge, but when the client's November 2007, medication administration record was reviewed, Cogentin .5 milligrams was documented as having been set-up to be administered. Celexa 10 milligrams daily were ordered upon discharge however the November 2007, medication administration record indicated

that Celexa 20 milligrams were set-up and administered. Prilosec 10 milligrams daily were ordered to be given upon discharge however the November 2007 medication administration record indicated that Prilosec 20 milligrams (two capsules) were set-up and administered. Risperdal .5 milligrams daily at bedtime was ordered upon discharge however the November 2007, medication administration record indicated that Risperdol .5 milligrams twice a day was set-up and administered. When interviewed, November 28, 2007, employee IE, a licensed practical nurse could not explain why the medications were not instituted as ordered upon discharge.

During observation at housing site I on Tuesday November 27, 2007, unlicensed employee ID was observed to administer client I4's 8:00 a.m. medications. Employee ID counted eleven and one half pills that were preset-up in client I4's medi-set slot for Tuesday at 8:00 a.m., and administered the pills to the client. The client's record was reviewed and it was noted that the client was to receive twelve and one half pills at 8:00 a.m. every morning instead of eleven and a half as observed.

When questioned about the discrepancy, employee IE, the licensed practical nurse (LPN) checked the client's medi-set, and noted a half of a pill was stuck to the bottom of the medi-set in the Tuesday 8:00 a.m. slot. Employee IE stated she was unsure why there would be an additional half of a tablet of medication in the slot, when the client had already received a half of a tablet that morning. The LPN identified the half of a tablet as Baclofen 5 milligrams. The LPN stated she spoke with employee ID regarding the medication pass. The LPN reported that employee ID stated that the morning of November 27, 2007, employee ID had noted there were no pills in client I4' s medi-set slot for Tuesday, November 27, 2007. Employee ID then asked nurse MA, a licensed practical nurse if she could move the pills that were pre set up in Friday's slot to Tuesday's slot. According to employee ID, nurse MA stated she could, so employee ID moved the client's pills from the Friday slot to the Tuesday slot. Nurse IE stated that maybe when employee ID moved the pills employee ID inadvertently dropped a pill on the floor. Nurse IE stated that there had not been pills in the Tuesday 8:00 a.m. slot because she had not had the time to fill the weekly medi-set for client I4 on Monday, November 26, 2007. When the medication discrepancy was noted, the reviewer requested nurse IE to assist in checking the accuracy of the amount of pills that were in the Wednesday 8:00 a.m. slot. There were twelve pills in the Wednesday 8:00 a.m. slot, when there should have been twelve and one half pills. Nurse IE could not explain why the half of a tablet of Baclofen was not in the Wednesday slot, nor why there would have been two half tablets in Tuesday's slot. In addition, it could not be determined what medication client I4 did not receive Tuesday morning at 8:00 a.m.

Client I4 had an order for Docusate Sodium 100 milligrams twice a day. The medications set up by the licensee's nurse in the medi-set revealed that the Docusate Sodium was only set up for one time daily at bedtime. When interviewed, November 28, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's Docusate Sodium was not set up twice a day as ordered.

Client I4's medications, that the nurses used to fill the client's weekly medi-set container, contained numerous expired medications. Twenty-seven bubble pack cards of client I4's regularly scheduled medications including Prilosec, Docusate Sodium, Toprol, Detrol, Baclofen, and Gabapenten were noted to have expiration dates ranging from June 5, 2007 to November 1, 2007. When interviewed, November 28, 2007, employee IE, a licensed practical nurse

confirmed that there were expired medications. She stated she tried to check the expiration dates when dispensing the medications in the medi-sets.

Physician orders on August 10, 2007, indicate client M1 was prescribed a transdermal patch, Androderm (testosterone) 5 mg. every day. The November MAR indicated the transdermal patch was not applied during November 2007. It was observed the medication cupboard did not contain the Androderm transdermal patches at 8:00 a.m., on November 28, 2007. Client M1 stated that he had not worn the Androderm patch for a long time. During an interview on November 29, 2007, the RN/owner reported that the transdermal patch had not been ordered from the pharmacy due to payment issues and therefore had not been administered to the client. She stated that staff failed to contact the physician regarding another order for the patch.

Progress notes on October 26, 2007, indicated client M1 had complained that he had not received his prescribed Coumadin, a blood thinner, for the past week. The physician's office was contacted and client M1 was transported to a clinic for an INR blood test. The INR was 1.7 (desired range was indicated as 2-3). The physician reordered the Coumadin 8 mg. every day. During an interview on November 29, the RN/owner indicated that it was believed the client had received the Coumadin. The client was sent to the clinic as a precautionary measure to have his INR checked. The owner stated that situation was not investigated to determine if a medication error had occurred.

Physician documentation on October 10, 2007, indicated client M1's laboratory results were abnormal and the physician ordered a hold on Zaroxalyn 5 mg., a diuretic, which was ordered as needed every day for weight gain over two pounds. On October 16, 2007, the physician ordered the hold continued. The MAR indicates Zaroxalyn was administered at 8:00 p.m., on November 11, 2007. A physician order to resume the use of the Zaroxalyn was not found in the medical record. During an interview on November 29, 2007, the RN/owner stated it appeared that the LPN had administered the medication on November 11, 2007, however she was unable to verify if an error had occurred as she was unfamiliar with the client's orders.

Client M2 received medication administration and blood glucose monitoring four times daily with sliding scale Novolog insulin coverage by unlicensed personnel. The November 2007, blood glucose/insulin flow sheet indicated client was scheduled for Novolog insulin 5 units subcutaneously at 5 pm and Lantus insulin 20 units subcutaneously at 9 pm. The November blood glucose/insulin flow sheet indicated the insulin and blood sugar checks were not administered on November 5 and 6, 2007, for the 5 pm insulin and blood sugar, November 15, 2007, for the 5pm and 9 pm insulin, November 25, 2007, for the 5 pm insulin, and November 27, 2007, for the 9 pm insulin. There was no documentation as to why the insulin was not administered and no evidence a registered nurse was contacted. When interviewed November 28, 2007, the owner/registered nurse indicated the personal care attendants should be charting insulin on the blood glucose/insulin flow sheets.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $ 5600.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$5600.00**. 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/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 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 18, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurely:

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 December 18, 2007.

The documents checked below are enclosed.

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

_____ 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 18, 2007

BEDS LICENSED:
HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Connie Ziarayo, LPN
Ann Obami, PCA
Abeba Gutama, PCA
Tenneh Fanbulleh, PCA

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #4

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visits made on December 5, 14, 17, and 18, 2007. 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 orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 is as follows:

1. MN Rule 4668.0150 Subp.2 **Not corrected** **$2800.00**

Based on observations, interview and record review, the licensee failed to ensure medications were administered as ordered for three of three clients' (HA, HB, and HC) records reviewed at site H. The findings include:

When interviewed on December 18, 2007 at 8:00 a.m., unlicensed employee HA stated that clients H2 and H3 had not received their 8:00 a.m. medications yet. When client's H2 and H3s' medi-set container was observed at 8:00 a.m., there were no pills in the 8:00 a.m. slot for these clients. Employee HB stated that she had taken clients H2 and H3s' medications out of the 8:00 a.m. slot around 7:30 a.m. on

December 18, 2007, and placed them in separate medicine cups. The medicine cup that contained client H3's medication was observed on the kitchen counter on top of a canister, the medicine cup with client H2's medication was observed placed at the table in the lower level of the home, where client H2 ate breakfast. Client H3 and H2s' medications were left unattended until clients H3 and H2 sat down at the table to eat breakfast at 8:30 and 8:35 a.m. respectively. Client H3 had a diagnosis of dementia, and had a history of taking another client's medication when they were left unattended. A nurses progress note dated October 5, 2007 read that on October 4, 2007 client HC had taken client H2's evening medications when they were left attended on a table. Client H3 needed to be transported to the emergency room for evaluation. The agency's policy titled, "PCA Medication Assistance Procedure" read, "Never leave medication unattended."

When interviewed on December 18, 2007 licensed practical nurse (LPN) IE stated that the agency's policy on medication administration was that the unlicensed staff assigned to a client would administer medications to the client they are responsible for. She stated that the unlicensed staff taking the medications out of a medi-box should be the person who administered the medication to the client, and then documented the administration of the medication for that client. Client H3's Personal Care Attendant (PCA) Medication Assistance documentation for December 18, 2007 at 8:00 a.m. had employee HC's initials indicating that she had administered the client's 8:00 a.m. medications, although employee HB stated that she had taken the client's medications out of the medi-set and placed them in a medication cup. Client H1's PCA Medication Administration documentation for December 18, 2007 at 8:00 a.m. indicated employee HA's initials indicating that she had administered the client's 8:00 a.m. medications, although employee HB stated that she had taken the client's medications out of the medi-set earlier.

On December 18, 2007 at 8:40 a.m. client H3's PCA Medication Assistance documentation was already signed off by employee HC as having administered the client's 12:00 noon medications for that day. Client H3 was to receive Gabapentin 100 milligrams (mg.) and Genebs 325 mg. at 12:00 noon. When asked on December 18, 2007, as to why the client's 12:00 noon medications were already signed off as administered at 8:40 a.m., employee HC responded she was "sorry." She stated the medication was not given.

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

3) The following referral/s is/are being made:
i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

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

December 18, 2007

Josephine Gurley, Administrator
Caremaxx Healthecare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On December 18, 2007, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007 with correction orders received by you on December 3, 2007.

The following correction orders were not corrected in the time period allowed for correction:

MN Rule 4668.0150 Subp. 2 **$2800.00**

Based on records review and interviews the licensee failed to ensure medications were received as ordered for three of four clients reviewed (A1, A2 and A3) at site A, for two of four clients reviewed (B1, and B2) at site B, for four of four clients reviewed (D1, D2, D3 and D4) at site D, for two of three clients reviewed (I3 and I4) at site I, and for two of four clients reviewed (M1 and M2) in house M. The findings include:

Client A1's record contained physician orders for diphenhydramine 25milligrams one to two capsules every six hours; and blood sugar checks with sliding scale coverage with regular insulin, four times daily. During observation of the set-up medications for client A1 on November 26, 2007, it was noted that the containers contained 25 milligrams of diphenhydramine that were being administered at 8AM, 5PM and 8PM; the November, 2007 medication administration record (MAR) also indicated that the client was having blood sugar checks done periodically. On interview, November 26, 2007, the personal care attendant (employee AA) stated that the client only had blood sugar checks done one time per day around 4PM. On interview, November 28, 2007, the LPN stated she did not know why the blood sugar checks were only being done one time per day; she could not find a physician order for this and she stated she would verify with the physician what the order should be.

Client A2 began receiving services July 18, 2005. He had a diagnosis of traumatic brain injury with left hemiplegia and received total assistance with all activities of daily living. The medication administration record and pharmacy printout for November 2007, indicated the client received Baclofen 5mg. TID, Colace 100 mg. BID, Effexor XR 150 mg. QD, Keppra 1000 mg. BID, Seroquel 50 mg. BID, and Trazadone 50 mg. QD. The November 2007, medication administration record was blank from November 1st to the 6th and from November 18th to the 21st. There was no indication that the medications were set up or given.

When interviewed on November 26, 2007, the LPN stated that a nurse would have set up the medications in a medi-set weekly and the unlicensed staff would have given them.
Client A2 had a physicians order dated November 6, 2007, for Vitamin B12 1000 mcg sublingual daily. The November 2007, medication administration record indicated it was first given on November 18, 2007. The Vitamin B12 was observed, November 28, 2007, to be supplied from an over the counter bottle labeled 1000 mcg tablets for oral use. When interviewed November 28, 2007, Unlicensed staff AA verified that this vitamin pill was set up daily in each medi-set and that the client swallowed the pill whole with the rest of his pills. She verified this was not the ordered liquid consistency as ordered by the physician for this medication. She stated that this is what the clients' wife brought in.
The nurse who set up the meds wasn't available to interview and the LPN on duty November 28, 2007 did not normally work at this site and did not know anything about it.

On November 28, 2007, during the 8 am observation of the medication pass, client A3 requested to see the medications, before the licensed practical nurse (LPN) administered them. Client A3 noted that there was a medication missing. All of the medications were then inspected against the medication administration record. During the inspection the LPN stated that client A3's Metformin 1000 milligrams was not in the client's medication container, so he had not set this medication up, however, he had initialed the Metformin for November 28, 2007, at 8am on the medication administration record (MAR) as given. During the inspection it was also noted that the Omeprazole had not be set up for the 8 am medications. The LPN stated that he had missed setting this medication up and he had not documented the medication as given. Before the administration of the medications the LPN found the Metformin for client A3 and the medication was administered. The November, 2007 medication administration record also indicated that aspirin, ibuprofen, ranitidine and Novolog insulin, being used for sliding scale, were being administered to client A3 on November 28, 2007, however, the record lacked physician orders for these medications. When interviewed, November 28, 2007, the LPN stated she did not know where the physician order for these medications was and she would check with the registered nurse/owner.

Client B1 had a physician order dated, September 12, 2007, for Certagen vitamins to be administered once daily. The November 2007, medication chart had "D/C" (discontinue) written across the spaces of calendar days for the Certagen. When interviewed November 27, 2007, the licensed practical nurse stated the physician had discontinued the Certagen but could not find the order.

