MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7009 1410 0000 2303 6376

January 19, 2011

Carol Overby, Administrator
Agewell Home Care
4940 Viking Drive Suite 545
Edina, MN 55435

RE: Results of State Licensing Survey

Dear Ms. Overby:

The above agency was surveyed November 1, 2, and 3, 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 6376

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 and Assisted Living Program

Patricia Nelson, Supervisor - (651) 201-4309

TO:	CAROLE OVERBY	DATE: January 19, 2011
PROVIDER:	AGEWELL HOME CARE	COUNTY: HENNEPIN
ADDRESS:	4940 VIKING DRIVE SUITE 545 EDINA, MN 55435	HFID: 23501

On November 1, 2 and 3, 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 4668.0016 Subp. 8

Waiver 99-7: MN Rule 4668.0865 Subp. 2 requirement not met

Based on observation, interview and record review, the agency failed to follow the conditions of the Class A Variance/Waiver for Central Medication Storage for Clients Living in Housing with Services Settings, 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 10 and was granted a variance under MN Rule 4668.0003 Subp. 11. The agency failed to ensure that the variance requirements of MN Rule 4668.0865 Subp. 2 were followed in that the agency failed to ensure a registered nurse conducted a nursing assessment of the client's functional status and need for central storage of medications and developed a service agreement for the provision of central storage for one of one client's (B1) record reviewed who was receiving central storage of medications. The findings include:

Client B1 began receiving services in a housing with services on November 13, 2009. The client's medications were observed November 2, 2010, to be stored in a locked medication cart with other clients' medications. The client's record lacked evidence the registered nurse had assessed the client's functional status and need for central storage of medications. The client's service agreement, dated November 13, 2009, indicated the client received medication administration, but did not include central storage of medications. When interviewed November 2, 2010, employee BD (registered nurse) stated that all of the medications for clients in the memory care unit are centrally stored in a locked medication cart. Employee BD went on to state she was unaware that an assessment for central storage of medications needed to be completed and needed to be included on the service agreement.

TO COMPLY: A failure to comply with the terms of a variance shall be deemed to be a violation of this chapter.

> **TO COMPLY with MN Rule 4668.0865 Subp. 2 :** For a client for whom medications will be centrally stored, a registered nurse must conduct a nursing assessment of a client's functional status and need for central medication storage, and develop a service plan for the provision of that service according to the client's needs and preferences. The service plan must include the frequency of supervision of the task and of the person providing the service for the client according to part 4668.0845. The service plan for central storage of medication must be maintained as part of the service plan required under part 4668.0815.

TIME PERIOD FOR CORRECTION: Thirty (30) days

2. MN Rule 4668.0065 Subp. 1

Based on interview and record review, the licensee failed to ensure that tuberculosis testing was completed prior to health care workers (HCWs) providing services to clients for four of seven employees' (HA, HB, HC and BC) records reviewed. The agency failed to follow any TB screening 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 BC (Home Health Aide/HHA) was hired November 23, 2009. Employee BC did not receive a two step mantoux (tuberculin skin testing) upon hire.

The agency provided information that on November 23, 2009, the employee received the first step mantoux. On November 26, 2009, the information indicated the mantoux reading was negative. There was no documentation that a second step mantoux was administered.

On November 1, 2010, at 12:30 p.m., the agency administrator stated the agency was at moderate risk on the tuberculin risk assessment completed by agency personnel. The administrator indicated all employees received the two step mantoux on hire unless documentation was provided that identified the new hire had received a two step mantoux within the previous year of hire to the agency. If this occurred, the new employee would have received a one step mantoux.

The policy and procedure Tuberculosis Control Program, dated March 18, 2009, identified the following: “The Two Step Test TST will be performed on individuals who have: a) never been tested, b) have no documentation of prior testing, c) do not remember being tested; or d) tested negative over 12 months ago.”

Information received via fax on November 5, 2010, indicated HHA/BC received a two step mantoux in 2007. There was no documentation the employee had received a two step mantoux within one year of hire to the agency.

Employees HA, HB and HC were hired and began providing home health services, February 23, 2006, January 30, 2008, and August 9, 2010, respectively. Employee HA had documentation of Mantoux testing April 5 and 13, 2005, September 11, 2007, and November 2, 2010. Employee HB had documentation of Mantoux testing January 11, 2008, January 22, 2009, and November 3, 2010. Employee HC had documentation of Mantoux testing August 26, 2009, and November 3, 2010.

Employees HA, HB and HC received the November 2010 tuberculosis testing during the survey of November 1 through November 3, 2010.

When interviewed November 3, 2010, employee I (operations manager) indicated that employee HA, HB and HC all got the most recent tuberculosis testing, during the survey, because the licensee realized during the survey that the tuberculosis testing was not up to date. Employee I stated the licensee had rated the agency as a moderate risk and therefore every year tuberculosis testing was required.

