MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6390

March 10, 2011

Kathleen Valusek, Administrator
In-Home Health Connection Inc
4570 West 77th Street Suite 165
Edina, MN 55435

RE: Results of State Licensing Survey

Dear Ms. Valusek:

The above agency was surveyed November 16 and 17, 2010, for the purpose of assessing compliance with state licensing regulations. State licensing orders are delineated on the attached Minnesota Department of Health (MDH) correction order form. The correction order form should be signed and returned to this office when all orders are corrected. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me. If further clarification is necessary, an informal conference can be arranged.

A final version of the Correction Order form is enclosed. This document will be posted on the MDH website.

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

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

Please feel free to call our office with any questions at (651) 201-4309.

Sincerely,

Patricia Nelson

Patricia Nelson, Supervisor
Home Care & Assisted Living Program

Enclosures

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

01/07 CMR3199

CERTIFIED MAIL #: 7009 1410 0000 2303 6383

FROM: Minnesota Department of Health, Division of Compliance Monitoring
85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900
Home Care & Assisted Living Program

Patricia Nelson, Program Supervisor - (651) 201-5273

TO:	KATHLEEN VALUSEK	DATE: March 10, 2011
PROVIDER:	IN-HOME HEALTH CONNECTION INC	COUNTY: HENNEPIN
ADDRESS:	4570 WEST 77TH ST SUITE 165 EDINA, MN 55435	HFID: 21893

On November 16 and 17, 2010, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed please sign and date, make a copy of the form for your records and return the original to the above address.

Signed:_____ Date: _____

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

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

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

1. MN Rule 4668.0030 Subp. 3

Based on interview and record review, the licensee failed to ensure that the client or the client's responsible party received a copy of the Minnesota Home Care Bill of Rights for two of four clients' (#2 and #3) records reviewed. The findings include:

Client #2 began receiving services from the licensee on December 17, 2009, which included foot care every three months and blood draws one to three times a month. There was no evidence that client #2 received a copy of the Minnesota Home Care Bill of Rights. When interviewed November 16, 2010, employee B (Vice President of Operations) confirmed client #2 did not receive a copy of the Home Care Bill of Rights.

Client #3 began receiving services from the licensee on August 18, 2010, which included blood draws every month and more frequently if needed. There was no evidence that client #3 received a copy of the Minnesota Home Care Bill of Rights. When interviewed November 17, 2010, at 9:30 a.m. the client stated he had not been provided with the home care bill rights, or had any information provided that gave contact information at the agency. The client's spouse was present during the interview and also verified they had not received any information that identified the home care agency. When interviewed November 17, 2010, employee G (unlicensed staff) confirmed she had not provided the client with this information.

TO COMPLY: The provider shall deliver the bill of rights at the time that the provider and the client or the client's responsible person agree to a service agreement, or before services are initiated, whichever is earlier.

TIME PERIOD FOR CORRECTION: Sixty (60) days

2. MN Rule 4668.0040 Subp. 2

Based on interview and record review, the licensee failed to ensure that clients received written notice of the agency's complaint/grievance procedure for two of four clients' (#2 and #3) records reviewed. The findings include:

Client #2 began receiving services from the licensee on December 17, 2009, which included foot care every three months and blood draws one to three times a month. There was no evidence that client #2 received written notice of the agency's complaint/grievance procedure. When interviewed November 16, 2010, employee B (Vice President of Operations) confirmed client #2 did not receive a copy of the agency's complaint/grievance procedure.

Client #3 began receiving services from the licensee on August 18, 2010, which included blood draws every month and more frequently if needed. There was no evidence that client #3 received written notice of the agency's complaint/grievance procedure. When interviewed November 17, 2010, client #3 stated he had not been provided with information of what to do or who to call if there were concerns regarding the care or services that were provided by the home care agency. The client and her/his spouse verified they had not been provided with the phone number to the agency, or information of who to contact at the state agency with concerns. The client's spouse stated, "That would be nice to have."