Client B2 was ventilator dependent (mechanical ventilation of the lungs). The client had orders for Albuterol 0.083% nebulizer one vial every 4-6 hours as needed for wheezing and Albuterol 90 mcg. (micrograms) inhaler two puffs as needed. The medications were not available for administration when the reviewer observed the client's medications on November 27, 2007. The reviewer noted these medications were still not available when the reviewer returned to the

facility at 7:14 am on November 29, 2007. Licensed staff person BB stated the medications were reordered on November 27, 2007, but licensed staff person BA called the pharmacy at 8:30 am on November 29, 2007, and requested refills. This reviewer contacted the pharmacy on November 29, 2007, and was informed that staff had initially reordered the medications on November 28, 2007, not on November 27, 2007, as was reported on interview.

Client D1's November 2007, medication administration record (MAR) indicated the Keppra 100 mg/ml 5 ml per G-tube twice daily was not administered on November 3 and 9, 2007, Ketoconazole 2% cream apply twice daily to face was not administered on November 1, 2, 3, 4, 5 and 18, 2007, Levothyroxine 75 mcg one tablet per G-tube every morning was not administered on November 3 and 13, 2007. Metoprolol 50 mg tablet take 1/1/2 tablets per g-tube twice daily was not administered on November 4, 2007, Mupirocin 2% ointment apply to G-tube site twice daily was not administered on November 2, 4, 6, 9, and 22, 2007, Prochlorperazine 5mg one tablet per feeding tube was not administered on November 1, 2, 3, 4 and 18, 2007. Spiriva 18 mcg one capsule inhaled daily for bronchospasm was not administered on November 1, 4, 17, 18 and 21, 2007. Amlodipine 2.5mg tablet one per g-tube every morning was not administered on November 3, 2007. C- Prevacid 10 ml per g-tube once daily was not administered on November 3, 2007. Cerovite liquid 15 ml per g-tube once daily was not administered on November 3 and 18 2007. Clotrimazole 1% cream apply to trach twice daily was not administered on November 3, 17, 18, 19 and 23, 2007. Combivent inhalation aerosol four puffs, four times daily, were not administered on November 5, 7, 11, 12, 18 and 19, 2007. Guaifenesin Syrup 10 ml per feeding tube twice daily for cough was not administered on November 2, 3, 6 and 22, 2007. Hydrocortisone 1.5% cream to face twice daily was not administered on November 2, 3, 4, 7, 16, 17 and 22, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.

Client D2's November 2007, MAR indicated the Bacitracin applied twice a day to G-tube site was not administered on November 19 and 20, 2007, A dressing change twice daily to the right lower extremity was not administered on November 19, 2007, Pummel and Phlegm fighter twice daily was not administered on November 18, 2007. Bisacodyl 10 mg suppository once daily was not administered on November 20, 2007. Milk of Magnesia 30 cc per feeding tube once daily was not administered on November 18, 2007. Albuterol nebulizer treatment 3cc four times daily was not administered on November 18 and 20, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 27, 2007, the registered nurse, employee DA, stated that the staff must have forgotten to document the medications as given.

Client D2 had an order for Prevacid suspension 2mg/ml 30 ml per feeding tube once daily since November 16, 2007. During observation on November 28, 2007, it was noted that the currently used Prevacid had expired on November 4, 2007. The November 2007 MAR indicated that the client had received it on November 17, 18, 19, 20 and 21, 2007.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that she was unaware that the bottle of Prevacid was expired.

Client D3's November 2007, MAR indicated the NPH insulin 12 units at 7:30 am was not administered on November 6 and 21, 2007. NPH insulin 7 units at 4:30 pm were not administered on November 10, 2007. Septra DS one tablet twice daily for 7 days was not

administered on November 6 and 7, 2007. Renegal 800 mg three tablets three times daily with meals was not administered on November 15 and 21, 2007. Blood sugar checks with sliding scale insulin were not administered on November 9 and 18, 2007. Seroquel 100 mg two tablets at bedtime were not administered on November 7, 2007. Sodium Bicarbonate 325 mg two tablets twice daily were not administered on November 4, 2007.

There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. Client D3 had a physician order dated August 2, 2007, for Novo Human insulin 8 units every morning and 5 units in the evening. The previous order dated July 11, 2007, was for Insulin Human NPH 12 units at 7:30 am and 7 units at 4:30 pm. Upon interview November 27, 2007 the registered nurse, employee DA stated she thought the orders from July 11, 2007, were the current orders.

Client D3 received dialysis three times weekly on Monday, Wednesday and Friday. The record indicated on November 5 and 7, 2007, the resident was at dialysis but documentation indicated he received sliding scale insulin on both days at 12 noon. When interviewed, November 28, 2007, the registered nurse, employee DA stated he received his 12 noon blood sugar check and sliding scale insulin at dialysis and not by the licensees' staff.

Client D4's November 2007, MAR indicated Protonix 40 mg one tablet daily was not administered on November 4, 2007. Accuzyme spray twice daily to right and left heels was not administered on November 14, 15, and 18, 2007. Vitamin C 500 mg twice a daily was not administered on November 7, 2007. Dressing change twice a daily to the feet was not administered on November 5, 2007. Flush PICC line twice daily with 5 cc of Normal Saline then 5 cc Heparin was not administered on November 5, 6 and 21, 2007. Tracheostomy care was not documented as being done on November 26, 2007, and change wound-vac dressing every Monday, Wednesday and Friday was not documented as done on November 7, 9, 16, 20 and 24, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 28, 2007, the registered nurse, employee DA indicated that the client would at times refuse treatments and medications.

During observation of a medication pass on Monday, November 26, 2007, at 12:50 p.m. employee IC, an unlicensed staff was observed to administer medication to client I3. During the medication pass it was noted that the client's prior Sunday evening pill was still in the medi-set. The medication was identified as Ferrous Sulfate 324 milligrams. Employee IC stated that if the client refused the medication it would be logged in the personal care attendant notes, the PCA would have contacted the nurse, and the nurse would have logged it in her notes. No notation was made regarding the client refusing his evening medication on November 26, 2007. It could not be determined why the medication was not administered.

Client I3 received six units of Lantus insulin at bedtime, and had Novolog insulin coverage by sliding scale at 8:00 a.m., 12:00 noon, 5:00 p.m. and bedtime. Unlicensed personnel documented that they administered the insulin that had been pre-set up by the nurse to client I3. When interviewed November 27, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's record indicated unlicensed staff had administered insulin.
Client I3 began receiving services from the home care provider on September 17, 2007. The client's services included one–to-one client to staff care ratio, medication administration and

central storage of medication from the licensee. The client had physician's orders for Haldol .4 milliliters intramuscularly every eight hours as needed for agitation. In addition the client received Ativan 1 milligrams four times a day, Risperdal .5 milligrams twice a day, Celexa forty milligrams every, and Ambien ten milligrams at bedtime. Nurses' notes dated September 17, 2007, read that client I3 was "very agitated, crying and yelling…refuses to stay seated. Was given Ativan upon arrival. No relief and about 1 hour later he was given Haldol IM." On September 18, 2007, "Very agitated up and about….given Haldol at 8:00 a.m." On September 19, 2007, "Up and about. Given Haldol at 8:00 a.m." On September 20, 2007, "Continues to be very restless, crying and moving from one position to another. Very unsteady…..Haldol IM given. Continues to receive Ativan as ordered." On September 23, 2007, "Increased agitation. Continues to receive Ativan and Haldol as ordered." A notation dated September 24, 2007 indicated the client was very lethargic, sleepy, hard to arouse from sleep. The client was then transported by ambulance to the hospital and admitted with a diagnosis of "Altered mental state." Hospital records indicated the client needed to be intubated upon admission. In addition, a hospital physician's note dated September 26, 2007, indicated the following, "It is possible that the patient may have overdosed on one or several of his psych meds as he takes several. This could cause a gradual change in mental status." A hospital physician's note dated October 3, 2007, read the licensee "was called and RN informed us that pt received several injections of Haldol the day of admission. This may explain his altered mental status." There was no further documentation in the client's record concerning the times/frequency he received the Haldol injections. Numerous requests were made by the reviewer to obtain the client's September 2007 medication administration record. The licensee did not provide the requested documentation.

The client returned from the hospital to the facility on October 5, 2007, and was readmitted to the hospital on October 8, 2007, because of increased edema in both legs. When discharged from the hospital October 10, 2007, the client's discharge orders included Norvasc ten milligrams daily. Client I3's October 2007, medication administration record indicated that on October 11, 2007, Norvasc five milligrams was set up in the client's medi-set instead of the ten milligrams as ordered.

Client I3 was readmitted to the hospital again on October 30, 2007, due to being "very lethargic, and stuperous." The client's admission diagnosis was "altered mental status." The hospital history and physical dated October 30, 2007, read, "The nursing home staff states that he has been receiving his medications although he could have access to them and could have overdosed." A notation by a hospital physician dated October 31, 2007, indicated the following, "Unfortunately I cannot tell from the notes available to what extent he (the client) was receiving any of his PRN. medications in the nursing home." The client was readmitted to the facility on November 1, 2007.

On November 6, 2007, client I3 readmitted to the hospital because of episodes of jerky movements. The client was discharged back to the facility on November 8, 2007. Cogentin one milligram twice a day was ordered upon discharge however Cogentin 0.5 milligrams was documented as having been set-up to be administered

The following medication discrepancies were noted from what the physician ordered for client I3 upon discharge, and what was documented as being set-up in the medi-set containers to be administered. Cogentin one milligram twice a day was ordered upon discharge, but when the client's November 2007, medication administration record was reviewed, Cogentin .5 milligrams was documented as having been set-up to be administered. Celexa 10 milligrams daily were

ordered upon discharge however the November 2007, medication administration record indicated that Celexa 20 milligrams were set-up and administered. Prilosec 10 milligrams daily were ordered to be given upon discharge however the November 2007 medication administration record indicated that Prilosec 20 milligrams (two capsules) were set-up and administered. Risperdal .5 milligrams daily at bedtime was ordered upon discharge however the November 2007, medication administration record indicated that Risperdol .5 milligrams twice a day was set-up and administered. When interviewed, November 28, 2007, employee IE, a licensed practical nurse could not explain why the medications were not instituted as ordered upon discharge.

During observation at housing site I on Tuesday November 27, 2007, unlicensed employee ID was observed to administer client I4's 8:00 a.m. medications. Employee ID counted eleven and one half pills that were preset-up in client I4's medi-set slot for Tuesday at 8:00 a.m., and administered the pills to the client. The client's record was reviewed and it was noted that the client was to receive twelve and one half pills at 8:00 a.m. every morning instead of eleven and a half as observed.

When questioned about the discrepancy, employee IE, the licensed practical nurse (LPN) checked the client's medi-set, and noted a half of a pill was stuck to the bottom of the medi-set in the Tuesday 8:00 a.m. slot. Employee IE stated she was unsure why there would be an additional half of a tablet of medication in the slot, when the client had already received a half of a tablet that morning. The LPN identified the half of a tablet as Baclofen 5 milligrams. The LPN stated she spoke with employee ID regarding the medication pass. The LPN reported that employee ID stated that the morning of November 27, 2007, employee ID had noted there were no pills in client I4' s medi-set slot for Tuesday, November 27, 2007. Employee ID then asked nurse MA, a licensed practical nurse if she could move the pills that were pre set up in Friday's slot to Tuesday's slot. According to employee ID, nurse MA stated she could, so employee ID moved the client's pills from the Friday slot to the Tuesday slot. Nurse IE stated that maybe when employee ID moved the pills employee ID inadvertently dropped a pill on the floor. Nurse IE stated that there had not been pills in the Tuesday 8:00 a.m. slot because she had not had the time to fill the weekly medi-set for client I4 on Monday, November 26, 2007. When the medication discrepancy was noted, the reviewer requested nurse IE to assist in checking the accuracy of the amount of pills that were in the Wednesday 8:00 a.m. slot. There were twelve pills in the Wednesday 8:00 a.m. slot, when there should have been twelve and one half pills. Nurse IE could not explain why the half of a tablet of Baclofen was not in the Wednesday slot, nor why there would have been two half tablets in Tuesday's slot. In addition, it could not be determined what medication client I4 did not receive Tuesday morning at 8:00 a.m.

Client I4 had an order for Docusate Sodium 100 milligrams twice a day. The medications set up by the licensee's nurse in the medi-set revealed that the Docusate Sodium was only set up for one time daily at bedtime. When interviewed, November 28, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's Docusate Sodium was not set up twice a day as ordered.

Client I4's medications, that the nurses used to fill the client's weekly medi-set container, contained numerous expired medications. Twenty-seven bubble pack cards of client I4's regularly scheduled medications including Prilosec, Docusate Sodium, Toprol, Detrol, Baclofen, and Gabapenten were noted to have expiration dates ranging from June 5, 2007 to November 1, 2007. When interviewed, November 28, 2007, employee IE, a licensed practical nurse

confirmed that there were expired medications. She stated she tried to check the expiration dates when dispensing the medications in the medi-sets.