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: Thirty (30) days

3. MN Rule 4668.0100 Subp. 2

Based on observation, record review and interview, the licensee failed to ensure that unlicensed staff were instructed by the registered nurse (RN) on the procedures for administration of medications and/or that he/she was competent to perform the procedure for three of seven employees' (BC, HD and HE) records reviewed. The findings include:

Employee BC (Home Health Aide) lacked evidence of documentation that a medication competency evaluation had been completed prior to performing the task of medication administration.

On November 2, 2010, at 1:20 p.m., employee BC entered a client apartment to administer medications. Employee BC verified the client's name, then took the medication box from the top of the refrigerator, opened the locked medication box and removed the weekly mediset. Employee BC dispensed the medications into the palm of the client's hand. When employee BC was asked what medications the client received, she responded, "I don't know what he gets, the nurse knows that, I only mark that I gave him his pills." Employee BC immediately left the apartment.

On review of employee BC's personnel file, it was noted that there was no documentation employee BC had received a medication administration competency evaluation. On November 2, 2009, at 4:50 p.m., employee BD (registered nurse) verified there was no documentation to reflect this had been done.

Employees HD and HE (unlicensed staff) were hired and began providing home care services November 4, 2009, and March 25, 2009, respectively. Time and assignment records, dated September 12, 2010, and October 3, 2010, respectively indicated employee HD and HE assisted with or reminded client #1 about medications. The employee assignment/care plan/service agreement indicated the client received administration of medications in the morning. There was no documented training or competency in medication administration for employees HD or HE.

When interviewed November 2, 2010, employee HE stated she administered oral medications to client #1. When interviewed November 2, 2010, employee HF (life care manager/RN) stated she didn't know if unlicensed staff was administering client #1's medication. When interviewed November 3, 2010, person G indicated client #1 could barely move his hands, so client #1 could not administer his own medications and that family or friends had trained staff to administer medications.

TO COMPLY: A person who satisfies the requirements of subpart 5 may administer medications, whether oral, suppository, eye drops, ear drops, inhalant, topical, or administered through a gastrostomy tube, if:

A. the medications are regularly scheduled;

B. in the case of pro re nata medications, the administration of the medication is reported to a registered nurse either:

(1) within 24 hours after its administration; or

(2) within a time period that is specified by a registered nurse prior to the administration;

C. prior to the administration, the person is instructed by a registered nurse in the procedures to

administer the medications to each client;

D. a registered nurse specifies, in writing, and documents in the clients' records, the procedures to administer the medications; and

E. prior to the administration, the person demonstrates to a registered nurse the person's ability to competently follow the procedure.

For purposes of this subpart, "pro re nata medication," commonly called p.r.n. medication, means a medication that is ordered to be administered to or taken by a client as necessary.

TIME PERIOD FOR CORRECTION: Fourteen (14) days

4. MN Rule 4668.0100 Subp. 4

Based on record review and interview, the licensee failed to ensure that unlicensed staff who performed delegated nursing procedures, demonstrated to the registered nurse (RN) that he/she was competent to perform the procedure for two of two employees' (HD and HE) records reviewed. The findings include:

Client H1 was admitted and began receiving home health services May 7, 2008. The service agreement, dated May 8, 2008, referred to the employee assignment sheet, dated September 25, 2009, which indicated unlicensed staff clean and empty catheter bag and perform catheter/condom care hygiene. The patient detail report, dated August 1 through November 1, 2010, indicated that employees HD and HE routinely completed catheter care for client H1.

There was no documentation of training and competency in catheter care for employees HD and HE. When interviewed November 2, 2010, employee HE indicated she performed catheter care for client H1, but maybe someone else had trained her.

When interviewed November 2, 2010, employee HF (RN) stated she had done some training and would bring the documentation to the office November 3, 2010. The documentation received on November 3, 2010, only included training on hoyer lifts and tube feedings.

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: Fourteen (14) days

5. MN Rule 4668.0100 Subp. 9

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) supervised unlicensed staff, every 14 days, for services that required supervision for one of one client's (H1) record reviewed. The findings include:

Client H1 was admitted and began receiving home health services May 7, 2008. Medication administration was initiated at an unknown date. Documented supervision of home health aide tasks was done January 13, 2010, February 28, 2010, March 10, 2010, April 10, 2010, August 12, 2010, and September 2, 2010.

The licensee's supervisory policy and procedure, dated August 26, 2008, stated the life care manager will make a supervisory visit every 14 days for clients who require a delegated task and every 30 days for clients who do not. There were no documented 14 day supervisory visits for the delegated task of medication administration.

When interviewed November 2, 2010, employee HE (unlicensed staff) stated she administered client #1's oral medications. When interviewed November 2, 2010, employee HF (RN) did not know that client #1 was getting medication administration or that supervisory visits were to be done every 14 days if the service provided was medication administration. When interviewed November 2, 2010, person G stated that client #1 slept until 12 noon or 1:00 p.m. everyday, but the RN usually came around 10:00 a.m. so she didn't understand how supervisory visits were conducted when the client was asleep.