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

A. the client's right to complain to the licensee about the services received;

B. the name or title of the person or persons to contact with complaints;

C. the method of submitting a complaint to the licensee;

D. the right to complain to the Minnesota Department of Health, Office of Health Facility Complaints; and

E. a statement that the provider will in no way retaliate because of a complaint.

TIME PERIOD FOR CORRECTION: Sixty (60) days

3. MN Rule 4668.0065 Subp. 1

Based on interview and record review, the licensee failed to ensure that tuberculin skin testing was completed following the tuberculosis screening guidelines for health care workers (HCW) in the Minnesota Department of Health Bulletin 09-04 for two of two employees**'** (G and F) records reviewed who were hired after March 2009. The agency failed to follow tuberculosis screening guidelines including the conditions of Information Bulletin 09-04: Pursuant to Minnesota Rule 4668.0016, and as defined in Minnesota Department of Health Information Bulletin 09-04 Tuberculosis Prevention and Control: Home Care. Minnesota Rule 4668.0065, Subpart 1, Tuberculosis Screening is waived. The findings include:

Employee F (registered nurse**)** was hired April 26, 2010, to provide direct care to clients. On July 21, 2010, the employee received a one step tuberculin skin test. The employee's record lacked evidence of that the employee had received a two step tuberculin skin test within the year prior to being hired by the agency.

Employee G (unlicensed staff) was hired on July 29, 2010, to provide direct care to clients. On July 29, 2010, the employee received a one step tuberculin skin test. The employee's record lacked evidence that the employee had received a two step tuberculin skin test within the year prior to being hired by the agency.

When interviewed November 17, 2010, employee A (owner/nurse practitioner) confirmed two step tuberculin skin tests were not completed on employees F and G. Employee A stated she was not aware of the Minnesota Department of Health's Information Bulletin 09-04 regarding tuberculosis screening guidelines and had not conducted a risk assessment of the agency.

TO COMPLY: - All paid HCWs (as defined in the "CDC Guidelines") must receive baseline TB screening. This screening must include a written assessment of any current TB symptoms, and a two-step tuberculin skin test (TST) or single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON® TB Gold or TB Gold - In Tube, T-SPOT ® .TB).

- All paid HCWs (as defined in the "CDC Guidelines") must receive serial TB screening based on the facility's risk level: (1) low risk - not needed; (2) medium risk - yearly; (3) potential ongoing transmission - consult the Minnesota Department of Health's TB Prevention and Control Program at 651-201-5414.

- HCWs with abnormal TB screening results must receive follow-up medical evaluation according to current CDC recommendations for the diagnosis of TB. See www.cdc.gov/tb

-·All reports or copies of HCW TSTs, IGRAs for M. tuberculosis, medical evaluation, and chest radiograph results must be maintained in the HCW's employee file.

-·All HCWs exhibiting signs or symptoms consistent with TB must be evaluated by a physician within 72 hours. These HCWs must not return to work until determined to be non-infectious.

TIME PERIOD FOR CORRECTION: Sixty (60) days

4. MN Rule 4668.0100 Subp. 4

Based on observation, interview and record review, the licensee failed to ensure that unlicensed staff were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that they were competent to perform the procedure for two of two unlicensed staffs' (E and G) records reviewed who performed blood draws. The findings include:

Employee E (unlicensed staff) was observed on November 17, 2010, at 7:30 a.m. to perform a blood draw on client #2 to obtain four blood specimens. There was no evidence in employee E's record that the RN had instructed the employee in the proper method to perform the delegated procedure nor was there evidence that the employee had demonstrated to the RN that she was competent to perform the procedure. When interviewed November 17, 2010, employee E stated she worked at a hospital drawing blood specimens and that was how she knew how to perform the procedure.

Employee G (unlicensed staff) began conducting blood draws on clients on July 29, 2010. The employee was observed on November 17, 2010, at 9:30 a.m. to draw blood from client #3. There was no evidence in employee G's record that the RN had instructed the employee in the proper method to perform the delegated procedure nor was there evidence that the employee had demonstrated to the RN that she was competent to perform the procedure. In addition, there were no written procedures on how to perform the blood draws.

When interviewed November 17, 2010, employee A (owner/nurse practitioner) stated that all the unlicensed staff had prior experience in blood draws as that was a requirement upon hire. Employee A stated that the employees had demonstrated their competency on performing venipunctures to her, but she had not documented the demonstration.