Physician orders on August 10, 2007, indicate client M1 was prescribed a transdermal patch, Androderm (testosterone) 5 mg. every day. The November MAR indicated the transdermal patch was not applied during November 2007. It was observed the medication cupboard did not contain the Androderm transdermal patches at 8:00 a.m., on November 28, 2007. Client M1 stated that he had not worn the Androderm patch for a long time. During an interview on November 29, 2007, the RN/owner reported that the transdermal patch had not been ordered from the pharmacy due to payment issues and therefore had not been administered to the client. She stated that staff failed to contact the physician regarding another order for the patch.

Progress notes on October 26, 2007, indicated client M1 had complained that he had not received his prescribed Coumadin, a blood thinner, for the past week. The physician's office was contacted and client M1 was transported to a clinic for an INR blood test. The INR was 1.7 (desired range was indicated as 2-3). The physician reordered the Coumadin 8 mg. every day. During an interview on November 29, the RN/owner indicated that it was believed the client had received the Coumadin. The client was sent to the clinic as a precautionary measure to have his INR checked. The owner stated that situation was not investigated to determine if a medication error had occurred.

Physician documentation on October 10, 2007, indicated client M1's laboratory results were abnormal and the physician ordered a hold on Zaroxalyn 5 mg., a diuretic, which was ordered as needed every day for weight gain over two pounds. On October 16, 2007, the physician ordered the hold continued. The MAR indicates Zaroxalyn was administered at 8:00 p.m., on November 11, 2007. A physician order to resume the use of the Zaroxalyn was not found in the medical record. During an interview on November 29, 2007, the RN/owner stated it appeared that the LPN had administered the medication on November 11, 2007, however she was unable to verify if an error had occurred as she was unfamiliar with the client's orders.

Client M2 received medication administration and blood glucose monitoring four times daily with sliding scale Novolog insulin coverage by unlicensed personnel. The November 2007, blood glucose/insulin flow sheet indicated client was scheduled for Novolog insulin 5 units subcutaneously at 5 pm and Lantus insulin 20 units subcutaneously at 9 pm. The November blood glucose/insulin flow sheet indicated the insulin and blood sugar checks were not administered on November 5 and 6, 2007, for the 5 pm insulin and blood sugar, November 15, 2007, for the 5pm and 9 pm insulin, November 25, 2007, for the 5 pm insulin, and November 27, 2007, for the 9 pm insulin. There was no documentation as to why the insulin was not administered and no evidence a registered nurse was contacted. When interviewed November 28, 2007, the owner/registered nurse indicated the personal care attendants should be charting insulin on the blood glucose/insulin flow sheets.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), you are assessed in the amount of: $2800.00.

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$2800.00**. 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/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 651-201-4301.

Sincerely,

Jean M. Johnston

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 18, 2008

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Amended Licensing Follow Up visit

Dear Ms. Gurley:

On December 17, 2007, you were hand delivered three Notice of Assessment for Noncompliance letters as the result of a follow-up visit conducted by staff of the Minnesota Department of Health, Case Mix Review Program. Subsequent to that delivery, an error was noted in the information on two of the letters that were delivered to you. **Please disregard the information on the first page of each of the original two letters that were delivered to you.**

Attached are the two corrected Notice of Assessment for Noncompliance letters. The amended information that has been corrected is underscored and the stricken [~~stricken~~] information has been removed.

The documents checked below are enclosed.

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

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

__X__ Notice of Assessment for Noncompliance with Correction Orders 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 M. Johnston

Jean Johnston, Program Manager
Case Mix Review Program

Enclosure(s)

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 17, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurely:

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 December 17, 2007.

The documents checked below are enclosed.

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

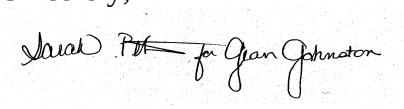
_____ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

__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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 17, 2007

BEDS LICENSED:
HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #3

ITEMS NOTED AND DISCUSSED:

An unannounced visit was made to follow-up on the status of state licensing orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visits made on December 5, 2007, December 14, 2007, and December 17, 2007. 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 orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007 is as follows:

1. MN Rule 4668.0150 Subp.2 **Not corrected** **$1400.00**

Based on observations, interview and record review, the licensee failed to ensure medications were administered as ordered for one of one client's (E1) record reviewed at site E. The findings include:

Client E1's record contained physician's orders for Nortriptyline 10 milligrams (mg) orally at bedtime, and Chlorpromazine 100 mg. orally every bedtime. The client's medi-set container for the Tuesday December 18, 2007 evening slot did not contain the Nortriptyline or Chlorpromazine. Client E1's Tuesday December 18, 2007 evening slot contained one tablet of Aspirin 81 mg., one tablet of Lisinopril 5 mg., one tablet of Wellbutrin XL 150 mg., and one Multivitamin. Although the client had physician's orders for the Aspirin, Lisinopril, Wellbutrin and Multivitam, these medications were ordered to be administered in the morning not evening. When interviewed on December 17, 2007, Licensed Practical Nurse (LPN) IE, confirmed the errors in the client's medication set-up for the evening of Tuesday December 18, 2007, and contacted the nurse responsible for the error.

Client E1's medi-set container was observed December 17, 2007 at 8:45 a.m. The slot for the morning of Sunday, December 16, 2007, contained one pill which was identified by LPN IE as Senna-Gen. When asked December 17, 2007 why a pill remained in the Sunday morning slot, LPN IE stated the client may have refused the medication. LPN IE stated the procedure when a client refused a medication was for the unlicensed staff to call the nurse, and document the refusal on the Personal Care Attendant (PCA) Daily Charting form. The PCA Daily Charting for 7:00 a.m. to 7:00 p.m. on December 16, 2007 did not indicate that the client refused any of her medications. Documentation by a PCA on the form indicated, "She took her medication." There was no documentation in client E1's record as to why the medication was not administered.

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

3) The following referral/s is/are being made: [select from below, delete those not applicable and renumber]
   i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

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

December 17, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On December 17, 2007 a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of a correction order issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007 with a correction order received by you on December ~~17~~, 3, 2007.

The following correction orders were not corrected in the time period allowed for correction:

MN Rule 4668.0150 Subp. 2 ` **~~$700.00~~ $1400.00**

Based on records review and interviews the licensee failed to ensure medications were received as ordered for three of four clients reviewed (A1, A2 and A3) at site A, for two of four clients reviewed (B1, and B2) at site B, for four of four clients reviewed (D1, D2, D3 and D4) at site D, for two of three clients reviewed (I3 and I4) at site I, and for two of four clients reviewed (M1 and M2) in house M. The findings include:

Client A1's record contained physician orders for diphenhydramine 25milligrams one to two capsules every six hours; and blood sugar checks with sliding scale coverage with regular insulin, four times daily. During observation of the set-up medications for client A1 on November 26, 2007, it was noted that the containers contained 25 milligrams of diphenhydramine that were being administered at 8AM, 5PM and 8PM; the November, 2007 medication administration record (MAR) also indicated that the client was having blood sugar checks done periodically. On interview, November 26, 2007, the personal care attendant (employee AA) stated that the client only had blood sugar checks done one time per day around 4PM. On interview, November 28, 2007, the LPN stated she did not know why the blood sugar checks were only being done one time per day; she could not find a physician order for this and she stated she would verify with the physician what the order should be.

Client A2 began receiving services July 18, 2005. He had a diagnosis of traumatic brain injury with left hemiplegia and received total assistance with all activities of daily living. The medication administration record and pharmacy printout for November 2007, indicated the client received Baclofen 5mg. TID, Colace 100 mg. BID, Effexor XR 150 mg. QD, Keppra 1000 mg. BID, Seroquel 50 mg. BID, and Trazadone 50 mg. QD. The November 2007, medication administration record was blank from November 1st to the 6th and from November 18th to the 21st. There was no indication that the medications were set up or given.

When interviewed on November 26, 2007, the LPN stated that a nurse would have set up the medications in a medi-set weekly and the unlicensed staff would have given them.
Client A2 had a physicians order dated November 6, 2007, for Vitamin B12 1000 mcg sublingual daily. The November 2007, medication administration record indicated it was first given on November 18, 2007. The Vitamin B12 was observed, November 28, 2007, to be supplied from an over the counter bottle labeled 1000 mcg tablets for oral use. When interviewed November 28, 2007, Unlicensed staff AA verified that this vitamin pill was set up daily in each medi-set and that the client swallowed the pill whole with the rest of his pills. She verified this was not the ordered liquid consistency as ordered by the physician for this medication. She stated that this is what the clients' wife brought in.
The nurse who set up the meds wasn't available to interview and the LPN on duty November 28, 2007 did not normally work at this site and did not know anything about it.

On November 28, 2007, during the 8 am observation of the medication pass, client A3 requested to see the medications, before the licensed practical nurse (LPN) administered them. Client A3 noted that there was a medication missing. All of the medications were then inspected against the medication administration record. During the inspection the LPN stated that client A3's Metformin 1000 milligrams was not in the client's medication container, so he had not set this medication up, however, he had initialed the Metformin for November 28, 2007, at 8am on the medication administration record (MAR) as given. During the inspection it was also noted that the Omeprazole had not be set up for the 8 am medications. The LPN stated that he had missed setting this medication up and he had not documented the medication as given. Before the administration of the medications the LPN found the Metformin for client A3 and the medication was administered. The November, 2007 medication administration record also indicated that aspirin, ibuprofen, ranitidine and Novolog insulin, being used for sliding scale, were being administered to client A3 on November 28, 2007, however, the record lacked physician orders for these medications. When interviewed, November 28, 2007, the LPN stated she did not know where the physician order for these medications was and she would check with the registered nurse/owner.

Client B1 had a physician order dated, September 12, 2007, for Certagen vitamins to be administered once daily. The November 2007, medication chart had "D/C" (discontinue) written across the spaces of calendar days for the Certagen. When interviewed November 27, 2007, the licensed practical nurse stated the physician had discontinued the Certagen but could not find the order.

Client B2 was ventilator dependent (mechanical ventilation of the lungs). The client had orders for Albuterol 0.083% nebulizer one vial every 4-6 hours as needed for wheezing and Albuterol 90 mcg. (micrograms) inhaler two puffs as needed. The medications were not available for administration when the reviewer observed the client's medications on November 27, 2007. The reviewer noted these medications were still not available when the reviewer returned to the

facility at 7:14 am on November 29, 2007. Licensed staff person BB stated the medications were reordered on November 27, 2007, but licensed staff person BA called the pharmacy at 8:30 am on November 29, 2007, and requested refills. This reviewer contacted the pharmacy on November 29, 2007, and was informed that staff had initially reordered the medications on November 28, 2007, not on November 27, 2007, as was reported on interview.

Client D1's November 2007, medication administration record (MAR) indicated the Keppra 100 mg/ml 5 ml per G-tube twice daily was not administered on November 3 and 9, 2007, Ketoconazole 2% cream apply twice daily to face was not administered on November 1, 2, 3, 4, 5 and 18, 2007, Levothyroxine 75 mcg one tablet per G-tube every morning was not administered on November 3 and 13, 2007. Metoprolol 50 mg tablet take 1/1/2 tablets per g-tube twice daily was not administered on November 4, 2007, Mupirocin 2% ointment apply to G-tube site twice daily was not administered on November 2, 4, 6, 9, and 22, 2007, Prochlorperazine 5mg one tablet per feeding tube was not administered on November 1, 2, 3, 4 and 18, 2007. Spiriva 18 mcg one capsule inhaled daily for bronchospasm was not administered on November 1, 4, 17, 18 and 21, 2007. Amlodipine 2.5mg tablet one per g-tube every morning was not administered on November 3, 2007. C- Prevacid 10 ml per g-tube once daily was not administered on November 3, 2007. Cerovite liquid 15 ml per g-tube once daily was not administered on November 3 and 18 2007. Clotrimazole 1% cream apply to trach twice daily was not administered on November 3, 17, 18, 19 and 23, 2007. Combivent inhalation aerosol four puffs, four times daily, were not administered on November 5, 7, 11, 12, 18 and 19, 2007. Guaifenesin Syrup 10 ml per feeding tube twice daily for cough was not administered on November 2, 3, 6 and 22, 2007. Hydrocortisone 1.5% cream to face twice daily was not administered on November 2, 3, 4, 7, 16, 17 and 22, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.

Client D2's November 2007, MAR indicated the Bacitracin applied twice a day to G-tube site was not administered on November 19 and 20, 2007, A dressing change twice daily to the right lower extremity was not administered on November 19, 2007, Pummel and Phlegm fighter twice daily was not administered on November 18, 2007. Bisacodyl 10 mg suppository once daily was not administered on November 20, 2007. Milk of Magnesia 30 cc per feeding tube once daily was not administered on November 18, 2007. Albuterol nebulizer treatment 3cc four times daily was not administered on November 18 and 20, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 27, 2007, the registered nurse, employee DA, stated that the staff must have forgotten to document the medications as given.

Client D2 had an order for Prevacid suspension 2mg/ml 30 ml per feeding tube once daily since November 16, 2007. During observation on November 28, 2007, it was noted that the currently used Prevacid had expired on November 4, 2007. The November 2007 MAR indicated that the client had received it on November 17, 18, 19, 20 and 21, 2007.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that she was unaware that the bottle of Prevacid was expired.