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: Fourteen (14) days

6. MN Rule 4668.0140 Subp. 1

Based on record review and interview, the licensee failed to ensure that a registered nurse (RN) reviewed and revised each client's service agreement when there was a change in a client's condition

that required a change in service for three of three clients' (A3, B2 and H1) records reviewed. The findings include:

Client A3 began receiving services from the licensee on January 27, 2009. Client A3's service agreement, dated December 9, 2009, indicated the client received assistance with medication set-up and medication administration, home health aide services as requested and escort assistance to meals daily. A nursing note, dated June 2, 2010, signed by employee AA (licensed practical nurse) indicated that client A3 was "more confused" and required daily assistance with cares by the home health aides. The note indicated that the client required a.m. and p.m. cares seven days a week and that the son agreed to increased services in the a.m. and p.m. The client's service agreement was not modified to reflect this increase in services. A nursing note, dated October 25, 2010, signed by employee AA indicated that reassurance checks three times at night were started for client A3 due to the client leaving the building unattended at night. The client's service agreement was not modified to reflect this additional service.

When interviewed November 3, 2010, employee AA confirmed the client's service agreement was not modified in June and October 2010 with the changes in client A3's services.

Client B2 began receiving services on April 6, 2010. The client's service agreement, dated May 7, 2010, indicated reassurance checks were to be done every hour except when the client was at day care. The client's care plan, dated October 19, 2010, indicated that reassurance checks were being done at 11:00 p.m., 2:00 a.m. and 5:00 a.m. The client's service agreement had not been updated to reflect these changes. When interviewed on November 2, 2010, employee BD (registered nurse) confirmed the client's service agreement had not been updated to reflect the changes.

Client H1 was admitted and began receiving home health services May 7, 2008. A supervisory visit, dated April 9, 2010, stated client "declining. Soon decision about having respirator." Medication administration was initiated at an unknown date. When interviewed November 2, 2010, employee HE (unlicensed staff) stated client #1 could not stand anymore and employees administered medications. When interviewed November 2, 2010, person G stated client #1 was barely able to move his hands anymore. There was no modification of the service agreement noted for client H1 when client H1's condition declined and medication administration was initiated.

When interviewed November 2, 2010, employee HF (RN) stated there was a definite decline in client H1's condition but she did not know the service agreement had to be updated with a change in condition.

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: Thirty (30) days

7. MN Rule 4668.0150 Subp. 3

Based on record review and interview, the licensee failed to have a current prescriber's order for medications for one of one client's (H1) record reviewed. The findings include:

Client H1 was admitted and began receiving home health services May 7, 2008. Time and assignment records dated, September 12, 2010, and October 3, 2010, respectively, indicated employee HD and HE assisted with or reminded client #1 about medications. The employee assignment/care plan/service agreement indicated administration of medications in the morning.

During the survey of November 1, 2 and 3, 2010, the surveyor was unable to reconcile the medications because there was no documentation of any prescriber's orders for medications.

When interviewed November 2, 2010, employee HF (registered nurse) stated she did not know that client #1 was getting medication administration. Employee HF indicated there were no prescriber's orders for whatever medications client #1 was being administered by the unlicensed staff.

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

TIME PERIOD FOR CORRECTION: Seven (7) days

8. MN Rule 4668.0160 Subp. 6

Based on record review and interview, the licensee failed to ensure medications that were administered were documented in the client's record for one of one client's (H1) record reviewed who received medication administration in the home. The findings include:

Client H1 was admitted and began receiving home health services May 7, 2008. Time and assignment records, dated September 12, 2010, and October 3, 2010, indicated employee HD and HE (unlicensed staff) assisted with or reminded client #1 about medications. The employee assignment/care plan/service agreement indicated administration of medications in the morning.

During the survey of November 1, 2 and 3, 2010, the surveyor was unable to reconcile the medications being administered, because there was no documentation of what medications client #1 was being administered.

When interviewed November 2, 2010, employee HE stated she administered client #1's oral medications. When interviewed November 2, 2010, employee HF (registered nurse/RN) did not know that client #1 was getting medication administration and indicated that there was no documentation of what medications client #1 was being administered by unlicensed staff.

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: Seven (7) days

9. MN Statute §144A.44 Subd. 1(2)

Based on observation, record review and interview, the licensee failed to provide care and services according to acceptable standards of practice related to medication administration, infection control, meeting identified client needs and lack of a registered nurse evaluation related to restraints for six of seven clients' (A1, A3, B1, B2, B5 and H1) records reviewed. The findings include:

1) Problems were identified related to medication administration:

Client A1 began receiving services from the licensee on May 12, 2007, which included medication set-ups by a nurse, medication administration by unlicensed staff, and blood glucose checks by unlicensed staff four times a day.

On November 2, 2010, at 11:00 a.m., employee AF (unlicensed staff) was observed to administer client A1's medications and insulin. After entering client A1's apartment, employee AF was observed to wash her hands and then sign client A1's Home Health Aide (HHA) Medication Reminder Record for October 2010 that she administered the client's noon oral mediations, noon insulin and noon sliding scale insulin all before she administered the medications/insulin. Employee AF was observed to administer the client's medications, check the client's blood glucose and hand the client her noon insulin. The client's blood glucose was 90 and the client did not require sliding scale insulin coverage in addition to her regularly scheduled insulin, although employee AF had already signed that she administered sliding scale insulin coverage. Employee AF did not circle the sliding scale insulin or note that the client did not receive sliding scale insulin coverage before she left the client's apartment.