TO COMPLY: A person who satisfies the requirements of subpart 5 may perform delegated medical or nursing and assigned therapy procedures, if:

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

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

C. prior to performing the procedures, the person demonstrates to a registered nurse or therapist, respectively, the person's ability to competently follow the procedures; and

D. the procedures for each client are documented in the clients' records.

TIME PERIOD FOR CORRECTION: Sixty (60) days

5. MN Rule 4668.0100 Subp. 5

Based on interview and record review, the licensee failed to ensure that unlicensed staff who performed the delegated task of blood draws, had successfully completed the training and/or passed the competency evaluation in the required topics for two of two unlicensed staffs' (E and G) records reviewed who performed blood draws. The findings include:

Employees E and G (unlicensed staff) were hired August 12, 2006, and July 29, 2010, respectively, to draw blood from clients. Employees E and G were observed on November 17, 2010, at 7:30 a.m. and 9:30 a.m. to perform blood draws on client #2 and client #3, respectively. There were no training and/or competency records for employees E and G that included the required topics of; observing, reporting, and documenting client status and the care or services provided; maintaining a clean, safe, and healthy environment; medication reminders; appropriate and safe techniques in personal hygiene and grooming, including bathing and skin care, the care of teeth, gums and oral prosthetic devices and assisting with toileting; adequate nutrition and fluid intake including basic meal preparation and special diets; communication skills; reading and recording temperature, pulse and respiration; basic elements of body functioning and changes in body function that must be reported to an appropriate health care professional; recognition of handling emergencies; physical, emotional and developmental needs of clients and ways to work with clients who have problems in these areas, including respect for the client, the client's property and the client's family; safe transfer techniques and ambulation; and range of motion and positioning.

When interviewed November 17, 2010, employee A (owner/nurse practitioner) and employee B (Vice President of Operations) confirmed employees E and G did not have training and/or competency that included the required topics.

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

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

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

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

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

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

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

(2) has had at least 20 hours of supervised practical training or experience performing home health aide tasks in a home setting under the supervision of a registered nurse, or completes the supervised

practical training or experience within one month after beginning work performing home health aide tasks, except that a class C licensee must have completed this supervised training or experience before a license will be issued; or

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

TIME PERIOD FOR CORRECTION: Sixty (60) days

6. MN Rule 4668.0100 Subp. 6

Based on interview and record review, the licensee failed to ensure that unlicensed staff that performed home health aide tasks completed at least eight hours of in-service training for each twelve months of employment for one of one unlicensed staff person's (E) record reviewed who had been employed greater than twelve months. The findings include:

Employee E (unlicensed staff) was hired on August 12, 2006, to perform venipunctures to obtain blood samples to be sent to a laboratory. A review of the employee's in-service training for the year 2009 revealed the employee only had three hours instead of eight hours as required.

When interviewed November 17, 2010, employee B (Vice President of Operations) confirmed employee E only had three hours of in-service training in 2009. Employee B stated the owner had not gotten in-service training materials out to the employees on a monthly basis as planned.

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

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

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

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

TIME PERIOD FOR CORRECTION: Sixty (60) days

7. MN Rule 4668.0100 Subp. 9

Based on interview and record review, the licensee failed to ensure that the registered nurse (RN) conducted supervisory visits of unlicensed staff that performed services that required supervision for two of two clients' (#2 and #3) records reviewed. The findings include:

Client #2 began receiving services from the licensee on December 17, 2009, which included blood draws by unlicensed staff one to three times a month. Documentation indicated the client had blood draws two to three times a month thus far in 2010. On November 17, 2010, at 7:30 a.m. employee E (unlicensed staff) was observed to perform the task of a blood draw on client #2. There were no supervisory visits by the RN in the client's record.

Client #3 began receiving services from the licensee on August 17, 2010, which included INR blood draws every month and more frequently if needed. Documentation revealed the client had blood draws on August 18, 2010, September 15, 2010, and October 13, 2010. On November 17, 2010, at 9:30 a.m. employee G (unlicensed staff) was observed to perform the task of a blood draw on client #3. There were no supervisory visits by the RN in the client's record.

When interviewed November 17, 2010, employee A (owner/nurse practitioner) confirmed there were no RN supervisory visits for clients #2 and #3. Employee A stated the agency did not do RN supervisory visits of the unlicensed staff that performed blood draws on clients.

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

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

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

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

If monitored by a licensed practical nurse, the client must be supervised at the residence by a registered nurse at least every other visit, and the licensed practical nurse must be under the direction of a registered nurse, according to Minnesota Statutes, sections 148.171 to 148.285.

TIME PERIOD FOR CORRECTION: Sixty (60) days

8. MN Rule 4668.0140 Subp. 1

Based on interview and record review, the licensee failed to ensure that a service agreement with the client or the client's responsible person was developed for two of four clients' (#2 and #3) records reviewed. The findings include:

Client #2 began receiving services from the licensee December 17, 2009, which included footcare every three months by licensed nurses and blood draws one to three times a month by unlicensed staff. There was no written service agreement with the client or the client's responsible person in the record. When interviewed November 17, 2010, employee A (owner/nurse practitioner) and employee B (Vice President of Operations) confirmed client #2 did not have a service agreement. Employee B stated they had not entered into a service agreement with clients whose care was managed by another entity.