Client D3's November 2007, MAR indicated the NPH insulin 12 units at 7:30 am was not administered on November 6 and 21, 2007. NPH insulin 7 units at 4:30 pm were not administered on November 10, 2007. Septra DS one tablet twice daily for 7 days was not

administered on November 6 and 7, 2007. Renegal 800 mg three tablets three times daily with meals was not administered on November 15 and 21, 2007. Blood sugar checks with sliding scale insulin were not administered on November 9 and 18, 2007. Seroquel 100 mg two tablets at bedtime were not administered on November 7, 2007. Sodium Bicarbonate 325 mg two tablets twice daily were not administered on November 4, 2007.
There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. Client D3 had a physician order dated August 2, 2007, for Novo Human insulin 8 units every morning and 5 units in the evening. The previous order dated July 11, 2007, was for Insulin Human NPH 12 units at 7:30 am and 7 units at 4:30 pm. Upon interview November 27, 2007 the registered nurse, employee DA stated she thought the orders from July 11, 2007, were the current orders.

Client D3 received dialysis three times weekly on Monday, Wednesday and Friday. The record indicated on November 5 and 7, 2007, the resident was at dialysis but documentation indicated he received sliding scale insulin on both days at 12 noon. When interviewed, November 28, 2007, the registered nurse, employee DA stated he received his 12 noon blood sugar check and sliding scale insulin at dialysis and not by the licensees' staff.

Client D4's November 2007, MAR indicated Protonix 40 mg one tablet daily was not administered on November 4, 2007. Accuzyme spray twice daily to right and left heels was not administered on November 14, 15, and 18, 2007. Vitamin C 500 mg twice a daily was not administered on November 7, 2007. Dressing change twice a daily to the feet was not administered on November 5, 2007. Flush PICC line twice daily with 5 cc of Normal Saline then 5 cc Heparin was not administered on November 5, 6 and 21, 2007. Tracheostomy care was not documented as being done on November 26, 2007, and change wound-vac dressing every Monday, Wednesday and Friday was not documented as done on November 7, 9, 16, 20 and 24, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that the client would at times refuse treatments and medications.

During observation of a medication pass on Monday, November 26, 2007, at 12:50 p.m. employee IC, an unlicensed staff was observed to administer medication to client I3. During the medication pass it was noted that the client's prior Sunday evening pill was still in the medi-set. The medication was identified as Ferrous Sulfate 324 milligrams. Employee IC stated that if the client refused the medication it would be logged in the personal care attendant notes, the PCA would have contacted the nurse, and the nurse would have logged it in her notes. No notation was made regarding the client refusing his evening medication on November 26, 2007. It could not be determined why the medication was not administered.

Client I3 received six units of Lantus insulin at bedtime, and had Novolog insulin coverage by sliding scale at 8:00 a.m., 12:00 noon, 5:00 p.m. and bedtime. Unlicensed personnel documented that they administered the insulin that had been pre-set up by the nurse to client I3. When interviewed November 27, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's record indicated unlicensed staff had administered insulin.
Client I3 began receiving services from the home care provider on September 17, 2007. The client's services included one–to-one client to staff care ratio, medication administration and

central storage of medication from the licensee. The client had physician's orders for Haldol .4 milliliters intramuscularly every eight hours as needed for agitation. In addition the client received Ativan 1 milligrams four times a day, Risperdal .5 milligrams twice a day, Celexa forty milligrams every, and Ambien ten milligrams at bedtime. Nurses' notes dated September 17, 2007, read that client I3 was "very agitated, crying and yelling…refuses to stay seated. Was given Ativan upon arrival. No relief and about 1 hour later he was given Haldol IM." On September 18, 2007, "Very agitated up and about….given Haldol at 8:00 a.m." On September 19, 2007, "Up and about. Given Haldol at 8:00 a.m." On September 20, 2007, "Continues to be very restless, crying and moving from one position to another. Very unsteady…..Haldol IM given. Continues to receive Ativan as ordered." On September 23, 2007, "Increased agitation. Continues to receive Ativan and Haldol as ordered." A notation dated September 24, 2007 indicated the client was very lethargic, sleepy, hard to arouse from sleep. The client was then transported by ambulance to the hospital and admitted with a diagnosis of "Altered mental state." Hospital records indicated the client needed to be intubated upon admission. In addition, a hospital physician's note dated September 26, 2007, indicated the following, "It is possible that the patient may have overdosed on one or several of his psych meds as he takes several. This could cause a gradual change in mental status." A hospital physician's note dated October 3, 2007, read the licensee "was called and RN informed us that pt received several injections of Haldol the day of admission. This may explain his altered mental status." There was no further documentation in the client's record concerning the times/frequency he received the Haldol injections. Numerous requests were made by the reviewer to obtain the client's September 2007 medication administration record. The licensee did not provide the requested documentation.

The client returned from the hospital to the facility on October 5, 2007, and was readmitted to the hospital on October 8, 2007, because of increased edema in both legs. When discharged from the hospital October 10, 2007, the client's discharge orders included Norvasc ten milligrams daily. Client I3's October 2007, medication administration record indicated that on October 11, 2007, Norvasc five milligrams was set up in the client's medi-set instead of the ten milligrams as ordered.

Client I3 was readmitted to the hospital again on October 30, 2007, due to being "very lethargic, and stuperous." The client's admission diagnosis was "altered mental status." The hospital history and physical dated October 30, 2007, read, "The nursing home staff states that he has been receiving his medications although he could have access to them and could have overdosed." A notation by a hospital physician dated October 31, 2007, indicated the following, "Unfortunately I cannot tell from the notes available to what extent he (the client) was receiving any of his PRN. medications in the nursing home." The client was readmitted to the facility on November 1, 2007.

On November 6, 2007, client I3 readmitted to the hospital because of episodes of jerky movements. The client was discharged back to the facility on November 8, 2007. Cogentin one milligram twice a day was ordered upon discharge however Cogentin 0.5 milligrams was documented as having been set-up to be administered.

The following medication discrepancies were noted from what the physician ordered for client I3 upon discharge, and what was documented as being set-up in the medi-set containers to be administered. Cogentin one milligram twice a day was ordered upon discharge, but when the client's November 2007, medication administration record was reviewed, Cogentin .5 milligrams was documented as having been set-up to be administered. Celexa 10 milligrams daily were

ordered upon discharge however the November 2007, medication administration record indicated that Celexa 20 milligrams were set-up and administered. Prilosec 10 milligrams daily were ordered to be given upon discharge however the November 2007 medication administration record indicated that Prilosec 20 milligrams (two capsules) were set-up and administered. Risperdal .5 milligrams daily at bedtime was ordered upon discharge however the November 2007, medication administration record indicated that Risperdol .5 milligrams twice a day was set-up and administered. When interviewed, November 28, 2007, employee IE, a licensed practical nurse could not explain why the medications were not instituted as ordered upon discharge.

During observation at housing site I on Tuesday November 27, 2007, unlicensed employee ID was observed to administer client I4's 8:00 a.m. medications. Employee ID counted eleven and one half pills that were preset-up in client I4's medi-set slot for Tuesday at 8:00 a.m., and administered the pills to the client. The client's record was reviewed and it was noted that the client was to receive twelve and one half pills at 8:00 a.m. every morning instead of eleven and a half as observed.

When questioned about the discrepancy, employee IE, the licensed practical nurse (LPN) checked the client's medi-set, and noted a half of a pill was stuck to the bottom of the medi-set in the Tuesday 8:00 a.m. slot. Employee IE stated she was unsure why there would be an additional half of a tablet of medication in the slot, when the client had already received a half of a tablet that morning. The LPN identified the half of a tablet as Baclofen 5 milligrams. The LPN stated she spoke with employee ID regarding the medication pass. The LPN reported that employee ID stated that the morning of November 27, 2007, employee ID had noted there were no pills in client I4' s medi-set slot for Tuesday, November 27, 2007. Employee ID then asked nurse MA, a licensed practical nurse if she could move the pills that were pre set up in Friday's slot to Tuesday's slot. According to employee ID, nurse MA stated she could, so employee ID moved the client's pills from the Friday slot to the Tuesday slot. Nurse IE stated that maybe when employee ID moved the pills employee ID inadvertently dropped a pill on the floor. Nurse IE stated that there had not been pills in the Tuesday 8:00 a.m. slot because she had not had the time to fill the weekly medi-set for client I4 on Monday, November 26, 2007. When the medication discrepancy was noted, the reviewer requested nurse IE to assist in checking the accuracy of the amount of pills that were in the Wednesday 8:00 a.m. slot. There were twelve pills in the Wednesday 8:00 a.m. slot, when there should have been twelve and one half pills. Nurse IE could not explain why the half of a tablet of Baclofen was not in the Wednesday slot, nor why there would have been two half tablets in Tuesday's slot. In addition, it could not be determined what medication client I4 did not receive Tuesday morning at 8:00 a.m.

Client I4 had an order for Docusate Sodium 100 milligrams twice a day. The medications set up by the licensee's nurse in the medi-set revealed that the Docusate Sodium was only set up for one time daily at bedtime. When interviewed, November 28, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's Docusate Sodium was not set up twice a day as ordered.

Client I4's medications, that the nurses used to fill the client's weekly medi-set container, contained numerous expired medications. Twenty-seven bubble pack cards of client I4's regularly scheduled medications including Prilosec, Docusate Sodium, Toprol, Detrol, Baclofen, and Gabapenten were noted to have expiration dates ranging from June 5, 2007 to November 1, 2007. When interviewed, November 28, 2007, employee IE, a licensed practical nurse

confirmed that there were expired medications. She stated she tried to check the expiration dates when dispensing the medications in the medi-sets.

Physician orders on August 10, 2007, indicate client M1 was prescribed a transdermal patch, Androderm (testosterone) 5 mg. every day. The November MAR indicated the transdermal patch was not applied during November 2007. It was observed the medication cupboard did not contain the Androderm transdermal patches at 8:00 a.m., on November 28, 2007. Client M1 stated that he had not worn the Androderm patch for a long time. During an interview on November 29, 2007, the RN/owner reported that the transdermal patch had not been ordered from the pharmacy due to payment issues and therefore had not been administered to the client. She stated that staff failed to contact the physician regarding another order for the patch.

Progress notes on October 26, 2007, indicated client M1 had complained that he had not received his prescribed Coumadin, a blood thinner, for the past week. The physician's office was contacted and client M1 was transported to a clinic for an INR blood test. The INR was 1.7 (desired range was indicated as 2-3). The physician reordered the Coumadin 8 mg. every day. During an interview on November 29, the RN/owner indicated that it was believed the client had received the Coumadin. The client was sent to the clinic as a precautionary measure to have his INR checked. The owner stated that situation was not investigated to determine if a medication error had occurred.

Physician documentation on October 10, 2007, indicated client M1's laboratory results were abnormal and the physician ordered a hold on Zaroxalyn 5 mg., a diuretic, which was ordered as needed every day for weight gain over two pounds. On October 16, 2007, the physician ordered the hold continued. The MAR indicates Zaroxalyn was administered at 8:00 p.m., on November 11, 2007. A physician order to resume the use of the Zaroxalyn was not found in the medical record. During an interview on November 29, 2007, the RN/owner stated it appeared that the LPN had administered the medication on November 11, 2007, however she was unable to verify if an error had occurred as she was unfamiliar with the client's orders.

Client M2 received medication administration and blood glucose monitoring four times daily with sliding scale Novolog insulin coverage by unlicensed personnel. The November 2007, blood glucose/insulin flow sheet indicated client was scheduled for Novolog insulin 5 units subcutaneously at 5 pm and Lantus insulin 20 units subcutaneously at 9 pm. The November blood glucose/insulin flow sheet indicated the insulin and blood sugar checks were not administered on November 5 and 6, 2007, for the 5 pm insulin and blood sugar, November 15, 2007, for the 5pm and 9 pm insulin, November 25, 2007, for the 5 pm insulin, and November 27, 2007, for the 9 pm insulin. There was no documentation as to why the insulin was not administered and no evidence a registered nurse was contacted. When interviewed November 28, 2007, the owner/registered nurse indicated the personal care attendants should be charting insulin on the blood glucose/insulin flow sheets.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$700.00** 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/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 651-201-4301.

Sincerely,

Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 17, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurely:

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 December 14, 2007.

The documents checked below are enclosed.

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

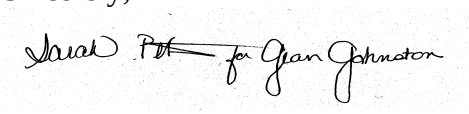
_____ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

__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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 14, 2007

BEDS LICENSED:
HOSP: _____ NH: _____ BCH: _____ SLFA: _____ SLFB: _____

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

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Connie Zirayo Licensed Practical Nurse
Emmanuel Ngarma PCA

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 November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visit made on December 5, 2007 and December 14, 2007. 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 orders issued as a result of a visit made on November 26, 27, 28, 29, 30, December 1, and 3, 2007, is as follows:

   1. MN Rule 4668.0150 Subp.2 **Not corrected** **$700.00**

   Based on observation, record review, and interview the licensee failed to ensure medications were administered as ordered for one of two clients (I1 and I3) records reviewed at site I. The findings include:

   Client I3 had physician orders for ferrous sulfate EC 324 milligrams (mg) three times daily, furesemide 20 mg daily, Haldol one mg twice daily, Hydralazine 10 mg three times daily, milk of magnesia 30 ml daily, Renal Caps one at bedtime, Phoslo one three times daily, Risperdal 0.5 mg three times daily, Omeprazole 20 mg twice daily, Lantus 6 units at bedtime, Advair inhaler one puff twice daily, Amlodipine one daily, aspirin 81 mg daily, Citalopram 20 mg daily, Depakote one twice daily, Docusate liquid 10 ml twice daily, Doxazosin Mesylate 2 mg daily, Benztropine one twice

daily. The PCA Medication Assistance Form was blank on December 11, and 12, 2007 for the 8 p.m. medication administration. Other unlicensed employee charting dated December 11, and 12, 2007 said "took his meds." There was no indication of who administered the medication or if the client self administered the medication as the form for documentation of administration was blank.