On November 2, 2010, at 1:00 p.m., the surveyor along with employee AB (registered nurse/RN) reviewed client A1's oral medications that had been set-up in a weekly medi-set container. The following discrepancies were noted with the medications that were set-up:

Client A1 had prescriber's orders, dated August 17, 2010, for Wellbutrin 50 milligrams twice a day and vitamin C 500 milligrams every day. There was no Wellbutrin or vitamin C set-up in the client's weekly medi-set in the morning, noon, 4:00 p.m. or bedtime slots. The client had a prescriber's order, dated August 17, 2010, for a multivitamin with minerals once a day. The client's weekly medi-set container had two multivitamins in the noon slots instead of one as prescribed.

When interviewed November 3, 2010, employee AA (licensed practical nurse) who had set up client A1's medications confirmed the discrepancies as listed. Employee AA stated she did not have any Wellbutrin to set-up for the client as she had run out and the pharmacy indicated it was too soon to refill it. Employee AA stated the multivitamin and vitamin C discrepancies were errors in setting up the medications.

On November 2, 2010, at 1:00 p.m., the surveyor along with employee AB reviewed client A1's insulin that had been set-up for the unlicensed staff to administer. The following discrepancies were noted with the client's insulin:

Client A1 had a prescriber's order, dated August 17, 2010, for Novolog Insulin 3 units at 4:00 p.m. The bag of insulin that had been set-up for the unlicensed staff to administer to client A1 had syringes which had 2 units in them instead of 3 units as ordered.

The client had a prescriber's order, dated August 17, 2010, to administer Novolog Insulin 5 units subcutaneously at noon. The home health aide (HHA) Medication Reminder Record for October 2010, that the HHAs sign that they administered the medication, indicated that Humalog 3 units was to be administered at noon. Five units of Novolog was observed to be set-up in the syringes and administered to the client.

The client had a prescriber's order, dated August 3, 2010, to use a sliding scale of insulin coverage at meal times only and that if the client's blood sugar was greater than 350 at bedtime that 3 units of Humalog insulin was to be administered. The client's October 2010 HHA Mediation Reminder Record indicated the client received the incorrect amount of insulin at bedtime on the following dates: October 3, 2010, bedtime blood glucose was 351-received 6 units of Humalog insulin; October 5, 2010, bedtime blood glucose was 284-received 4 units of Humalog insulin; October 12, 2010, bedtime blood glucose was 291-received 4 units of Humalog insulin; October 13, 2010, bedtime blood glucose was 363-received 6 units of Humalog insulin; October 15, 2010, bedtime blood glucose was 129-received 1 unit of Humalog insulin; October 21, 2010, bedtime blood glucose was 114-received 1 unit of Humalog insulin; October 25, 2010, bedtime blood glucose was 319-received 5 units of Humalog insulin.

When interviewed employees AB and AC (registered nurse) confirmed client A1's 4:00 p.m. insulin had been set-up incorrectly, that her HHA Medication Reminder Record had an inaccurate dosage for the client's noon insulin and that that the unlicensed staff were administering the incorrect amount of insulin to client A1 at bedtime.

Client H1 was admitted and began receiving home health services May 7, 2008. Time and assignment records, dated September 12, 2010, and October 3, 2010, indicated employee HD and HE (unlicensed

staff) assisted with or reminded the client about medications. The employee assignment/care plan/service agreement indicated the client received administration of medications in the morning.

When interviewed November 2, 2010, employee HE (unlicensed staff) stated she gave client H1 the medications that client H1's wife set up for him. When interviewed November 2, 2010, regarding having unlicensed staff administer medications that family set up, employee HG (director of life care services/registered nurse/RN) stated "that is a problem." When interviewed November 2, 2010, employee HF (RN) did not know that unlicensed staff were administering medications that client's wife was setting up.

2) Problems were identified related to infection control:

Client A1 began receiving services from the licensee on May 12, 2007, which included blood glucose checks by unlicensed staff four times a day. On November 2, 2010, at 11:05 a.m., employee AF (unlicensed staff) was observed to perform a blood glucose check on client A1. The surveyor noted that employee AF did not put a lancet in the pen that was used to prick the client's finger, as there was already a lancet in the pen. When questioned regarding the lancet, employee AF stated she put a new lancet in the client's pen that morning when she performed the client's 8:00 a.m. blood glucose check. Employee AF stated the lancet was reused and only changed one time a day. The box of lancets indicated: "Immediately remove used lancet. To avoid accidental injury do not store lancet in device. Insert new lancet in lancet holder with each use." When interviewed November 2, 2010, employee AC (registered nurse) stated she was not aware that staff were reusing client A1's blood glucose monitoring lancets. Employee AC stated the lancets were for single use only and that staff should be using a new one each time they checked the client's blood glucose.