Client #3 began receiving services from the licensee on August 17, 2010, which included monthly blood draws. The prescriber's orders indicated the potential for more frequent blood draws depending on Coumadin (anticoagulant) changes. There was no written service agreement with the client or the client's responsible person in the record. When interviewed November 17, 2010, employee A confirmed a service agreement was not developed for client #3 or for any clients that received laboratory services from the agency.

TO COMPLY: No later than the second visit to a client, a licensee shall enter into a written service agreement with the client or the client's responsible person. Any modifications of the service agreement must be in writing and agreed to by the client or the client's responsible person.

TIME PERIOD FOR CORRECTION: Sixty (60) days

9. MN Rule 4668.0140 Subp. 2

Based on interview and record review, the licensee failed to ensure that the service agreement included an accurate description of the services and/or the frequency of the services to be provided for two of two clients' (#1 and #4) records reviewed who had service agreements. The findings include:

Client #1 began receiving services from the licensee on December 4, 2008, which included foot care by licensed nurses. Client #1 had prescriber's orders for foot care every two months. The client had two service agreements, one dated December 4, 2008, and one dated May 12, 2010. Both service agreements indicated a foot care assessment was to be done by the registered nurse on the initial visit and "as needed." The service agreements also indicated that the licensed practical nurse was to provide foot care, but the service did not include a frequency the service was to be provided. When interviewed November 17, 2010, employee B (Vice President of Operations) confirmed client #1's service agreement did not include the frequency of the foot care.

Client #4's service agreement, dated January 16, 2009, identified the client was to receive an initial assessment for foot care and foot care as needed. The service was to be provided by a registered or licensed practical nurse. When interviewed on November 16, 2010, employee B (Vice President of Operations) stated the client's service agreement was not an accurate description of the service the client received and that the client had never received foot care from agency personnel.

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.

TIME PERIOD FOR CORRECTION: Sixty (60) days

10. MN Rule 4668.0150 Subp. 6

Based on interview and record review, the licensee failed to ensure orders for treatments were renewed every three months by the prescriber for one of one client's (#1) record reviewed who had orders for a treatment. The findings include:

Client #1 began receiving services from the licensee on December 4, 2008, which included footcare every two months. Client #1 had a prescriber's order, dated January 6, 2009, for foot care which indicated the following order "Double or Triple Antibiotic ointment to nicks in skin prn (pro ra nata or whenever necessary)-report to MD (medical doctor)." This treatment was not reviewed by the prescriber every three months as required. The only prescriber's review of this treatment order was on May 12, 2010.

When interviewed November 17, 2010, employee B (Vice President of Operations) confirmed client #1's treatment order had not been renewed by the prescriber every three months.

TO COMPLY: All orders must be renewed at least every three months.

TIME PERIOD FOR CORRECTION: Sixty (60) days

11. MN Rule 4668.0160 Subp. 6

Based on record review and interview, the licensee failed to ensure that a summary following the termination of services was documented for one of one client's (#5) record reviewed who no longer received services from the licensee. The findings include:

Client #5 was noted on a discharge log provided by the agency that she/he was deceased in the past six months. A review of client #5's record indicated the client started foot care service every three months starting on October 30, 2009. There was no notation in the client's record that the client was deceased or that services had ended.

When interviewed November 16, 2010, employee B (Vice President of Operations) confirmed that the client was no longer receiving services and that there was no notation of the termination of services or that the client had expired in the client's record.

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.

Class C licensees need only include the information required by items A, B, and E. Class E licensees need only include the information required by items A, B, D, and E.

TIME PERIOD FOR CORRECTION: Sixty (60) days

12. MN Rule 4668.0180 Subp. 2

Based on interview, record review and document review, the licensee failed to ensure that at least one home care service the agency offered was provided directly by employees of the agency. The findings include:

The licensee did not provide at least one home care service directly. The provider's renewal application for licensure dated January 28, 2010, indicated that the home care services provided by the agency were registered nursing (RN) services both directly and by contract and licensed practical nursing (LPN) services by contract.

When interviewed November 16, 2010, employee B (Vice President of Operations) confirmed they had one registered nurse who was employed by the agency, but the remainder five RNs and four LPNs were hired as independent contractors. When interviewed November 17, 2010, employee A (owner/nurse practitioner) stated she was not aware that one of the home care services provided needed to be provided directly in its entirety.