Client I1's current medication supply was stored in central storage in two large cardboard boxes. The supply contained one bubble pack of Fexofenadine 60 mg that expired on December 5, 2007. When interviewed on December 14, 2007 LPN IE confirmed the medication was expired.

During observation of client I1's medication administration on December 14, 2007, LPN IE administered the 8 am and 9 am medication to client I1 by G- tube at 8 am. The December medication administration record (MAR) which was used by the LPN to set up medication for client I1 indicated the clients medications were ordered to be administered at 8am and 9am. The December MAR was signed each day through December 14, 2007 and indicated medications were administered to the client at 8am and 9am. When interviewed December 14, 2007, LPN IE stated she always gave the 8 am and 9 am medications together. She indicated she gave them within a "one hour" window.

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

3) The following referral/s is/are being made: [select from below, delete those not applicable and renumber]
i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

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

December 17, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On December 14, 2007 a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of a correction order issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007 with a correction order received by you on December ~~17~~, 3, 2007.

The following correction orders were not corrected in the time period allowed for correction:

MN Rule 4668.0150 Subp. 2 ` **$700.00**

Based on records review and interviews the licensee failed to ensure medications were received as ordered for three of four clients reviewed (A1, A2 and A3) at site A, for two of four clients reviewed (B1, and B2) at site B, for four of four clients reviewed (D1, D2, D3 and D4) at site D, for two of three clients reviewed (I3 and I4) at site I, and for two of four clients reviewed (M1 and M2) in house M. The findings include:

Client A1's record contained physician orders for diphenhydramine 25milligrams one to two capsules every six hours; and blood sugar checks with sliding scale coverage with regular insulin, four times daily. During observation of the set-up medications for client A1 on November 26, 2007, it was noted that the containers contained 25 milligrams of diphenhydramine that were being administered at 8AM, 5PM and 8PM; the November, 2007 medication administration record (MAR) also indicated that the client was having blood sugar checks done periodically. On interview, November 26, 2007, the personal care attendant (employee AA) stated that the client only had blood sugar checks done one time per day around 4PM. On interview, November 28, 2007, the LPN stated she did not know why the blood sugar checks were only being done one time per day; she could not find a physician order for this and she stated she would verify with the physician what the order should be.

Client A2 began receiving services July 18, 2005. He had a diagnosis of traumatic brain injury with left hemiplegia and received total assistance with all activities of daily living. The medication administration record and pharmacy printout for November 2007, indicated the client received Baclofen 5mg. TID, Colace 100 mg. BID, Effexor XR 150 mg. QD, Keppra 1000 mg. BID, Seroquel 50 mg. BID, and Trazadone 50 mg. QD. The November 2007, medication administration record was blank from November 1st to the 6th and from November 18th to the 21st. There was no indication that the medications were set up or given.

When interviewed on November 26, 2007, the LPN stated that a nurse would have set up the medications in a medi-set weekly and the unlicensed staff would have given them.
Client A2 had a physicians order dated November 6, 2007, for Vitamin B12 1000 mcg sublingual daily. The November 2007, medication administration record indicated it was first given on November 18, 2007. The Vitamin B12 was observed, November 28, 2007, to be supplied from an over the counter bottle labeled 1000 mcg tablets for oral use. When interviewed November 28, 2007, Unlicensed staff AA verified that this vitamin pill was set up daily in each medi-set and that the client swallowed the pill whole with the rest of his pills. She verified this was not the ordered liquid consistency as ordered by the physician for this medication. She stated that this is what the clients' wife brought in.
The nurse who set up the meds wasn't available to interview and the LPN on duty November 28, 2007 did not normally work at this site and did not know anything about it.

On November 28, 2007, during the 8 am observation of the medication pass, client A3 requested to see the medications, before the licensed practical nurse (LPN) administered them. Client A3 noted that there was a medication missing. All of the medications were then inspected against the medication administration record. During the inspection the LPN stated that client A3's Metformin 1000 milligrams was not in the client's medication container, so he had not set this medication up, however, he had initialed the Metformin for November 28, 2007, at 8am on the medication administration record (MAR) as given. During the inspection it was also noted that the Omeprazole had not be set up for the 8 am medications. The LPN stated that he had missed setting this medication up and he had not documented the medication as given. Before the administration of the medications the LPN found the Metformin for client A3 and the medication was administered. The November, 2007 medication administration record also indicated that aspirin, ibuprofen, ranitidine and Novolog insulin, being used for sliding scale, were being administered to client A3 on November 28, 2007, however, the record lacked physician orders for these medications. When interviewed, November 28, 2007, the LPN stated she did not know where the physician order for these medications was and she would check with the registered nurse/owner.

Client B1 had a physician order dated, September 12, 2007, for Certagen vitamins to be administered once daily. The November 2007, medication chart had "D/C" (discontinue) written across the spaces of calendar days for the Certagen. When interviewed November 27, 2007, the licensed practical nurse stated the physician had discontinued the Certagen but could not find the order.

Client B2 was ventilator dependent (mechanical ventilation of the lungs). The client had orders for Albuterol 0.083% nebulizer one vial every 4-6 hours as needed for wheezing and Albuterol 90 mcg. (micrograms) inhaler two puffs as needed. The medications were not available for administration when the reviewer observed the client's medications on November 27, 2007. The reviewer noted these medications were still not available when the reviewer returned to the

facility at 7:14 am on November 29, 2007. Licensed staff person BB stated the medications were reordered on November 27, 2007, but licensed staff person BA called the pharmacy at 8:30 am on November 29, 2007, and requested refills. This reviewer contacted the pharmacy on November 29, 2007, and was informed that staff had initially reordered the medications on November 28, 2007, not on November 27, 2007, as was reported on interview.

Client D1's November 2007, medication administration record (MAR) indicated the Keppra 100 mg/ml 5 ml per G-tube twice daily was not administered on November 3 and 9, 2007, Ketoconazole 2% cream apply twice daily to face was not administered on November 1, 2, 3, 4, 5 and 18, 2007, Levothyroxine 75 mcg one tablet per G-tube every morning was not administered on November 3 and 13, 2007. Metoprolol 50 mg tablet take 1/1/2 tablets per g-tube twice daily was not administered on November 4, 2007, Mupirocin 2% ointment apply to G-tube site twice daily was not administered on November 2, 4, 6, 9, and 22, 2007, Prochlorperazine 5mg one tablet per feeding tube was not administered on November 1, 2, 3, 4 and 18, 2007. Spiriva 18 mcg one capsule inhaled daily for bronchospasm was not administered on November 1, 4, 17, 18 and 21, 2007. Amlodipine 2.5mg tablet one per g-tube every morning was not administered on November 3, 2007. C- Prevacid 10 ml per g-tube once daily was not administered on November 3, 2007. Cerovite liquid 15 ml per g-tube once daily was not administered on November 3 and 18 2007. Clotrimazole 1% cream apply to trach twice daily was not administered on November 3, 17, 18, 19 and 23, 2007. Combivent inhalation aerosol four puffs, four times daily, were not administered on November 5, 7, 11, 12, 18 and 19, 2007. Guaifenesin Syrup 10 ml per feeding tube twice daily for cough was not administered on November 2, 3, 6 and 22, 2007. Hydrocortisone 1.5% cream to face twice daily was not administered on November 2, 3, 4, 7, 16, 17 and 22, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.

Client D2's November 2007, MAR indicated the Bacitracin applied twice a day to G-tube site was not administered on November 19 and 20, 2007, A dressing change twice daily to the right lower extremity was not administered on November 19, 2007, Pummel and Phlegm fighter twice daily was not administered on November 18, 2007. Bisacodyl 10 mg suppository once daily was not administered on November 20, 2007. Milk of Magnesia 30 cc per feeding tube once daily was not administered on November 18, 2007. Albuterol nebulizer treatment 3cc four times daily was not administered on November 18 and 20, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 27, 2007, the registered nurse, employee DA, stated that the staff must have forgotten to document the medications as given.

Client D2 had an order for Prevacid suspension 2mg/ml 30 ml per feeding tube once daily since November 16, 2007. During observation on November 28, 2007, it was noted that the currently used Prevacid had expired on November 4, 2007. The November 2007 MAR indicated that the client had received it on November 17, 18, 19, 20 and 21, 2007.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that she was unaware that the bottle of Prevacid was expired.

Client D3's November 2007, MAR indicated the NPH insulin 12 units at 7:30 am was not administered on November 6 and 21, 2007. NPH insulin 7 units at 4:30 pm were not administered on November 10, 2007. Septra DS one tablet twice daily for 7 days was not

administered on November 6 and 7, 2007. Renegal 800 mg three tablets three times daily with meals was not administered on November 15 and 21, 2007. Blood sugar checks with sliding scale insulin were not administered on November 9 and 18, 2007. Seroquel 100 mg two tablets at bedtime were not administered on November 7, 2007. Sodium Bicarbonate 325 mg two tablets twice daily were not administered on November 4, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. Client D3 had a physician order dated August 2, 2007, for Novo Human insulin 8 units every morning and 5 units in the evening. The previous order dated July 11, 2007, was for Insulin Human NPH 12 units at 7:30 am and 7 units at 4:30 pm. Upon interview November 27, 2007 the registered nurse, employee DA stated she thought the orders from July 11, 2007, were the current orders.

Client D3 received dialysis three times weekly on Monday, Wednesday and Friday. The record indicated on November 5 and 7, 2007, the resident was at dialysis but documentation indicated he received sliding scale insulin on both days at 12 noon. When interviewed, November 28, 2007, the registered nurse, employee DA stated he received his 12 noon blood sugar check and sliding scale insulin at dialysis and not by the licensees' staff.

Client D4's November 2007, MAR indicated Protonix 40 mg one tablet daily was not administered on November 4, 2007. Accuzyme spray twice daily to right and left heels was not administered on November 14, 15, and 18, 2007. Vitamin C 500 mg twice a daily was not administered on November 7, 2007. Dressing change twice a daily to the feet was not administered on November 5, 2007. Flush PICC line twice daily with 5 cc of Normal Saline then 5 cc Heparin was not administered on November 5, 6 and 21, 2007. Tracheostomy care was not documented as being done on November 26, 2007, and change wound-vac dressing every Monday, Wednesday and Friday was not documented as done on November 7, 9, 16, 20 and 24, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 28, 2007, the registered nurse, employee DA indicated that the client would at times refuse treatments and medications.

During observation of a medication pass on Monday, November 26, 2007, at 12:50 p.m. employee IC, an unlicensed staff was observed to administer medication to client I3. During the medication pass it was noted that the client's prior Sunday evening pill was still in the medi-set. The medication was identified as Ferrous Sulfate 324 milligrams. Employee IC stated that if the client refused the medication it would be logged in the personal care attendant notes, the PCA would have contacted the nurse, and the nurse would have logged it in her notes. No notation was made regarding the client refusing his evening medication on November 26, 2007. It could not be determined why the medication was not administered.

Client I3 received six units of Lantus insulin at bedtime, and had Novolog insulin coverage by sliding scale at 8:00 a.m., 12:00 noon, 5:00 p.m. and bedtime. Unlicensed personnel documented that they administered the insulin that had been pre-set up by the nurse to client I3. When interviewed November 27, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's record indicated unlicensed staff had administered insulin.
Client I3 began receiving services from the home care provider on September 17, 2007. The client's services included one–to-one client to staff care ratio, medication administration and central storage of medication from the licensee. The client had physician's orders for Haldol .4 milliliters intramuscularly every eight hours as needed for agitation. In addition the client

received Ativan 1 milligrams four times a day, Risperdal .5 milligrams twice a day, Celexa forty milligrams every, and Ambien ten milligrams at bedtime. Nurses' notes dated September 17, 2007, read that client I3 was "very agitated, crying and yelling…refuses to stay seated. Was given Ativan upon arrival. No relief and about 1 hour later he was given Haldol IM." On September 18, 2007, "Very agitated up and about….given Haldol at 8:00 a.m." On September 19, 2007, "Up and about. Given Haldol at 8:00 a.m." On September 20, 2007, "Continues to be very restless, crying and moving from one position to another. Very unsteady…..Haldol IM given. Continues to receive Ativan as ordered." On September 23, 2007, "Increased agitation. Continues to receive Ativan and Haldol as ordered." A notation dated September 24, 2007 indicated the client was very lethargic, sleepy, hard to arouse from sleep. The client was then transported by ambulance to the hospital and admitted with a diagnosis of "Altered mental state." Hospital records indicated the client needed to be intubated upon admission. In addition, a hospital physician's note dated September 26, 2007, indicated the following, "It is possible that the patient may have overdosed on one or several of his psych meds as he takes several. This could cause a gradual change in mental status." A hospital physician's note dated October 3, 2007, read the licensee "was called and RN informed us that pt received several injections of Haldol the day of admission. This may explain his altered mental status." There was no further documentation in the client's record concerning the times/frequency he received the Haldol injections. Numerous requests were made by the reviewer to obtain the client's September 2007 medication administration record. The licensee did not provide the requested documentation.