When interviewed November 2, 2010, at 11:05 a.m., employee AF (unlicensed staff) stated that several times client A1's blood glucose monitoring machine had malfunctioned and she had used the back-up blood glucose monitoring machine which was stored in the nursing office. When questioned November 2, 2010, whether there were any special cleaning instructions of the back-up blood glucose monitoring machine when it was used for other clients, employee AF stated she was not aware of any special cleaning instructions. When interviewed November 2, 2010, employee AC (registered nurse) stated they had a back-up blood glucose monitoring machine in case one of the clients' machines malfunctioned.

Employee AC stated she was not aware of any special cleaning instructions of the machine after use, although stated she would expect that staff would wipe the machine down with a alcohol preparation pad. The manufacturer's cleaning recommendations were reviewed and it stated, "Meter can be cleaned using a moist (not wet) lint-free tissue with a mild detergent or disinfecting solution (1 part bleach mixed with 9 parts water). Do not use alcohol."

On November 2, 2010, at 10:45 a.m., during the tour of the housing with services (HWS) with the employee BD (registered nurse/lead life care manager) the following was observed:

Client B1 was noted to have a yellow foam mattress positioned against the wall in the bedroom that lacked a cleanable/wipeable surface. The foam mattress also had several areas on the edges where the foam had torn off. The foam mattress had several discolored darkened circular areas visible on the surface of the foam.

Client B5 was noted to have a yellow foam mattress positioned against the wall in the bedroom and a yellow foam mattress was noted under the client's bed. The foam mattress did not have a cleanable/wipeable surface. The foam mattress was also noted to have several areas on the edges where the foam had torn off. The foam mattress had several discolored darkened circular area visible on the surface of the foam.

Employee BD stated she did not know about the mattresses and verified the foam was a non cleanable surface. The RN indicated used on the floor along side the bed in the event the client fell out of the bed.

Employee BB (RN) did not perform hand washing when performing the task of medication set up for client B5 who received medication set up and medication administration services from the agency. On November 2, 2010, at 11:00 a.m. employee BB was observed to be seated in a chair at the desk located in the common area on the Reflections unit. Employee BB had removed medication bottles from the medication cart and placed them on the desk where she was stationed. It was noted the RN removed a jar of "butt paste" that was stored with the bottles of oral medications. It was also noted the RN had several layers of disposable gloves on. The RN poured pills into the palm of her gloved left hand and then picked one pill at a time and put the pill into the mediset with her gloved right hand. The RN was observed to use the telephone, pick up keys, use a pen to document, and move items around. The RN was observed to remove a disposable glove from her left hand and put the same glove back on her left hand. When a layer of the disposable gloves was removed, the dirty gloves were placed on the desk with the containers of medications that were being dispensed. The RN had at least two layers of disposable gloves on her hands at all time.

When interviewed November 2, 2010, employee BB stated "cleanliness" when asked the procedure for glove use. Employee BB verified she had touched many items while doing the medication set up task, and verified she touched each pill that was dispensed. When questioned about hand washing, employee BB stated if she were in the hospital she would wash her hands prior to medication set up. Employee BB verified she had several layers of gloves on, and verified she had not washed her hands nor used the hand sanitizer that was located on the desk. She also verified she had put the soiled removed gloves on the desk surface along side the medications.

Employee BC (Home Health Aide/HHA) did not wash her hands prior to medication administration for client B4 or before leaving a clients apartment. On November 2, 2010, at 1:20 p.m., employee BC entered a client apartment to administer medications. The HHA proceeded to administer medications without washing her hands. The HHA left the client's apartment immediately after putting the locked medication box away and did not wash her hands before she left the apartment.

The agency's policy and procedure for infection control, dated July, 29, 2010, identified the following: "Hand washing is crucial. Wash hands: 1) After touching blood, body fluids, feces, or contaminated items (regardless of whether or not gloves are worn). 2) Immediately after gloves or gowns are removed. 3) As necessary between tasks and procedures on the same resident to prevent cross-contamination of different body sites, and between all resident contacts."

3) Problems were identified related to meeting the identified needs of clients:

Client A3 began receiving services from the licensee on January 27, 2009, which included assistance with medications and personal cares as requested. Documentation in the client's record and interviews with staff indicated the client's cognition deteriorated and he wandered out of the building on at least

three separate occasions. The home care provider identified that the client required a higher level of supervision/care, but did not assure he received the assessed level of care/services.