TO COMPLY: The licensee shall provide at least one of the following home care services directly:

A. professional nursing;

B. physical therapy;

C. speech therapy;

D. respiratory therapy;

E. occupational therapy;

F. nutritional services;

G. medical social services;

H. home health aide tasks; or

I. provision of medical supplies and equipment when accompanied by the provision of a home care service.

TIME PERIOD FOR CORRECTION: Sixty (60) days

13. MN Statute §626.557 Subd. 14(b)

Based on interview and record review, the licensee failed to ensure that an individualized abuse prevention plan was developed for three of four clients' (#2, #3 and #4) records reviewed. The findings include:

Client #2 began receiving services from the licensee on December 17, 2009, which included footcare every three months and blood draws one to three times a month. Client #2 resided in a locked group home due to memory deficits. There was no evidence that an individualized abuse prevention plan had been developed for the client.

Client #3 began receiving services from the licensee on August 17, 2010 which included monthly blood draws for INR (blood coagulation test). There was no evidence that an individualized abuse prevention plan had been developed for the client.

When interviewed November 17, 2010, employee A (owner/nurse practitioner) confirmed clients who received laboratory services from the agency did not have an individualized abuse prevention plan.

Client #4's Vulnerable Adult Assessment, dated January 16, 2009, identified the following; "Client does not fit criteria of being vulnerable." Client #4's record indicated the client had severe agoraphobia (fear of leaving home). A history and physical completed on March 10, 2008, identified the client with diagnoses that included hypothyroid, agoraphobia, hyperlipidemia and reflux disease.

When interviewed November 17, 2010, employee A confirmed client #4's severe agoraphobia prevented her from leaving her home, thus the reason for being admitted for home care services. The client's severe agoraphobia was not identified on her Vulnerable Adult Assessment as vulnerability.

TO COMPLY: Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

TIME PERIOD FOR CORRECTION: Sixty (60) days

14. MN Statute §144A.44 Subd. 1(2)

Based on observation, interview and record review, the licensee failed to ensure that care and services were provided according to accepted medical and nursing standards related to infection control practices for two of two clients (#2 and #3) reviewed. The findings include:

Employee F and G (unlicensed staff) failed to perform hand washing before and after drawing blood, and failed to provide safe disposition of contaminated lab draw supplies which included sharps and blood vials.

On November 17, 2010, at 7:30 a.m. employee F was observed at client #2's home to draw blood specimens from the client. Employee F was observed to set up her supplies for the blood draw and put on a pair of disposable gloves. Employee F did not wash her hand prior to applying the gloves. The employee used what appeared to be a butterfly type needle that contained a small tube with a connecter that attached to the blood vial and dispensed the blood. Blood was noted to flow through the clear tubing into the blood vial. After completion of the blood draw, the employee was noted to dispose of the contaminated needle and tubing into a small uncovered plastic cup in her carrying case. The employee removed her gloves and packed up her equipment. When questioned November 17, 2010, as to where she was going to dispose of the contaminated needle and tubing and that she had placed in an uncovered plastic cup in her carrying case, she stated she would put it in a sharps container once she got to her car. The employee left the house without washing her hands. When at the employee's car, the surveyor asked to see the sharps container. Employee F opened the back of her vehicle and stated she must have forgotten to grab a sharps container when she was at the office. Employee F stated she was on her way to another client's home to do another blood draw.

On November 17, 2010, at 9:30 a.m. employee G was observed at client #3's home to draw a blood specimen from the client. The employee opened a carrying case that contained the blood draw equipment. The employee removed a top tray from the container and placed it on the client's floor. Supplies were removed from the lower section of the container that also appeared to have a plastic bag

with soiled items. The employee proceeded for preparation of the blood draw. The employee did not wash her hands prior to putting on disposable gloves. The employee used what appeared to be a butterfly type needle that contained a small tube with a connecter that attached to the blood vial and dispensed the blood. Blood was noted to flow through the clear tubing into the blood vial. After completion of the blood draw, the employee was noted to dispose of the contaminated needle and tubing into the plastic bag stored in the bottom of the case that contained clean lab draw supplies. The plastic bag was so full it could not be closed and contaminated items were falling out of the bag. There was no noted separation of clean and dirty items. The employee did not wash her hands after the task was competed.