The client returned from the hospital to the facility on October 5, 2007, and was readmitted to the hospital on October 8, 2007, because of increased edema in both legs. When discharged from the hospital October 10, 2007, the client's discharge orders included Norvasc ten milligrams daily. Client I3's October 2007, medication administration record indicated that on October 11, 2007, Norvasc five milligrams was set up in the client's medi-set instead of the ten milligrams as ordered.

Client I3 was readmitted to the hospital again on October 30, 2007, due to being "very lethargic, and stuperous." The client's admission diagnosis was "altered mental status." The hospital history and physical dated October 30, 2007, read, "The nursing home staff states that he has been receiving his medications although he could have access to them and could have overdosed." A notation by a hospital physician dated October 31, 2007, indicated the following, "Unfortunately I cannot tell from the notes available to what extent he (the client) was receiving any of his PRN. medications in the nursing home." The client was readmitted to the facility on November 1, 2007.

On November 6, 2007, client I3 readmitted to the hospital because of episodes of jerky movements. The client was discharged back to the facility on November 8, 2007. Cogentin one milligram twice a day was ordered upon discharge however Cogentin 0.5 milligrams was documented as having been set-up to be administered.

The following medication discrepancies were noted from what the physician ordered for client I3 upon discharge, and what was documented as being set-up in the medi-set containers to be administered. Cogentin one milligram twice a day was ordered upon discharge, but when the client's November 2007, medication administration record was reviewed, Cogentin .5 milligrams was documented as having been set-up to be administered. Celexa 10 milligrams daily were ordered upon discharge however the November 2007, medication administration record indicated that Celexa 20 milligrams were set-up and administered. Prilosec 10 milligrams daily were

ordered to be given upon discharge however the November 2007 medication administration record indicated that Prilosec 20 milligrams (two capsules) were set-up and administered. Risperdal .5 milligrams daily at bedtime was ordered upon discharge however the November 2007, medication administration record indicated that Risperdol .5 milligrams twice a day was set-up and administered. When interviewed, November 28, 2007, employee IE, a licensed practical nurse could not explain why the medications were not instituted as ordered upon discharge.

During observation at housing site I on Tuesday November 27, 2007, unlicensed employee ID was observed to administer client I4's 8:00 a.m. medications. Employee ID counted eleven and one half pills that were preset-up in client I4's medi-set slot for Tuesday at 8:00 a.m., and administered the pills to the client. The client's record was reviewed and it was noted that the client was to receive twelve and one half pills at 8:00 a.m. every morning instead of eleven and a half as observed.

When questioned about the discrepancy, employee IE, the licensed practical nurse (LPN) checked the client's medi-set, and noted a half of a pill was stuck to the bottom of the medi-set in the Tuesday 8:00 a.m. slot. Employee IE stated she was unsure why there would be an additional half of a tablet of medication in the slot, when the client had already received a half of a tablet that morning. The LPN identified the half of a tablet as Baclofen 5 milligrams. The LPN stated she spoke with employee ID regarding the medication pass. The LPN reported that employee ID stated that the morning of November 27, 2007, employee ID had noted there were no pills in client I4' s medi-set slot for Tuesday, November 27, 2007. Employee ID then asked nurse MA, a licensed practical nurse if she could move the pills that were pre set up in Friday's slot to Tuesday's slot. According to employee ID, nurse MA stated she could, so employee ID moved the client's pills from the Friday slot to the Tuesday slot. Nurse IE stated that maybe when employee ID moved the pills employee ID inadvertently dropped a pill on the floor. Nurse IE stated that there had not been pills in the Tuesday 8:00 a.m. slot because she had not had the time to fill the weekly medi-set for client I4 on Monday, November 26, 2007. When the medication discrepancy was noted, the reviewer requested nurse IE to assist in checking the accuracy of the amount of pills that were in the Wednesday 8:00 a.m. slot. There were twelve pills in the Wednesday 8:00 a.m. slot, when there should have been twelve and one half pills. Nurse IE could not explain why the half of a tablet of Baclofen was not in the Wednesday slot, nor why there would have been two half tablets in Tuesday's slot. In addition, it could not be determined what medication client I4 did not receive Tuesday morning at 8:00 a.m.

Client I4 had an order for Docusate Sodium 100 milligrams twice a day. The medications set up by the licensee's nurse in the medi-set revealed that the Docusate Sodium was only set up for one time daily at bedtime. When interviewed, November 28, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's Docusate Sodium was not set up twice a day as ordered.

Client I4's medications, that the nurses used to fill the client's weekly medi-set container, contained numerous expired medications. Twenty-seven bubble pack cards of client I4's regularly scheduled medications including Prilosec, Docusate Sodium, Toprol, Detrol, Baclofen, and Gabapenten were noted to have expiration dates ranging from June 5, 2007 to November 1, 2007. When interviewed, November 28, 2007, employee IE, a licensed practical nurse confirmed that there were expired medications. She stated she tried to check the expiration dates when dispensing the medications in the medi-sets.

Physician orders on August 10, 2007, indicate client M1 was prescribed a transdermal patch, Androderm (testosterone) 5 mg. every day. The November MAR indicated the transdermal patch was not applied during November 2007. It was observed the medication cupboard did not contain the Androderm transdermal patches at 8:00 a.m., on November 28, 2007. Client M1 stated that he had not worn the Androderm patch for a long time. During an interview on November 29, 2007, the RN/owner reported that the transdermal patch had not been ordered from the pharmacy due to payment issues and therefore had not been administered to the client. She stated that staff failed to contact the physician regarding another order for the patch.

Progress notes on October 26, 2007, indicated client M1 had complained that he had not received his prescribed Coumadin, a blood thinner, for the past week. The physician's office was contacted and client M1 was transported to a clinic for an INR blood test. The INR was 1.7 (desired range was indicated as 2-3). The physician reordered the Coumadin 8 mg. every day. During an interview on November 29, the RN/owner indicated that it was believed the client had received the Coumadin. The client was sent to the clinic as a precautionary measure to have his INR checked. The owner stated that situation was not investigated to determine if a medication error had occurred.

Physician documentation on October 10, 2007, indicated client M1's laboratory results were abnormal and the physician ordered a hold on Zaroxalyn 5 mg., a diuretic, which was ordered as needed every day for weight gain over two pounds. On October 16, 2007, the physician ordered the hold continued. The MAR indicates Zaroxalyn was administered at 8:00 p.m., on November 11, 2007. A physician order to resume the use of the Zaroxalyn was not found in the medical record. During an interview on November 29, 2007, the RN/owner stated it appeared that the LPN had administered the medication on November 11, 2007, however she was unable to verify if an error had occurred as she was unfamiliar with the client's orders.

Client M2 received medication administration and blood glucose monitoring four times daily with sliding scale Novolog insulin coverage by unlicensed personnel. The November 2007, blood glucose/insulin flow sheet indicated client was scheduled for Novolog insulin 5 units subcutaneously at 5 pm and Lantus insulin 20 units subcutaneously at 9 pm. The November blood glucose/insulin flow sheet indicated the insulin and blood sugar checks were not administered on November 5 and 6, 2007, for the 5 pm insulin and blood sugar, November 15, 2007, for the 5pm and 9 pm insulin, November 25, 2007, for the 5 pm insulin, and November 27, 2007, for the 9 pm insulin. There was no documentation as to why the insulin was not administered and no evidence a registered nurse was contacted. When interviewed November 28, 2007, the owner/registered nurse indicated the personal care attendants should be charting insulin on the blood glucose/insulin flow sheets.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$700.00** 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

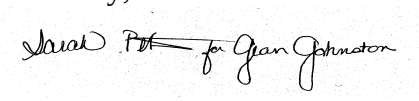
FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800 Subp. 6, the (correction order has/the correction orders have) not been corrected, another fine may be assessed. This fine shall be double the 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 651-201-4301.

Sincerely,



Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

December 17, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

Re: Licensing Follow Up visit

Dear Ms. Gurely:

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 December 3, 2007.

The documents checked below are enclosed.

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

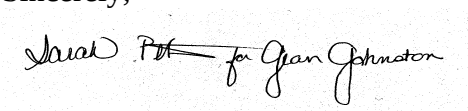
_____ MDH Correction Order and Licensed Survey Form
Correction order(s) issued pursuant to visit of your facility.

__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: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit

01/07 CMR1000

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

INFORMATIONAL MEMORANDUM

PROVIDER: CAREMAXX HEALTH CARE SYSTEMS

DATE OF SURVEY: December 5, 2007

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

NAME (S) AND TITLE (S) OF PERSONS INTERVIEWED:
Theresa Zayne Unlicensed Care Giver
Loupu Crawford Unlicensed Care Giver
Veronica Matthew Unlicensed Care Giver
Josephine Smith Unlicensed Care Giver
Vicki Briggs LPN
Maureen Nyamagwa, RN/ADON
Roni Oberuomo, PCA
Josephine Bayo, PCA
Vicki Wilson, LPN
Connie Zirayo, LPN
Theo Barboro, LPN
L. Wilson Unlicensed Care Giver

SUBJECT: Licensing Survey _____ Licensing Order Follow Up: #1 (24 hr order)

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 November 26, 27, 28, 29, 30, December 1, and 3, 2007 and subsequent follow up visits made on December 5, 2007. 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.

MN Rule 4668.0150 Subp. 2 **FINE $350.00**

Based on record review, interviews and observations, the licensee failed to ensure that medications were administered as ordered for three of four clients reviewed (L1, L2, and L4) at site L, one of one client

(J2) record reviewed at site J and four of four client records reviewed (G1, G2, G3, and G4) at site G. The findings include:

When interviewed December 5, 2007, Registered Nurse (RN) FH stated it was the licensee's procedure for licensed nurses to set up medications weekly in medi-set containers for each client in residence L, the unlicensed caregivers (PCA) were instructed to check the PCA medication assistance sheet for each client before administering the client's medications. The PCA medication assistance sheet only denoted the number of medications to be administered by the PCA for each time in the medi-set container. A licensed nurse was to be contacted if there was a discrepancy between the number of pills in the medi-set and the number of pills identified in the PCA medication assistance sheet.

During observation December 5, 2007 client L1's 8:00 a.m. medi-set contained fifteen pills. The PCA medication assistance sheet indicated the 8:00 a.m. medi-set was to contain thirteen pills. One of the medication bubble packs contained 20 mg. tablets of Celexa and another medication bubble pack contained 40 mg. tablets. When counted, the medi-set pill box contained three 20 mg. tablets of Celexa, which was the correct dosage. However, the nurse set up three 20 mg tablets of Celexa, rather than one 20 mg. tablet and one 40 mg. tablet, which also contributed to a discrepancy in the number of pills to be administered.

Client L1 had a physician order, originally dated May 17, 2007, for one tablet of Calcium three times daily at 12:00 p.m., 4:00 p.m. and 8:00 p.m. Client L1's unsigned orders for November 2007 indicated the prescriber had not prescribed Docusate Sodium. One pill of Docusate Sodium was observed in the 8:00 a.m. pill boxes for December 6, 7, 8 and 9, 2007. The label on the Docusate Sodium container indicated the medication was filled for client L3 not client LI.

Client L1's physician orders included an order for Celexa 60 mg. to be administered in the morning. The "December" PCA medication assistance sheet directed two pills to be administered at 12:00 p.m. every day instead of in the morning as ordered.

Physician's orders indicated Client L1 was originally prescribed Lactase, for lactose intolerance, on May 17, 2007. Two tablets of Lactase were to be administered every Monday, Wednesday and Friday at 11:30 a.m. The medi-set did not contain the Lactase tablets and there was no supply of the medication in the L residence on December 5, 2007. At 10:10 p.m., on December 5, 2007, RN FH reported she contacted the pharmacy to fill the prescription.

Client L2's PCA medication assistance sheet dated "December" indicated seven tablets were to be administered at daily at 8:00 a.m. The medi-set 8:00 a.m. boxes contained eight pills to be administered on December 6, 7, 8 and 9, 2007. When interviewed by telephone, December 5, 2007, employee FI, an LPN, stated the additional tablet was Vistaril 25 mg., which was ordered as needed (PRN). Employee FI stated she was aware the PRN medication was not to be placed in the pill boxes with the scheduled drugs. The PCA medication assistance sheet indicated client L2 was not to receive pills at 12:00 p.m., 4:00 p.m. and 8:00 p.m. The medi-set boxes for 8:00 p.m. contained eleven pills for administration on December 5, 6, 7, 8 and 9, 2007. Physician orders indicated client L2 was to receive eleven pills at 8:00 p.m.

On December 5, 2007, at 4:50 p.m., employee LB, an unlicensed care giver, was observed to remove four pills out of client L4's 4:00 p.m. medication box and hand the medications to client L4, who had started to consume the evening meal. It was determined that two of the four pills were Glipzide, an

antidiabetic medication. The label on the Glipzide container and the physician's order indicated Glipzide was to be administered thirty minutes before meals.