Client A3's progress notes signed by employee AA (licensed practical nurse) indicated the following:

- A note, dated May 20, 2010, indicated client A3 was found outside the building at 6:00 a.m. in his pajamas. Employee AA spoke with the client's son about the client's "dementia getting more severe." Services were increased on June 2, 2010, to include assistance with personal cares in the morning and evening because of the client's "confusion."
- A note, dated July 22, 2010, indicated client A3 was "found outside yesterday morning at 6:00 a.m. when home health aide arrived. They had a hard time getting him in. Resident said I'm waiting for my son. Son called and updated. Family declined memory care a few weeks ago when we had an opening."
- A note, dated October 8, 2010, indicated, "PT/OT (physical therapy/occupational therapy) has been coming to help me assess and encourage family that we can do more for resident and that he is in a very demented way. OT to do a cognitive assess to encourage memory care."
- A note, dated October 23, 2010, indicated that at 12:45 a.m., "HHA (home health aide) reported resident was seen outside knocking at the back door to get in. Had no pajamas on. When asked where he was going he said he wanted to go to toilet." Employee AA noted that she visited with the client in the morning following the incident and the client did not remember going outside. The note indicated a voice mail message was left for the sone two sons.
- A note, dated October 25, 2010, indicated three times a night reassurance checks were added to the client's care.

When interviewed November 2, 2010, at 3:00 p.m. employees AD (licensed practical nurse) and employee AC (registered nurse) indicated that client A3 was more appropriate for the memory care unit, but the family refused. Employees AD and AC felt that client A3's safety was a concern and that it was an "accident waiting to happen." When questioned regarding the OT cognitive assessment referenced in the October 8, 2010, nursing note, employee AC stated she was not aware if the OT assessment had been done. Employee AC confirmed there was not an OT assessment in client A3's record.

When interviewed November 2, 2010, at 3:40 p.m. employee AG (unlicensed staff) stated client A3 was very confused, unable to do his care and couldn't remember things. Employee AG stated she had been reporting to the nurses for the last two months that client A3 was going to wander out of the building and not come back.

When interviewed November 3, 2010, at 10:30 a.m. employee AA (licensed practical nurse-Life Care Manager for client A3) stated she felt client A3 had needed the care/supervision of a memory care unit for "quite some time now." Employee AA stated she requested OT do a cognitive assessment to help support her findings that the client needed 24 hour/care and supervision to help "persuade the family." Employee AA stated she had just received a faxed copy of the OT assessment November 3, 2010, but had verbally discussed with the OT the findings that client A3 needed increased care and supervision prior to receiving the written copy. When questioned regarding what measures other than reassurance checks three times a night were put into place based on the OT's assessment of requiring 24 hour care/supervision, employee AA stated nothing else, because that was all the family would pay for.

The OT notes were reviewed. A series of OT visit notes dated October 11, 13, 18 and 25, 2010, indicated that cognitive testing occurred. The OT note, dated October 25, 2010, indicated the scores of the cognitive assessments, reported observations and recommendations were reviewed with agency staff and the plan was to discharge from OT on October 27, 2010. The note further indicated "24 hour supervision is recommended to ensure safety, based on above test results, staff feedback and OT observation, recommend that pt move to the Memory Care Unit."

Client H1 was admitted and began receiving home health services May 7, 2008. The assessment form/RN evaluation, dated May 6, 2008, indicated client H1 used a device to eat, had access to nutrition and the client's spouse provided medication administration.

When interviewed November 3, 2010, person G stated client H1 had been able to feed himself with a device but barely had movement in his hands anymore so he needed to be fed. Time and assignment records dated, September 12, 2010, and October 3, 2010, indicated employee HD and HE (unlicensed staff) assisted with or reminded client H1 about medications. The employee assignment/care plan/service agreement indicated administration of medications in the morning.

There was no current RN evaluation regarding the decline of physical abilities and need for increased home health services for client H1. When interviewed November 2, 2010, employee HF (RN) confirmed a RN evaluation should have been completed in April 2010.

4) Problems were identified with the lack of an RN evaluation related to restraints.

Client #B1 began receiving services on November 13, 2009 and has a diagnosis of dementia. During a tour of the facility with employee BD (registered nurse) on November 2, 2010, metal side rails were observed to be attached to each side of the client's bed. Employee BD indicated the side rails and mats were used because the client would fall out of bed, or try to get out of bed and fall.

The client's care plan dated June 24, 2010, July 14, 2010, July 30, 2010, and August 31, 2010, indicated that daily at 7:30 p.m. side rails are on bed, black cushion goes between mattress and safety rail, and make sure the bed is in low position.

The client assessment, dated November 13, 2009, did not address the need for side rails. The only documentation in the client's record pertaining to the side rails was a risk release form, dated September 30, 2010, and signed by the client's family indicating they had been explained the risks of side rail use and that they would assume responsibility for this risk. The client's record indicated the client fell on September 24, 2010. The client's service agreement, dated November 13, 2009, did not indicate the use of restraints.