During an interview with employee G on November 17, 2010, at 9:50 a.m. it was observed the employee had two unused sharp containers in the trunk of her car. It was also observed that other lab draw supplies were lying around randomly in the trunk of the employee's car and were not contained in a clean or sanitary manner. The employee verified she should be using the designated sharp containers for the disposal of sharps and blood contaminated supplies, but stated when she had a full bag she usually would dispose of the contaminated supplies at the lab sites. The employee verified the contaminated blood draw supplies were from various clients. The employee also verified she had not washed or sanitized her hands prior to performing the task and she had not washed or sanitized her hands after the task of drawing blood or before she left the client's home.

Client #2 began receiving services from the licensee on December 17, 2009, which included blood draws by unlicensed staff one to three times a month. Documentation indicated the client had blood draws two to three times a month thus far in 2010. There were no supervisory visits by the RN in the client's record.

Client #3 began receiving services from the licensee on August 17, 2010, which included INR blood draws every month and more frequently if needed. Documentation revealed the client also had blood draws on August 18, 2010, September 15, 2010, and October 13, 2010. There were no supervisory visits by the RN in the client's record.

When interviewed November 17, 2010, employee A (owner/nurse practitioner) confirmed there were no RN supervisory visits for clients #2 and #3. Employee A stated the agency did not do RN supervisory visits of the unlicensed staff that performed blood draws on clients.

The agency utilized a machine called "Pro Time" which measured a client's Protime (PT) and Internation Normalized Ratio (INR) by using a fingerstick sample of blood. On November 16, 2010, employee D (unlicensed staff) demonstrated to the surveyor how the machine was used. Employee D stated the agency had three of these machines and the three machines were used for multiple clients. Employee D stated she used the Pro Time machine to test multiple clients' INR five to six times a week. Employee D stated she took the machine with her into client's private homes, assisted living facilities and nursing homes. When questioned as to how frequently she cleaned the machine, employee D stated she wiped the machine down with a wet cloth or paper towel about one time a week. Employee D stated if she saw visible blood spills in the well of the machine, she utilized a cotton tip applicator with alcohol on it to clean the device. When questioned November 17, 2010, employee A (owner/nurse practitioner) stated the agency did not have a written policy/procedure regarding cleaning of the Pro Time machines that were used for multiple clients.

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

TIME PERIOD FOR CORRECTION: Sixty (60) days

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 0150 0003 5688 9149

August 21, 2008

Kathleen Valusek, Administrator
In Home Lab Connection Inc
4570 West 77th St Suite 165
Edina, MN 55435

Re: Results of State Licensing Survey

Dear Ms. Valusek:

The above agency was surveyed on July 23, 24, and 28, 2008, 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: Ramsey County Social Services
Ron Drude, Minnesota Department of Human Services
Sherilyn Moe, Office of the Ombudsman

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: IN HOME LAB CONNECTION INC

HFID #: 21893

Date(s) of Survey: July 23, 24 and 28, 2008

Project #: QL21893005

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** X Met ___ Correction Order(s) issued X Education Provided **Expanded Survey** X 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** _X_ Met ___ Correction Order(s) issued _X_ Education Provided **Expanded Survey** _X_ 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** _X_ Met ___ Correction Order(s) issued _X_ Education Provided **Expanded Survey** _X_ 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 Electronically Transmitted Orders.	• **Client records are maintained and retained securely.** • **Client records contain all required documentation.** • Client information is released only to appropriate parties. • Discharge summaries are available upon request.	**Focus Survey** _X_ Met ___ Correction Order(s) issued _X_ Education Provided **Expanded Survey** _X_ Survey not Expanded ___ Met

Indicators of Compliance	Outcomes Observed	Comments
Non-compliance with this variance will result in a correction order issued under 4668.0016.]		____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** _X_Met ____Correction Order(s) issued _X_Education Provided **Expanded Survey** _X_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 Services setting with regards to medication administration, storage	• 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** _X_Met ____Correction Order(s) issued _X_Education Provided **Expanded Survey** _X_Survey not Expanded ____Met ____Correction Order(s) issued ____Education Provided **Follow-up Survey** #___ ____New Correction

Indicators of Compliance	Outcomes Observed	Comments
and disposition. Non-compliance with this variance will result in a correction order issued under 4668.0016.]		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** _X_Met ____Correction Order(s) issued _X_Education Provided **Expanded Survey** _X_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: _X_ 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.

A draft copy of this completed form was left with Judy Abraham,Manager, at an exit conference on July 28, 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).