Client L4's PCA medication assistance sheet dated December 2007, read that two tablets were to be administered at 12:00 p.m. and five tablets were to be administered daily at 8:00 p.m. The medi-set boxes for 12:00 p.m., on December 6, 7, 8 and 9, 2007, did not contain any medications. The pill boxes for 8:00 p.m., on December 5, 6, 7, 8 and 9, 2007, contained seven pills. Client L4's physician orders indicated that client L4 was to receive seven pills at 8:00 p.m.

Client J2's PCA medication assistance sheet dated December 2007, read that he was to receive two pills at 4:00 p.m. On December 5, 2007 client J2's medi-set container was reviewed with employee JA, an unlicensed caregiver who passed medications. The medi-set contained three pills in the 4:00 p.m. area for Wednesday, Thursday, Friday and Saturday. The physician's orders dated December 2007 stated the client was to receive Lamictal 150 mg. (milligrams), two tabs, at 4:00 p.m.

When interviewed December 5, 2007 employee IE a nurse stated that the nurse only initials the day the medications are set up in the medi-set. She also stated that the number of days the medications are placed in the medi-set varies. Employee IE also reported that employee JA had called the nurse who set up the medications and reported the discrepancy in the number of pills that had been set up for 4:00 p.m. The nurse came to the facility and removed Zyprexa 5 mg, one tablet, from the 4:00 p.m. slot in the medi-set as it was to be administered at 12 noon. It was not determined how many pills were administered on the prior days at 4:00 p.m.

Client G4 had an order for Clindamycin Phosphate 1% twice daily. There was no medication available for client G1. On the evening December 5, 2007 client G1 was observed stating to her care giver that she had reminded staff early that day that she was out of the medication and that "it should have been ordered." Sit G had a pharmacy delivery of medications at 7:57 pm. There was no Clindamycin Phosphate 1% in the delivery. When interviewed, December 5, 2007, employee GA, an unlicensed care giver confirmed the medication was not available. Client G1's PCA medication assistance sheet dated December 2007, read that she was to receive five pills at 8:00 a.m. The medi-set 8 a.m. slots contained four pills. Client G1's unsigned prescriber orders indicated the client was to receive four pills at 8 am. The Sunday 8:a.m. medi-set container was set up but missing the Metformin 1000mg as ordered. When interviewed December 5, 2007, employee GA, an unlicensed care giver who administered medication was unaware of the discrepancy. Client G1's medication central storage area contained three cards, partially utilized, of Lamactil 25 milligrams (mg) take 2 (50 mg) twice daily. There was no order for this medication nor was it listed on the medication administration record to be set up. Client G1 was to receive Novolog insulin 2 units as needed for sliding scale insulin coverage. When observed December 5, 2007, the medication was pre drawn in syringes. One of the pre drawn syringes contained .05 units instead of the two units as ordered and indicated on the storage bag they were in. This was confirmed with employee GA December 5, 2007.

Client G2's medication orders dated December 2007, read that she was to receive one to two Tylenol 325 mg every three to four hours as needed for pain. There was no Tylenol available for client G2. When interviewed December 5, 2007 employee GA stated if the client needed the medication they would have to call a nurse and maybe the nurse could bring the medication from another house.

Client G3's PCA medication assistance sheet dated December 2007, read that she was to receive eight and on half pills at 8: a.m., one and one half pills at noon, and seven and one half pills at 8:p.m. On December 5, 2007 client G3's medi-set container was reviewed with employee GA, an unlicensed

caregiver who passed medications. The medi-set did not contain any medications in the 8: p.m. containers. The 8: a.m. containers contained a white and pink capsule with a red band in the center stamped 44-107 which was not ordered, had no prescription container at site G for it and that was unable to be identified by this reviewer or employee GA. Upon determination at 7:30 p.m that there were no 8 p.m. medications for the client employees GA and later GD called for a nurse to come ad set up medications. At 8:17 p.m. a nurse arrived but left with out setting up the 8 p.m. medications. At 8:45 p.m. another nurse arrived to set up the medication.

At 8 p.m employee GD, an unlicensed care giver, was observed to pass medications to clients. The employee did not was her hands prior to administration nor did she check the PCA medication administration sheet for the number of pills each client was to receive. The employee did not count the pills before administering them. Instead she opened the medi-sets into her ungloved hand and handed the pills to the respective clients. When interviewed December 5, 2007 employee GD stated she thought what was set up was okay to give.

Client G4's PCA medication assistance sheet dated December 2007, read that she was to receive six and on half pills at 8 p.m. On December 5, 2007 client G4's medi-set container was reviewed with employee GA, an unlicensed caregiver who passed medications. The medi -set contained five pills and two half pills. Client G4's prescriber orders indicated the client was to receive five pills and two half pills at 8 p.m. When interviewed December 5, 2007 employee GA stated she was unaware there was a discrepancy in what was ordered and set up and what the PCA medication assistance sheet indicated.

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

3) The following referral/s is/are being made:
   i) OHFC- VAA

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail #: Hand Delivered

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

December 17, 2007

Josephine Gurley, Administrator
Caremaxx Healthcare Systems
7700 Shingle Creek Drive
Brooklyn Park, MN 55443

RE: QL21374003

Dear Ms. Gurley:

On December 5, 2007, a reinspection of the above provider was made by the survey staff of the Minnesota Department of Health, to determine the status of correction orders issued during an survey completed on November 26, 27, 28, 29, and 30, 2007 & December 1, 3, 4, 5, 11 and 12, 2007 with correction orders received by you on December 3, 2005.

The following correction orders were not corrected in the time period allowed for correction:

MN Rule 4668.0150 Subp. 2 **$350.00**

Based on records review and interviews the licensee failed to ensure medications were received as ordered for three of four clients reviewed (A1, A2 and A3) at site A, for two of four clients reviewed (B1, and B2) at site B, for four of four clients reviewed (D1, D2, D3 and D4) at site D, for two of three clients reviewed (I3 and I4) at site I, and for two of four clients reviewed (M1 and M2) in house M. The findings include:

Client A1's record contained physician orders for diphenhydramine 25milligrams one to two capsules every six hours; and blood sugar checks with sliding scale coverage with regular insulin, four times daily. During observation of the set-up medications for client A1 on November 26, 2007, it was noted that the containers contained 25 milligrams of diphenhydramine that were being administered at 8AM, 5PM and 8PM; the November, 2007 medication administration record (MAR) also indicated that the client was having blood sugar checks done periodically. On interview, November 26, 2007, the personal care attendant (employee AA) stated that the client only had blood sugar checks done one time per day around 4PM. On interview, November 28, 2007, the LPN stated she did not know why the blood sugar checks were only being done one time per day; she could not find a physician order for this and she stated she would verify with the physician what the order should be.

Client A2 began receiving services July 18, 2005. He had a diagnosis of traumatic brain injury with left hemiplegia and received total assistance with all activities of daily living. The medication administration record and pharmacy printout for November 2007, indicated the client

received Baclofen 5mg. TID, Colace 100 mg. BID, Effexor XR 150 mg. QD, Keppra 1000 mg. BID, Seroquel 50 mg. BID, and Trazadone 50 mg. QD. The November 2007, medication administration record was blank from November 1st to the 6th and from November 18th to the 21st. There was no indication that the medications were set up or given.

When interviewed on November 26, 2007, the LPN stated that a nurse would have set up the medications in a medi-set weekly and the unlicensed staff would have given them.
Client A2 had a physicians order dated November 6, 2007, for Vitamin B12 1000 mcg sublingual daily. The November 2007, medication administration record indicated it was first given on November 18, 2007. The Vitamin B12 was observed, November 28, 2007, to be supplied from an over the counter bottle labeled 1000 mcg tablets for oral use. When interviewed November 28, 2007, Unlicensed staff AA verified that this vitamin pill was set up daily in each medi-set and that the client swallowed the pill whole with the rest of his pills. She verified this was not the ordered liquid consistency as ordered by the physician for this medication. She stated that this is what the clients' wife brought in. The nurse who set up the meds wasn't available to interview and the LPN on duty November 28, 2007 did not normally work at this site and did not know anything about it.

On November 28, 2007, during the 8 am observation of the medication pass, client A3 requested to see the medications, before the licensed practical nurse (LPN) administered them. Client A3 noted that there was a medication missing. All of the medications were then inspected against the medication administration record. During the inspection the LPN stated that client A3's Metformin 1000 milligrams was not in the client's medication container, so he had not set this medication up, however, he had initialed the Metformin for November 28, 2007, at 8am on the medication administration record (MAR) as given. During the inspection it was also noted that the Omeprazole had not be set up for the 8 am medications. The LPN stated that he had missed setting this medication up and he had not documented the medication as given. Before the administration of the medications the LPN found the Metformin for client A3 and the medication was administered. The November, 2007 medication administration record also indicated that aspirin, ibuprofen, ranitidine and Novolog insulin, being used for sliding scale, were being administered to client A3 on November 28, 2007, however, the record lacked physician orders for these medications. When interviewed, November 28, 2007, the LPN stated she did not know where the physician order for these medications was and she would check with the registered nurse/owner.

Client B1 had a physician order dated, September 12, 2007, for Certagen vitamins to be administered once daily. The November 2007, medication chart had "D/C" (discontinue) written across the spaces of calendar days for the Certagen. When interviewed November 27, 2007, the licensed practical nurse stated the physician had discontinued the Certagen but could not find the order.

Client B2 was ventilator dependent (mechanical ventilation of the lungs). The client had orders for Albuterol 0.083% nebulizer one vial every 4-6 hours as needed for wheezing and Albuterol 90 mcg. (micrograms) inhaler two puffs as needed. The medications were not available for administration when the reviewer observed the client's medications on November 27, 2007. The reviewer noted these medications were still not available when the reviewer returned to the facility at 7:14 am on November 29, 2007. Licensed staff person BB stated the medications were reordered on November 27, 2007, but licensed staff person BA called the pharmacy at 8:30 am on November 29, 2007, and requested refills. This reviewer contacted the pharmacy on

November 29, 2007, and was informed that staff had initially reordered the medications on November 28, 2007, not on November 27, 2007, as was reported on interview.

Client D1's November 2007, medication administration record (MAR) indicated the Keppra 100 mg/ml 5 ml per G-tube twice daily was not administered on November 3 and 9, 2007, Ketoconazole 2% cream apply twice daily to face was not administered on November 1, 2, 3, 4, 5 and 18, 2007, Levothyroxine 75 mcg one tablet per G-tube every morning was not administered on November 3 and 13, 2007. Metoprolol 50 mg tablet take 1/1/2 tablets per g-tube twice daily was not administered on November 4, 2007, Mupirocin 2% ointment apply to G-tube site twice daily was not administered on November 2, 4, 6, 9, and 22, 2007, Prochlorperazine 5mg one tablet per feeding tube was not administered on November 1, 2, 3, 4 and 18, 2007. Spiriva 18 mcg one capsule inhaled daily for bronchospasm was not administered on November 1, 4, 17, 18 and 21, 2007. Amlodipine 2.5mg tablet one per g-tube every morning was not administered on November 3, 2007. C- Prevacid 10 ml per g-tube once daily was not administered on November 3, 2007. Cerovite liquid 15 ml per g-tube once daily was not administered on November 3 and 18 2007. Clotrimazole 1% cream apply to trach twice daily was not administered on November 3, 17, 18, 19 and 23, 2007. Combivent inhalation aerosol four puffs, four times daily, were not administered on November 5, 7, 11, 12, 18 and 19, 2007. Guaifenesin Syrup 10 ml per feeding tube twice daily for cough was not administered on November 2, 3, 6 and 22, 2007. Hydrocortisone 1.5% cream to face twice daily was not administered on November 2, 3, 4, 7, 16, 17 and 22, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information.

Client D2's November 2007, MAR indicated the Bacitracin applied twice a day to G-tube site was not administered on November 19 and 20, 2007, A dressing change twice daily to the right lower extremity was not administered on November 19, 2007, Pummel and Phlegm fighter twice daily was not administered on November 18, 2007. Bisacodyl 10 mg suppository once daily was not administered on November 20, 2007. Milk of Magnesia 30 cc per feeding tube once daily was not administered on November 18, 2007. Albuterol nebulizer treatment 3cc four times daily was not administered on November 18 and 20, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 27, 2007, the registered nurse, employee DA, stated that the staff must have forgotten to document the medications as given.

Client D2 had an order for Prevacid suspension 2mg/ml 30 ml per feeding tube once daily since November 16, 2007. During observation on November 28, 2007, it was noted that the currently used Prevacid had expired on November 4, 2007. The November 2007 MAR indicated that the client had received it on November 17, 18, 19, 20 and 21, 2007.
When interviewed, November 28, 2007, the registered nurse, employee DA indicated that she was unaware that the bottle of Prevacid was expired.