The agency's restraint procedure indicated the following conditions must be meet if a restraint was to be used, prior approval from the agency's general manager to verify usage intention, the client/resident must be able to remove the restraint, client/resident must have a means to solicit help if necessary, caregivers provide routine checks on the resident at a minimum of every hour to solicit for needs such as food, water, toileting, activities, etc., and documentation of all said activities must be completed. The procedure goes on to indicate that in the event a restraint is deemed appropriate as a therapeutic intervention, the registered nurse must: 1. inform the resident, family, or legal representative of alternatives to the restraint and the risks and benefits of the physical restraint and the alternative treatment options; 2. obtain a signed consent form authorizing restraint use and acknowledging that you

have explained the benefits and risks of the alternative treatment options; 3. obtain a written order from the physician that contains statements and determinations regarding the medical symptoms that the restraint will treat and specifies the circumstances under which the restraint is to be used; 4. once you have begun using the restraint, you should also do the following; monitor the use of the restraint by the resident/client, paying particular attention to whether the restraint poses any dangers or risks to the individual because they are unable to use it appropriately, the design of the restraint permits the resident/client to be caught or entangled, or the integrity of the restraint has been impaired, periodically, in consultation with the resident/client, the responsible party, and the attending physician, re-evaluate the need for the restraint; 5. Document all of the steps in the Service Plan/Agreement on the modification form; and 6. make sure that the staff is aware of the interventions.

When interviewed November 2, 2010, employee BE (licensed practical nurse) stated the metal side rails were put on the client's bed about a month ago and prior to that a blue mess side rail that slipped under the mattress was used. Employee BE went on to state that the family requested the use of the side rails to prevent the client from falling out of bed and that they had signed a waiver for the use of side rails. Employee BE confirmed the client's service agreement did not address the use of side rails and there is no documentation in the client's record to indicate that the agency's policy and procedure for restraint use had been followed.

Client B2 began receiving services on April 6, 2010. The client has a diagnosis of Alzheimer's disease.
The client's care plan, dated October 19, 2010, indicated staff was to make sure that they attach the strap to the hook on the door before they leave the apartment and that reassurance checks are to be completed at 11:00 p.m., 2:00 a.m. and 5:00 a.m. The only documentation in the client's record pertaining to the use of the strap is was dated September 26, 2010, which stated the client was up in the hallway during the night attempting to enter another client's apartment and staff was unsure if the strap had been placed on the door. The client's life care management record indicated the following; February 4, 2010, the resident does wander out of the apartment; April 19, 2010, the client was found in another client's apartment; April 28, 2010, indicated the home health aide (HHA) could not locate the client, her husband stated she went out of the apartment to throw out the trash, and the HHA checked the building and found her in another male client's apartment; May 7, 2010, the client was found in another resident's apartment and that the husband was not aware the client was not in the apartment; May 26, 2010, the client went into another client's apartment after returning from day care program; and September 26, 2010, the client was up in the hallway during the night attempting to enter another client's apartment. The client's nursing assessment, dated February 4, 2010, had not been updated to reflect the need for the use of the straps. The client's record did not contain documentation to reflect less restrictive options had been tried or the risks of strapping the doors closed.

During a tour of the client's apartment on November 3, 2010, with employee BD (registered nurse/RN) a sign was observed on the outside of the apartment door alerting staff to open the door slowly because there was a strap on the door. The client's family was at the apartment at the time and indicated that the strap was to be used at all times to prevent the client from leaving the apartment and also showed the surveyor and employee BD another strap that is used to strap the client's hall closet door to the bathroom door to prevent the client from getting to the living room and kitchen at night. Employee BD was unaware that this second strap was being used.

When interviewed November 2, 2010, employee BF (registered nurse) stated that the strap was to be placed on the apartment door to prevent the client from wandering out of the client's apartment. Employee BF also stated that there was no assessment for the use of the straps on the door or that less

restrictive options had been tried or that the risks of strapping the doors shut had been explained to the client or family.

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: Thirty (30) days

11. MN Statute §626.557 Subd. 14(b)

Based on observation, record review and interview, the licensee failed to ensure a current individualized assessment of client vulnerabilities and/or an individual abuse prevention plan for five of seven client (A3, B2, B3, B4 and H1) records reviewed. The findings include:

Client A3 began receiving services from the licensee on January 27, 2009. Client A3's vulnerability assessment, dated December 9, 2009, identified the following areas as being vulnerable: the client was oriented to person, place and time, but not aware of the date; has a chronic condition/pain disability; has functional limitations; presence of risk factors in the environment or with other family members and at risk or had a history of falls. There were no specific measures identified for these areas to assist in minimizing the risk of abuse to the client. In addition, nursing progress notes in client A3's record, dated October 23, 2010, July 22, 2010, and May 20, 2010, indicated that the client was found outside the building either in his pajamas or unclothed. Nursing progress notes dated June 2 and 16, 2010, July 22, 2010, August 25, 2010, and October 8 and 23, 2010, indicated client A3 has become "more confused" and required more services due to declining cognition. The client's vulnerability assessment was not updated to reflect these changes.

When interviewed November 3, 2010, employee AC (registered nurse) confirmed client A3's vulnerability assessment had not been updated to include the client's declining cognition and increased vulnerability, nor did it include specific measures to assist in minimizing the risk of abuse of abuse to the client in the areas the client was identified as vulnerable.