Client D3's November 2007, MAR indicated the NPH insulin 12 units at 7:30 am was not administered on November 6 and 21, 2007. NPH insulin 7 units at 4:30 pm were not administered on November 10, 2007. Septra DS one tablet twice daily for 7 days was not administered on November 6 and 7, 2007. Renegal 800 mg three tablets three times daily with meals was not administered on November 15 and 21, 2007. Blood sugar checks with sliding scale insulin were not administered on November 9 and 18, 2007. Seroquel 100 mg two tablets

at bedtime were not administered on November 7, 2007. Sodium Bicarbonate 325 mg two tablets twice daily were not administered on November 4, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. Client D3 had a physician order dated August 2, 2007, for Novo Human insulin 8 units every morning and 5 units in the evening. The previous order dated July 11, 2007, was for Insulin Human NPH 12 units at 7:30 am and 7 units at 4:30 pm. Upon interview November 27, 2007 the registered nurse, employee DA stated she thought the orders from July 11, 2007, were the current orders.

Client D3 received dialysis three times weekly on Monday, Wednesday and Friday. The record indicated on November 5 and 7, 2007, the resident was at dialysis but documentation indicated he received sliding scale insulin on both days at 12 noon. When interviewed, November 28, 2007, the registered nurse, employee DA stated he received his 12 noon blood sugar check and sliding scale insulin at dialysis and not by the licensees' staff.

Client D4's November 2007, MAR indicated Protonix 40 mg one tablet daily was not administered on November 4, 2007. Accuzyme spray twice daily to right and left heels was not administered on November 14, 15, and 18, 2007. Vitamin C 500 mg twice a daily was not administered on November 7, 2007. Dressing change twice a daily to the feet was not administered on November 5, 2007. Flush PICC line twice daily with 5 cc of Normal Saline then 5 cc Heparin was not administered on November 5, 6 and 21, 2007. Tracheostomy care was not documented as being done on November 26, 2007, and change wound-vac dressing every Monday, Wednesday and Friday was not documented as done on November 7, 9, 16, 20 and 24, 2007. There was no documentation in the client record as to why the medications were not administered as ordered. The MAR had blank areas rather than documentation of administration, refusal, or other information. When interviewed, November 28, 2007, the registered nurse, employee DA indicated that the client would at times refuse treatments and medications.

During observation of a medication pass on Monday, November 26, 2007, at 12:50 p.m. employee IC, an unlicensed staff was observed to administer medication to client I3. During the medication pass it was noted that the client's prior Sunday evening pill was still in the medi-set. The medication was identified as Ferrous Sulfate 324 milligrams. Employee IC stated that if the client refused the medication it would be logged in the personal care attendant notes, the PCA would have contacted the nurse, and the nurse would have logged it in her notes. No notation was made regarding the client refusing his evening medication on November 26, 2007. It could not be determined why the medication was not administered.

Client I3 received six units of Lantus insulin at bedtime, and had Novolog insulin coverage by sliding scale at 8:00 a.m., 12:00 noon, 5:00 p.m. and bedtime. Unlicensed personnel documented that they administered the insulin that had been pre-set up by the nurse to client I3. When interviewed November 27, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's record indicated unlicensed staff had administered insulin.

Client I3 began receiving services from the home care provider on September 17, 2007. The client's services included one–to-one client to staff care ratio, medication administration and central storage of medication from the licensee. The client had physician's orders for Haldol .4 milliliters intramuscularly every eight hours as needed for agitation. In addition the client received Ativan 1 milligrams four times a day, Risperdal .5 milligrams twice a day, Celexa forty milligrams every, and Ambien ten milligrams at bedtime. Nurses' notes dated September 17,

2007, read that client I3 was "very agitated, crying and yelling…refuses to stay seated. Was given Ativan upon arrival. No relief and about 1 hour later he was given Haldol IM." On September 18, 2007, "Very agitated up and about….given Haldol at 8:00 a.m." On September 19, 2007, "Up and about. Given Haldol at 8:00 a.m." On September 20, 2007, "Continues to be very restless, crying and moving from one position to another. Very unsteady…..Haldol IM given. Continues to receive Ativan as ordered." On September 23, 2007, "Increased agitation. Continues to receive Ativan and Haldol as ordered." A notation dated September 24, 2007 indicated the client was very lethargic, sleepy, hard to arouse from sleep. The client was then transported by ambulance to the hospital and admitted with a diagnosis of "Altered mental state." Hospital records indicated the client needed to be intubated upon admission. In addition, a hospital physician's note dated September 26, 2007, indicated the following, "It is possible that the patient may have overdosed on one or several of his psych meds as he takes several. This could cause a gradual change in mental status." A hospital physician's note dated October 3, 2007, read the licensee "was called and RN informed us that pt received several injections of Haldol the day of admission. This may explain his altered mental status." There was no further documentation in the client's record concerning the times/frequency he received the Haldol injections. Numerous requests were made by the reviewer to obtain the client's September 2007 medication administration record. The licensee did not provide the requested documentation.

The client returned from the hospital to the facility on October 5, 2007, and was readmitted to the hospital on October 8, 2007, because of increased edema in both legs. When discharged from the hospital October 10, 2007, the client's discharge orders included Norvasc ten milligrams daily. Client I3's October 2007, medication administration record indicated that on October 11, 2007, Norvasc five milligrams was set up in the client's medi-set instead of the ten milligrams as ordered.

Client I3 was readmitted to the hospital again on October 30, 2007, due to being "very lethargic, and stuperous." The client's admission diagnosis was "altered mental status." The hospital history and physical dated October 30, 2007, read, "The nursing home staff states that he has been receiving his medications although he could have access to them and could have overdosed." A notation by a hospital physician dated October 31, 2007, indicated the following, "Unfortunately I cannot tell from the notes available to what extent he (the client) was receiving any of his PRN. medications in the nursing home." The client was readmitted to the facility on November 1, 2007.

On November 6, 2007, client I3 readmitted to the hospital because of episodes of jerky movements. The client was discharged back to the facility on November 8, 2007. Cogentin one milligram twice a day was ordered upon discharge however Cogentin 0.5 milligrams was documented as having been set-up to be administered

The following medication discrepancies were noted from what the physician ordered for client I3 upon discharge, and what was documented as being set-up in the medi-set containers to be administered. Cogentin one milligram twice a day was ordered upon discharge, but when the client's November 2007, medication administration record was reviewed, Cogentin .5 milligrams was documented as having been set-up to be administered. Celexa 10 milligrams daily were ordered upon discharge however the November 2007, medication administration record indicated that Celexa 20 milligrams were set-up and administered. Prilosec 10 milligrams daily were ordered to be given upon discharge however the November 2007 medication administration record indicated that Prilosec 20 milligrams (two capsules) were set-up and administered.

Risperdal .5 milligrams daily at bedtime was ordered upon discharge however the November 2007, medication administration record indicated that Risperdol .5 milligrams twice a day was set-up and administered. When interviewed, November 28, 2007, employee IE, a licensed practical nurse could not explain why the medications were not instituted as ordered upon discharge.

During observation at housing site I on Tuesday November 27, 2007, unlicensed employee ID was observed to administer client I4's 8:00 a.m. medications. Employee ID counted eleven and one half pills that were preset-up in client I4's medi-set slot for Tuesday at 8:00 a.m., and administered the pills to the client. The client's record was reviewed and it was noted that the client was to receive twelve and one half pills at 8:00 a.m. every morning instead of eleven and a half as observed.

When questioned about the discrepancy, employee IE, the licensed practical nurse (LPN) checked the client's medi-set, and noted a half of a pill was stuck to the bottom of the medi-set in the Tuesday 8:00 a.m. slot. Employee IE stated she was unsure why there would be an additional half of a tablet of medication in the slot, when the client had already received a half of a tablet that morning. The LPN identified the half of a tablet as Baclofen 5 milligrams. The LPN stated she spoke with employee ID regarding the medication pass. The LPN reported that employee ID stated that the morning of November 27, 2007, employee ID had noted there were no pills in client I4' s medi-set slot for Tuesday, November 27, 2007. Employee ID then asked nurse MA, a licensed practical nurse if she could move the pills that were pre set up in Friday's slot to Tuesday's slot. According to employee ID, nurse MA stated she could, so employee ID moved the client's pills from the Friday slot to the Tuesday slot. Nurse IE stated that maybe when employee ID moved the pills employee ID inadvertently dropped a pill on the floor. Nurse IE stated that there had not been pills in the Tuesday 8:00 a.m. slot because she had not had the time to fill the weekly medi-set for client I4 on Monday, November 26, 2007. When the medication discrepancy was noted, the reviewer requested nurse IE to assist in checking the accuracy of the amount of pills that were in the Wednesday 8:00 a.m. slot. There were twelve pills in the Wednesday 8:00 a.m. slot, when there should have been twelve and one half pills. Nurse IE could not explain why the half of a tablet of Baclofen was not in the Wednesday slot, nor why there would have been two half tablets in Tuesday's slot. In addition, it could not be determined what medication client I4 did not receive Tuesday morning at 8:00 a.m.

Client I4 had an order for Docusate Sodium 100 milligrams twice a day. The medications set up by the licensee's nurse in the medi-set revealed that the Docusate Sodium was only set up for one time daily at bedtime. When interviewed, November 28, 2007, employee IE, a licensed practical nurse stated she wasn't sure why the client's Docusate Sodium was not set up twice a day as ordered.

Client I4's medications, that the nurses used to fill the client's weekly medi-set container, contained numerous expired medications. Twenty-seven bubble pack cards of client I4's regularly scheduled medications including Prilosec, Docusate Sodium, Toprol, Detrol, Baclofen, and Gabapenten were noted to have expiration dates ranging from June 5, 2007 to November 1, 2007. When interviewed, November 28, 2007, employee IE, a licensed practical nurse confirmed that there were expired medications. She stated she tried to check the expiration dates when dispensing the medications in the medi-sets.

Physician orders on August 10, 2007, indicate client M1 was prescribed a transdermal patch, Androderm (testosterone) 5 mg. every day. The November MAR indicated the transdermal patch was not applied during November 2007. It was observed the medication cupboard did not contain the Androderm transdermal patches at 8:00 a.m., on November 28, 2007. Client M1 stated that he had not worn the Androderm patch for a long time. During an interview on November 29, 2007, the RN/owner reported that the transdermal patch had not been ordered from the pharmacy due to payment issues and therefore had not been administered to the client. She stated that staff failed to contact the physician regarding another order for the patch.

Progress notes on October 26, 2007, indicated client M1 had complained that he had not received his prescribed Coumadin, a blood thinner, for the past week. The physician's office was contacted and client M1 was transported to a clinic for an INR blood test. The INR was 1.7 (desired range was indicated as 2-3). The physician reordered the Coumadin 8 mg. every day. During an interview on November 29, the RN/owner indicated that it was believed the client had received the Coumadin. The client was sent to the clinic as a precautionary measure to have his INR checked. The owner stated that situation was not investigated to determine if a medication error had occurred.

Physician documentation on October 10, 2007, indicated client M1's laboratory results were abnormal and the physician ordered a hold on Zaroxalyn 5 mg., a diuretic, which was ordered as needed every day for weight gain over two pounds. On October 16, 2007, the physician ordered the hold continued. The MAR indicates Zaroxalyn was administered at 8:00 p.m., on November 11, 2007. A physician order to resume the use of the Zaroxalyn was not found in the medical record. During an interview on November 29, 2007, the RN/owner stated it appeared that the LPN had administered the medication on November 11, 2007, however she was unable to verify if an error had occurred as she was unfamiliar with the client's orders.

Client M2 received medication administration and blood glucose monitoring four times daily with sliding scale Novolog insulin coverage by unlicensed personnel. The November 2007, blood glucose/insulin flow sheet indicated client was scheduled for Novolog insulin 5 units subcutaneously at 5 pm and Lantus insulin 20 units subcutaneously at 9 pm. The November blood glucose/insulin flow sheet indicated the insulin and blood sugar checks were not administered on November 5 and 6, 2007, for the 5 pm insulin and blood sugar, November 15, 2007, for the 5pm and 9 pm insulin, November 25, 2007, for the 5 pm insulin, and November 27, 2007, for the 9 pm insulin. There was no documentation as to why the insulin was not administered and no evidence a registered nurse was contacted. When interviewed November 28, 2007, the owner/registered nurse indicated the personal care attendants should be charting insulin on the blood glucose/insulin flow sheets.

TO COMPLY: Medications and treatments must be administered by a nurse or therapist qualified to perform the order or by a person who performs home health aide tasks under the direction and supervision of the nurse or therapist consistent with part 4668.0100, subparts 2 to 4.

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

Therefore, in accordance with Minnesota Statutes 144.653 and 144A.45, subdivision 2. (4), the total amount you are assessed is: **$350.00**. 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, Facility and Provider Compliance Division, within 15 days of the receipt of this notice.

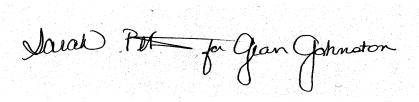
FAILURE TO CORRECT: In accordance with Minnesota Rule 4668.0800, Subp.7, if, upon subsequent re-inspection after a fine has been imposed under MN Rule 4668.0800Subp. 6, the (correction order has/the correction orders have) not been corrected, another fine may be assessed. This fine shall be double the 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 651-201-4301.

Sincerely,



Jean Johnston
Program Manager
Case Mix Review Program

cc: Hennepin County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman
Mary Henderson, Program Assurance
Jocelyn Olson, Attorney General Office
Deb Peterson, Attorney General's Office – MA Fraud
MN Board of Nursing
Brooklyn Park Police Department-Attn: Officer William Breth, COPS Unit