Client B2 began receiving services on April 6, 2010. The client has a diagnosis of Alzheimer's disease. The client's life care management record indicated the following; February 4, 2010, the resident does wander out of the apartment; April 19, 2010, the client was found in another client's apartment; April 28, 2010, indicated the home health aide (HHA) could not locate the client, her husband stated she went out of the apartment to throw out the trash, and the HHA checked the building and found her in another male client's apartment; May 7, 2010, the client was found in another resident's apartment and that husband was not aware the client was not in the apartment; May 26, 2010, the client went into another client's apartment after returning from day care program; and September 26, 2010, the client was up in the hallway during the night attempting to enter another client's apartment. The vulnerable adult assessment dated February 2, 2010, did not address the vulnerability of wandering. The client's vulnerable adult assessment had not been updated to reflect the client's wandering. When interviewed November 3, 2010, employee BD (registered nurse) stated the vulnerable adult assessment, dated February 3, 2010, had been completed prior to the client beginning services and had not been updated to reflect the client's wandering.

Client B3 lacked a plan to minimize the vulnerability risk areas that were identified on the admission health history and nursing assessment, dated November 23, 2009. The client was identified with the following risk areas: 1) Not able to manage finances. 2) Not able to understand/follow directions. 3) Has functional limitations. 4) Has visual difficulties, and 5) Has contact with other vulnerable adults. The client's plan of care lacked directives to minimize the risk of the above identified vulnerabilities.

Client B4's admission health history and nursing assessment completed on November 19, 2009, identified the following vulnerable risk areas: 1) not able to manage finances, and 2) has contact with other vulnerable adults. The client's plan of care lacked directives to minimize the above risks.

The agency's admission health history and nursing assessment form included the vulnerability assessment section. This section also included the statement "A plan to minimize the risk of abuse/neglect as identified in this assessment, of both the client and other vulnerable adults, has been established and documented in the employee assignment." This section was not checked off as completed in either B3's or B4's assessment. When interviewed November 2, 2010, at 4:50 p.m. employee BD (registered nurse) verified there was no plan identified to minimize the vulnerability risk areas that were identified for clients B3 or B4.

Client H1 was admitted and began receiving home health services May 7, 2008. The vulnerable adult assessment, dated May 6, 2008, indicated the client was able to access adequate nutrition and that the spouse provided medication administration. When interviewed November 2, 2010, employee HE (unlicensed staff) stated client H1 could not stand anymore and employees administered medications. When interviewed November 2, 2010, person G stated client H1 was barely able to move his hands anymore. When interviewed November 2, 2010, employee HF (RN) stated that the VA assessment certainly wasn't current anymore.

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

TIME PERIOD FOR CORRECTION: Thirty (30) days

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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7004 1350 0003 0567 0131

August 14, 2007

Carol Overby, Administrator
Agewell Home Care
4940 Viking Drive Suite 545
Edina, MN 55435

Re: Results of State Licensing Survey

Dear Ms. Overby:

The above agency was surveyed on July 23, 24, 25, and 30, 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

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: AGEWELL HOME CARE

HFID #: 23501

Date(s) of Survey: July 23, 24, 25 and 30, 2007

Project #: QL23501004

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** ____Met _X_Correction Order(s) issued _X_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
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** ____Met _X_Correction Order(s) issued _X_Education Provided **Expanded Survey** ____Survey not Expanded _X_Met ____Correction Order(s) issued _X_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** _X_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 4668.0065 Subp. 1

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that employees had tuberculosis screening prior to providing direct care to clients for one of two licensed employees (C) records reviewed. The findings include:

Employee C began working as a licensed direct care / managerial staff February of 2006. There was no evidence of tuberculosis screening in her record. The Chief Operating Officer confirmed there was no screening in the record.

2. MN Rule 4668.0100 Subp. 4

INDICATOR OF COMPLIANCE: # 5

Based on record review and interview, the licensee failed to ensure that unlicensed personnel were instructed by the registered nurse (RN) in the proper method to perform a delegated nursing procedure and demonstrated to the RN that he/she was competent to perform the procedure for one of five current clients (#5) records reviewed. The findings include:

Client #5's record indicated he received eye care twice daily between July 1, 2007, and July 25, 2007 form the employee #E an unlicensed direct care staff. During an interview July 24, 2007, client #5 reported that he had trouble with eye infections. Client #5's record lacked a procedure and directions for the eye care. There was no evidence that employee #E had received instruction from an RN or demonstrated competency related to eye care. When interviewed July 25, 2007 the RN confirmed that instructions and a competency test related to eye care had not been performed.

3. MN Rule 4668.0150 Subp. 3

INDICATOR OF COMPLIANCE: # 6

Based on record review and interview, the licensee failed to ensure that orders for medications and treatments were dated and signed by the prescriber in three of six client (#2, #4 and ##5) records reviewed. The findings include:

Client #2 began receiving medication set up January of 2007. Clients #4 and #5 began receiving medication administration July of 2007. Physician's orders for clients #2, #4 and #5, had not been signed or dated by the prescriber. When interviewed, July 25, 2007, Chief Operating Officer confirmed the above findings.

A draft copy of this completed form was left with Lisa Weber, COO, at an exit conference on July 30, 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).